CHAPTER 7
COMORBID PSYCHIATRIC ILLNESS

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7.1. Introduction

Co-occurring mental health disorders among opioid treatment program (OTP) patients are more the rule than the exception. People with serious mental illness are three times more likely to suffer from alcohol or drug abuse. Similarly, people with substance use disorders (SUD) are three times more likely to have mental illness than those without SUD [227]. Among the homeless, rates of alcohol and drug abuse are six to seven times higher than those in the general population [228]. Eighty-two per cent of prisoners with mental health disorders have SUD [229]. Half of the total cigarette sales are to those with mental illness, and in California alone, 40,000 people died each year from tobacco-related diseases, at a 16 billion dollar cost between health care and lost productivity [230, 231].

Although co-occurring disorders are common, they are often missed or neglected and many patients do not receive adequate treatment [232]. There is a general lack of SUD screening in the evaluation of psychiatric patients, and likewise, there is little psychiatric screening for presence of co-occurring psychiatric disorders among patients seeking treatment for SUD. OTP physicians can play an important role in closing this public healthcare gap by screening, diagnosing and initiating appropriate mental health treatment, and making referrals for provision of comprehensive, collaborative care.

7.2. Evaluation

Screening for co-occurring disorders is best incorporated into the admission evaluation process and continued throughout treatment. Many validated screening and assessment tools are available in the public domain through the Substance and Mental Health Services Administration. Table 7.2.1 lists examples of brief screening tools that use self-reported data and do not require special training to administer. For consistency, the clinic should establish a policy to determine the timing and methodology of screening.

Screening tools are just what they are called: screening tools. Each has strengths and weaknesses. Clinicians should familiarize themselves with the tools they choose to use and realize that a positive screen alerts the clinician to the need for more in depth evaluation. A screening tool is not a substitute for a thorough, face-to-face interview with an experienced clinician upon which a diagnosis is based. The current accepted psychiatric diagnoses are governed by the DSM-5 of the APA [2].

Mental health disorders may pre-exist, coincide with, or occur independently of drug effects. They may also follow as a consequence of substance use. They may complicate the evaluation of, treatment planning for, and treatment response to both disorders. Until recently, many clinicians were taught that a mental health disorder diagnosis should not be made in the presence of drug use because drugs alter the clinical manifestations of mental health disorders. This may be true when patients are intoxicated or in early withdrawal, so the best time to evaluate for co-occurring mental health disorders is after acute drug effects have worn off, which is usually within a few days to a few weeks. Unfortunately, persistent psychosis, lasting months to years, can occur with chronic severe stimulant use, especially methamphetamine,

Table 7.2.1

Example of Screening Tools

Depression	Patient Health Questionnaire (PHQ-9)
Bipolar Disorder	Mood Disorder Questionnaire (MDQ)
Anxiety Disorder	Generalized Anxiety Disorder 7-item (GAD-7) scale
Trauma	PTSD Checklist for DSM-5 (PCL-5) Life Event Checklist Domestic Violence Screening Tool: Hurt, Insulted, Threatened with Harm and Screamed (HITS)
Suicide	Columbia-Suicide Severity Rating Scale (C-SSRS)

and neurocognitive impairment may not resolve after toxic inhalant use. It is generally accepted among addiction physicians that a co-occurring mental health disorder is present if symptoms such as disabling depression or anxiety persist despite a sustained abstinence from substance use of around 6 months.

Accurate diagnosis may be difficult in the early stages of substance use treatment because symptoms of intoxication and withdrawal often overlap with common mental health symptoms like anxiety, depression, poor concentration, and psychosis. It is optimal to allow resolution of acute intoxication and/or withdrawal prior to initiating non-emergent, maintenance psychopharmacological treatment [233]. In cases requiring more urgent treatment, such as suicidality or persistent psychosis, consideration should be given to the patients' personal and family history of MH diagnosis and treatment, including suicidal ideation or attempts, and the temporal relationship of current symptoms to substance use. These factors may help to guide the preliminary MH diagnosis and treatment of acute mental health disorders. Patients presenting with risk of violent behavior (i.e., toward others or self) generally require the structure and safety of an inpatient setting in order to stabilize mental health and substance-related symptoms.

Other clinical information that can aid in diagnosing mental health disorders in this context include family history of SUD and mental health disorders, and the patients' temporal developmental history of the emergence of mental health symptoms. Collateral history from family, friends, and prior treatment providers, as well as toxicological monitoring, and serial clinical observations over time can all be helpful in determining whether the clinical presentation is due to substance use, an independent psychiatric disorder or a combination of the two.

7.3. Treatment

Fragmentation has been, and continues to be, a barrier to optimizing the management of co-occuring SUD and psychiatric disorders. This barrier is recognized, is an ongoing topic of discussion and has yet to be resolved. In general, treatment for co-occurring substance use and psychiatric disorders is provided in one of three models: sequential, parallel, or integrated.

The sequential model is perhaps the most traditional. In this model, the SUD that brought the patient into treatment, for example OUD would be treated while co-occurring disorders, like alcohol and tobacco would be left unaddressed or treatment would be postponed until later. A classic example of this is the residential treatment programs that allowed patients to bring cigarettes and smoking paraphernalia into the facility without restriction and/or incorporated smoking breaks into the program schedule. There was a widespread misconception that addressing the co-occurring disorders would detract from progress in recovery from the primary disorder. In the sequential model of treatment, patient with an OUD (for example) would be treated with methadone at the methadone clinic and later sent to a mental health clinic for the treatment of his or her PTSD or anxiety.

The parallel model is an improvement over the sequential approach. In this model, co-occurring disorders are treated at the same time but in different treatment settings and by different providers.

The integrated model is the ideal one. Truly integrated care means that patients with co-occurring disorders are offered services for both disorders in one location by a cross-trained staff. Integrated care lowers barriers to receiving treatment for both conditions.

Unfortunately, the term integrated services does not consistently refer to the optimized treatment described above. It may be used in a broad and imprecise way to include services that provide individual, group, couples and family therapy.

In reality, integrated models of care are uncommon in SUD treatment. Traditional OTPs, methadone clinics, are rarely equipped to handle the mental health needs of their patients on site. Historically OTP staff have a background in substance use treatment with limited mental health treatment experience. When these limitations exist in an OTP, patients with mental health symptoms would benefit from referral to a psychiatrist in the community or a mental health clinic. Coordination of care between the OTP physician and the mental health care provider is essential. The OTP is in a position to observe the patient more frequently, so can alert the psychiatrist/mental health provider if significant clinical change occurs.

7.3.1. Treatment of Acute Manifestations

The initial management of patients presenting with acute psychiatric symptoms is primarily determined by their clinical manifestations. The underlying psychiatric diagnosis, if one exists, is deferred for later consideration.

When treating patients with acute psychiatric manifestations, the paramount considerations are patient safety and resolution or stabilization of symptoms. Management strategies include: hospitalization, use of medication, behavioral therapies, and calm reassurance in a quiet, non-threatening environment in an effort to "talk down" the patient. The latter approach is often effective for patients with acute drug-induced psychosis. Patients with more persistent symptoms may require short term treatment with medications, generally a short acting antipsychotic or an anxiolytic.The risk of harm to self or others should be assessed by a qualified mental health clinician with training and experience in assessments for suicidality, and levels of risk for harm to self and others. A plan for care is essential. The need for hospitalization should be carefully considered. State law for managing the assessment results must be followed, including Duty to Warn.

In addition to acute stabilization of symptoms and assurance of patient safety, a major goal of this phase of treatment is establishing trust and to forming a treatment alliance that will facilitate the progression of treatment from the acute to the the maintenance phase.

7.3.2. Maintenance and Relapse Prevention

During the maintenance phase, the main goals are to avoid:

1. over-treating a drug-induced psychiatric disorder that may resolve with cessation of use, and
2. prematurely discontinuing treatment of an underlying psychiatric disorder that is prone to relapse once treatment is discontinued.

While there are no hard and fast rules about treatment during the maintenance phase, a reasonable approach is to proceed cautiously, being aware of the possibility of over treatment, observing for signs and symptoms of medication toxicity and watching for recurrence of symptoms after treatment is discontinued.

The choice of pharmacotherapy should be strategic, choosing one medication to address multiple issues whenever possible. For example, a medication like bupropion should be considered when smoking, stimulant use, and depression are clinical concerns.

Many times co-occurring substance use disorders and mental health disorders in a given patient are treated separately, with one prescriber managing the SUD and another MH disorder. Each prescriber adheres to the current recommended practices and applicable guidelines for the disorder he or she is treating. In this situation,

Table 7.3.1

Examples of Important Drug-drug Interactions Between Psychotropic Medications and Methadone [234, 235]

Medication	Interaction with methadone
SSRIs	■ QT prolongation ■ Fluvoxamine may increase methadone levels ■ Methadone may enhance serotonergic effects (risk serotonin syndrome)
SNRIs	■ Duloxetine and methadone levels may increase ■ Methadone may enhance serotonergic effects (risk serotonin syndrome)
TCAs	■ QT prolongation ■ Methadone may increase desipramine levels ■ Methadone may enhance serotonergic effects (risk serotonin syndrome)
St. John's wort	■ St. John's wort may decrease methadone levels
Antipsychotics	■ Sedation, cognitive dysfunction, QT prolongation
Benzodiazepines and zolpidem-like sedatives	■ Respiratory depression, sedation, cognitive dysfunction
Phenytoin, carbamazepine, phenobarbital	■ Decreases methadone levels and can cause opioid withdrawal

the prescribers must be aware of common drug-drug interactions between such medications used to treat these disorders. This is particularly true when a patient is being prescribed methadone. Serious interactions may produce sedation, QTc prolongation and/or anticholinergic reactions. Many mental health medications have the potential to be a metabolic inhibitors or potentiators of methadone, which may produce fluctuation in serum methadone levels. When levels fall, patients are at a risk of adverse effects related to overmedication, or methadone toxicity (see Table 7.3.1).

When MH medications are prescribed for patients with co-occuring SUD, the abuse liability of the medication must be considered, whether or not the medication is a controlled substance. To the extent possible, medications with the least potential for misuse or adverse interaction should be prescribed. For example, non-benzodiazepines alternatives would be preferred for the management of anxiety in patients on opioid agonist treatment for OUD because the risk of respiratory depression increases when benzodiazepines are taken in combination with methadone or buprenorphine (CSAT 2005). In addition, patients with OUD are at increased risk of becoming addicted to benzodiazepines. When medications with abuse potential are prescribed, risk mitigation procedures are essential and include use of the lowest effective dose on a fixed dosing schedule (avoid "as needed") dispensing medications at the OTP window to allow observed dosing, and close monitoring through toxicology testing, call backs, pill counts and review of CURES reports (CA's PDMP).

7.4. Behavioral Therapies

In the treatment of patients with co-occurring MH and SUD, behavioral therapies may serve as an important adjunct to pharmacotherapies or may be sufficient on their own. In some cases, a trial of behavioral theray should e considered first, and pharmacotherapy added if it proves insufficients. Behavioral therapies include individual, family and group modalities.

Examples of behavioral therapies developed for co-occurring disorders include:

- Integrated Group Therapy (for bipolar disorder and substance use; Weiss and Connery 2011)
- Seeking Safety (for PTSD and substance use disorder; Najavits 2002)
- The Women's Recovery Group (for women with co-occurring substance use disorders and mental health/trauma disorders; Greenfield 2016).

Examples of behavioral therapies addressing substance use disorders include:

- Group Drug Counseling (Daley and Douaihy 2011)
- Cognitive Behavior Therapy for Relapse Prevention (Carroll 1998)
- Motivational Enhancement Therapy (Miller 1995).

Case management to address basic needs, such as housing, finances, access to social services, is an essential aspect of an integrated and comprehensive treatment plan. Family education and support are critical to optimizing recovery outcomes.

People with SUD have higher rates of mortality than the general population, especially from suicide and violence (Dwyer-Lindgren et al. 2018). Because of this it is important to carefully assess suicidality and violence risk during longitudinal care of patients with opioid use disorders for risk of suicidality and violence during longitudinal care, especially in the presence of co-occurring disorders (Bohnert et al. 2017). Knowledge of risk factors (e.g., depression, personality disorder, psychosis, and prior self-harm or suicide attempts) and serial careful assessment throughout the course of treatment can help to identify patients at increased risk and facilitate timely and appropriate interventions.

Changes in a patient's condition, such as worsening anxiety, and mood symptoms, insomnia, negative thoughts (despair, hopelessness), substance use, interpersonal conflicts, financial stressors, or other negative life events, warrant safety re-assessment. Changes in psychosis (hallucination, delusions, and disordered or disorganized thinking) are commonly associated with elevated risk of harm to self and/or others. In all cases, treatment planning includes interventions to address identified risk. Interventions may include increased frequency of monitoring, adjustment of medication(s), and provision of more intensive psychosocial adjuncts to assist a patient to acquire and use more effective coping skills. High-risk circumstances, involving imminent risk of harm to self or others, warrant immediate referral for hospitalization.

7.5. Most Common Psychiatric Disorders

7.5.1. Clinical Considerations for the Treatment of Common Co-occurring Disorders

Schizophrenia

Over a third of patients with schizophrenia meet the diagnostic criteria for a SUD. The most commonly used substances in this population include nicotine, cocaine, alcohol, and cannabis. In this context, some of the second-generation antipsychotics are advantageous, such as clozapine, risperidone, olanzapine, and aripiprazole. OTP physicians who come from specialties outside of psychiatry may choose to refer these patients to a psychiatrist, continuing to prescribe for the OUD and coordinating care as needed.

Bipolar disorder

Bipolar disorder, especially the rapid-cycling type, commonly co-occurs with SUD. Use of certain anticonvulsants may be advantageous over lithium, but the plan of treatment should be developed after and guided by the results of a thorough psychiatric assessment.

Depression and Depressive Disorders

Depression is perhaps the most common psychiatric symptom reported by patients seeking treatment for SUD. Many of these patients are experiencing major life crises. Some are being compelled to enter treatment because of legal, social or financial issues. Not all patients presenting with symptoms of depression have a depressive disorder. Intoxication with and withdrawal from multiple substances may produce symptoms of depression. However, most depressive symptoms exhibited by patients admitted for treatment of alcohol, cocaine, methamphetamine and opioid use disorders cleared within a matter of a few days to a few weeks. Depressive symptoms that persist beyond a few weeks warrant serious consideration of a co-occurring depressive disorder requiring treatment, especially when there is a history of, depression, suicidal ideation or suicide attempts during a period of sustained abstinence. The co-occurrence of opioid use disorder and depressive disorder heightens suicide risks (Darke et al. 2015).

Intervention for presumed depressive disorder, especially in patients with significant functional impairment should be considered. Effective treatment includes the use of antidepressants (first-line agents include selective serotonin reuptake inhibitors or mixed serotonin-norepinephrine reuptake inhibitors, bupropion, mirtazapine) and behavioral treatments.

Anxiety

Anxiety is common in patients with substance use disorders. It is important to distinguish between anxiety that is normal and helps to facilitate positive behavior change, and anxiety that is interfering with treatment or causing significant functional impairment. In the latter cases, behavioral therapies, especially cognitive behavioral therapies and exposure-desensitization therapies, provide the safest and most effective treatment for anxiety disorders and are preferred. These may be delivered alone or combined with serotonergic antianxiety medications.

The use of benzodiazepines for the treatment of anxiety in patients with co-occuring substance use disorders deserves some comments. Benzodiazepines are effective antianxiety medications, particularly in the short term, but this class of medication poses different risks for patients with SUD, especially opioid and alcohol use disorders, than it does for patients without use disorders.

Patients in treatment for SUDs are often anxious because of stressful life events and crises, past, present and anticipated. They find that benzodiazepines bring prompt relief for the duration of their pharmacologic effect, but that anxiety returns when they wear off. Having experienced this rapid relief, many become unwilling to try non-benzodiazepine alternatives that take weeks to months and several dose adjustments to reach full therapeutic effect. When these patients remain on benzodiazepine indefinitely, the dose tends to escalate as the patient develops tolerance. With chronic use, they may lose their efficacy, but despite describing significant amounts of anxiety, patients may believe that benzodiazepines are the only thing that works for them. Discontinuation causes an unpleasant and potentially dangerous withdrawal. Attempts to taper must be gradual and work best if non-benzodiazepine anxiolytics are started to help manage anxiety associated with withdrawal and/or re-emergence of the original anxiety disorder. Because of the difficulties described, caution should be exercised when and if benzodiazepines are started; an exit plan is also recommended.

Patients who use heroin, or are prescribed methadone or other opioids, often find that taking a benzodiazepine at the same time produces a unique and highly enjoyable high, particularly when their tolerance to opioids no longer allows them to experience a high with the opioid alone.

Trauma and PTSD

Patients with substance use disorder commonly experienced childhood and adult traumas, which may lead to posttraumatic stress disorder (PTSD). PTSD and substance use are often inter-reinforcing conditions: PTSD can lead to self-medication to manage symptoms, and substance use increases risk of exposure to trauma (e.g., intimate partner violence and sex trafficking, exposure to criminal violence and substance-related injury) as well as the risk of developing PTSD after experiencing a traumatic event (Chilcoat and Breslau 1998). Treating the affected population may be particularly challenging, as patients with a history of trauma may have more severe psychiatric and medical comorbidities, be mistrustful, and struggle with treatment engagement. Therefore is it is important to assess for PTSD, recognize ways that trauma may be affecting the patient, and

Table 7.4.1

The Role of the Otp Clinician with Regard to Co-occurring Mental Health Disorders

- Evaluate for co-occurring mental health and trauma disorders at intake and establish a system of ongoing, longitudinal re-assessment
- Provide integrated treatment and/or appropriate referrals to community providers along with highly collaborative co-management
- Promote simultaneous treatment for both disorders to counter patients' tendency to favor addressing one disorder over the other
- Recognize risk factors for harm to self or others, assess carefully, and refer to acute treatment if needed
- Be aware of drug-drug interactions between medications used to treat MH disorders and OUD, especially methadone; choose medications to minimize the risk for adverse interactions
- Integrate family, significant others, and legal systems in patient care and emphasize the importance of this with patients receiving care

provide trauma-informed interventions. Additionally, both disorders should be treated concurrently, as a reduction in substance use may unmask PTSD symptoms. Evidence-based integrated therapies for co-occurring trauma disorders and substance use disorder include Seeking Safety (Najavits 2002) and Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE; Back et al. 2014). Case management is an essential aspect of ongoing safety assessment and family management in those with trauma disorders.

Personality Disorders

Antisocial personality disorder (ASD) is common among people with OUDs, and associated with poorer treatment outcomes. At the same time, many patients with OUD may be misdiagnosed with ASD due to behaviors associated with the addiction. For instance, as with other illicit drug use disorders, patients who are actively using opioids may engage in antisocial behaviors to obtain heroin or illicit opioids. Daily use of opioids is expensive. People who are desperate to obtain opioids to avoid the painful opioid withdrawal syndrome may lie, steal, or sell drugs to obtain money to purchase opioids. These behaviors remit for persons without ASD when they are abstinent from illicit drugs and tend to return with relapse to drug use. This pattern is different from what the DSM-5 criteria required to diagnose ASD.

Thoughtful assessment is advised when evaluating patients who present with challenging behaviors that may relate solely to OUD or may reflect a co-occurring personality disorder. Patients with true personality disorder, especially borderline personality disorder, require specific treatments to reduce risk for self-harm and suicide. Many OUD patients with co-occurring personality disorder are also victims of intimate partner violence and sex trafficking, adding another compelling need for thoughtful and accurate assessment and provision of trauma-informed care and violence prevention. Positive treatment outcomes require individualized care for each person's history and social determinants of health.

Where ASD is diagnosed, in addition to referring the patient to appropriate treatment, a well-structured treatment plan includes clear behavioral boundaries and contingencies for OTP policy violations. Collaboration with legal systems is a protective component of comprehensive care and patients post-incarceration are at very high risk for opioid poisoning with relapse; thus OTPs serve an important transitional function for this population.

Treating patients with co-occurring disorders is challenging, but also equally rewarding. While some patients, especially those with personality disorders, may present a greater challenge, proper diagnosis, effective planning, and a cooperative approach to treatment can yield positive results.