



**UW PACC**

Psychiatry and Addictions Case Conference

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# DIAGNOSING MENTAL HEALTH DISORDERS IN OUD

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# SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?



# OBJECTIVES

1. Review prevalence of co-occurring disorders with OUD
2. Highlight clinical considerations in diagnostic process
3. Share screening tools for mental health disorders

**Research Report**

Revised April 2020

# Common Comorbidities with Substance Use Disorders Research Report

- Comorbidity is when two illnesses occur in the same person simultaneously or sequentially.
- The illnesses interact, affecting the course and prognosis of both.

# WHY IS THERE COMORBIDITY?

- **Common risk factors can contribute to both** – Genetic vulnerability, epigenetic influences (stress/trauma), shared brain pathways involvement (reward, impulse control, decision making) and neurotransmitter systems implicated in both.
- **Mental illness can contribute to drug use** – theory of self medication.
- **Substance use can contribute to development of mental illness** – kindle predisposition to develop illness

- **Half** of those who experience mental illness during their lives will also experience a SUD and vice versa
- Patients with comorbid disorders demonstrate poorer treatment adherence and higher rates of treatment dropout than those without mental illness
- **43%** of patients in SUD treatment for OUD had a dx of mental illness – depression and anxiety

- Patients entering treatment for SUDs should be screened for psychiatric illnesses and vice versa.
- Integrated treatment for comorbid drug use and mental illness is superior when compared to separate treatment of each

## **Mental Health and Psychosocial Needs of Patients Being Treated for Opioid Use Disorder in a Primary Care Residency Clinic**

[Stephanie A. Hooker](#),<sup>1,2</sup> [Michelle D. Sherman](#),<sup>1</sup> [Mary Lonergan-Cullum](#),<sup>1</sup> [Adam Sattler](#),<sup>1</sup> [Bruce S. Liese](#),<sup>3</sup>  
[Kathryn Justesen](#),<sup>1</sup> [Tanner Nissly](#),<sup>1</sup> and [Robert Levy](#),<sup>1</sup>

- 100 patients - OUD on buprenorphine
- **44%** anxiety, **31%** depression
- **81%** traumatic event, **52%** PTSD – only **25%** shared dx with PCP on initial visit.
- 54% unemployed, 75% low income, 51% food insecure
- 67% retained at 6 months
- Hx of IVDU were more likely to discontinue treatment



## PRIMARY PSYCHIATRIC DISORDER VS SUBSTANCE INDUCED



- Clarify chronologic onset of symptoms
- Ask about last use (>30 days)
- Distinguish if symptoms occurred in presence/absence of substance use
- Clarify relation to substance use
- Reassess after period of abstinence

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**ID #:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

# Mood Disorder Questionnaire (MDQ)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Check (✓) the answer that best applies to you.  
Please answer each question as best you can.

	Yes	No
<b>1. Has there ever been a period of time when you were not your usual self and...</b>		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family in trouble?	<input type="radio"/>	<input type="radio"/>
<b>2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? Please check 1 response only.</b>	<input type="radio"/>	<input type="radio"/>
<b>3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? Please check 1 response only.</b>		
<input type="radio"/> No problem <input type="radio"/> Minor problem <input type="radio"/> Moderate problem <input type="radio"/> Serious problem		
<b>4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?</b>	<input type="radio"/>	<input type="radio"/>
<b>5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?</b>	<input type="radio"/>	<input type="radio"/>

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

- Mood lability, elevation, swings:
  - Intoxication
  - Withdrawal
  - Affective Disorder
  - Personality Disorder
  - Anxiety “racing thoughts”

## GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals    \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ =

*Total score*    \_\_\_\_\_

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at [rs8@columbia.edu](mailto:rs8@columbia.edu). PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

## Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

## PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES

NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

---

### **In the past month, have you...**

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES

NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

YES

NO

3. been constantly on guard, watchful, or easily startled?

YES

NO

4. felt numb or detached from people, activities, or your surroundings?

YES

NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

YES

NO

PCL-5

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

## Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date				
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.		Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
3. How often do you have problems remembering appointments or obligations?						
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
<b>Part A</b>						
7. How often do you make careless mistakes when you have to work on a boring or difficult project?						
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
10. How often do you misplace or have difficulty finding things at home or at work?						
11. How often are you distracted by activity or noise around you?						
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
13. How often do you feel restless or fidgety?						
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?						
15. How often do you find yourself talking too much when you are in social situations?						
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
17. How often do you have difficulty waiting your turn in situations when turn taking is required?						
18. How often do you interrupt others when they are busy?						
<b>Part B</b>						



Brief Addiction Monitor (BAM)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**1. In the past 30 days, would you say your physical health has been:**

- Excellent
- Very Good
- Good
- Fair
- Poor

**2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

**3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?**

- 0
- 1-3
- 4-8
- 9-15
- 16-30

# THANK YOU!



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