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The authors reported no potential conflict of interest relevant to this article.

Caring for patients with co-occurring mental health & substance use disorders

Consider substance abuse if Tx for mood or anxiety disorders is ineffective. Don't defer treating a mental health issue until a substance use disorder is resolved.

THE CASE

Janice J* visits her family physician with complaints of chest pain, shortness of breath, and heart palpitations that are usually worse at night. Her medical history is significant for deep vein thrombosis secondary to an underlying hypercoagulability condition (rheumatoid arthritis) diagnosed 2 months earlier. She also has a history of opioid use disorder and has been on buprenorphine/naloxone therapy for 3 years. Her family medical history is unremarkable. She works full-time and lives with her 8-year-old son. On physical exam, she appears anxious; her cardiac and pulmonary exams are normal. A completed workup rules out cardiac or pulmonary problems.

- WHAT IS YOUR DIAGNOSIS?
- HOW WOULD YOU TREAT THIS PATIENT?

**The patient's name has been changed to protect her identity.*

CO-OCCURRING DISORDERS: SCOPE OF THE PROBLEM

Co-occurring disorders, previously called "dual diagnosis," refers to the coexistence of a mental health disorder and a substance use disorder. The obsolete term, dual diagnosis, specified the presence of 2 co-occurring Axis I diagnoses or the presence of an Axis I diagnosis and an Axis II diagnosis (such as mental disability). The change in nomenclature more precisely describes the co-existing mental health and substance use disorders.

Currently the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*, (*DSM-5*) includes no diagnostic criteria for this dual condition.[1] The criteria for mental health disorders and for substance use disorders comprise separate lists. Criteria for substance use disorder fall broadly into categories of "impaired [self] control, social impairment, risky behaviors, increased tolerance, and withdrawal symptoms."[1] It is estimated that 8.5 million US adults have co-occurring disorders, per the 2017 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration.[2] Distinguishing which of the 2 conditions occurred first can be challenging. It has been suggested that the lifetime prevalence of a mental health disorder with a coexisting substance use dis-

TABLE 1

US prevalence of mental health disorders and their association with co-occurring substance use disorder

Mental health disorder	General population prevalence	Prevalence in co-occurring substance use disorder
Anxiety[1,4,5]	28.8%	24.5%
Major depression[1,4,5]	7% (12 mo)	21.8%
Schizophrenia[1,6]	0.3%-0.7%	10%-70%[a]
Bipolar I and bipolar II[1,7]	0.6%-2.4%	30%-50%
Post-traumatic stress disorder[1,8]	3.5%, 8.7% (age > 75 y)	38%

[a]Although the overall prevalence of schizophrenia is low, the prevalence of associated substance use disorders has varied dramatically in studies, with some findings as high as 70%.

order is greater than 40%[3,4] (**TABLE 1**[1,4-8]). For patients with schizophrenia and bipolar disorder, these numbers may be higher.

The consequences of undiagnosed and untreated co-occurring disorders include poor medication adherence, physical comorbidities (and decreased overall health), diminished self-care, increased suicide risk or aggression, increased risky sexual behavior, and possible incarceration.[9]

WHEN SHOULD YOU SUSPECT CO-OCCURRING DISORDERS?

With some patients, only one diagnosis may be apparent at a given point, which could make it difficult to expeditiously recognize the onset of a co-occurring condition. For example, if a patient with anxiety has been treated successfully for years and then experiences a worsening of symptoms, it's possible a physician might increase the dosage of anxiety medication without reevaluating for a substance use disorder. However, when both co-occurring disorders are present, the patient usually exhibits a greater number of symptoms and, if the full scope of the condition remains unrecognized, will likely respond poorly to therapy and have a prolonged course to resolution.[3,8-13] Consider a co-occurring substance use disorder if treatment resistance persists, or if a patient has a recurrence or an exacerbation of a previously well-treated psychiatric disorder.

Diagnosing a second condition can also be difficult when a patient's symptoms are actually adverse effects of substances or prescribed medications. For example, a patient with worsening anxiety may also exhibit increasing blood pressure resistant to treatment. The cause of the patient's fluctuating blood pressures may actually be the result of his or her use of alcohol to self-treat the anxiety. In addition to self-medication, other underlying factors may be at play, including genetic vulnerability, environment, and lifestyle.[14] In the case we present, the patient's conditions arose independently.

Anxiety disorders, with a lifetime risk of 28.8% in the US population,[4] may be the primary mental health issue in many patients with co-occurring disorders, but this cannot be assumed in lieu of a complete workup.[2,8,9,15] Substance use disorders in the general population have a past-year and lifetime prevalence of 14.6%.[1,4,16,17] Because the causal and temporal association between anxiety and substance abuse is not always clear, it's important to separate the diagnoses of the mental health and substance use disorders.

MAKING THE DIAGNOSIS

To make an accurate diagnosis of co-occurring disorder, it is essential to take a complete history focusing on the timeline of symptoms, previous diagnoses and treatments, if any, and substance-free periods. Details gathered from these inquiries will help to separate symptoms of a primary mental health disorder from adverse effects of medication, withdrawal symptoms, or symptoms related to an underlying chronic medical condition.

CONTINUED

The estimated lifetime prevalence of coexisting mental health and substance use disorders is > 40%.

TABLE 2

Medications commonly used to treat mental health and substance use disorders

Mental health/substance use disorder	First-line medication	Additional therapy based on symptoms
Psychotic disorder[25]	Antipsychotic	SSRI or SNRI
Bipolar[26]	Mood stabilizer	SSRI or SNRI
Depressive disorder[27]	SSRI or SNRI	Bupropion, TCA, MAOI
Anxiety disorder[28]	SSRI or SNRI	TCAs benzodiazepines (in certain situations)
Alcohol use disorder[29]	Naltrexone, acamprosate, disulfiram	
Opioid use disorder[30]	Naltrexone, methadone,[a] buprenorphine[a]	
Nicotine use disorder[30]	Bupropion, nicotine replacement (patches, inhalers, gum)	

MAOI, monoamine oxidase inhibitor; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant.

[a]Requires special licensing.

Optimally, the diagnosis of a mental health disorder should be considered following a substance-free period. If this is not possible, a chart review may reveal a time when the patient did not have a substance use disorder.[18]

A diagnosis of substance use disorder requires that the patient manifest at least 2 of 11 behaviors listed in the *DSM-5* over a 12-month period.[1] The criteria focus on the amount of substance used, the time spent securing the substance, risky behaviors associated with the substance, and tolerance to the substance.

DON'T DEFER MENTAL HEALTH Tx

It is necessary to treat co-occurring disorders simultaneously. The old idea of deferring treatment of a mental health issue until the substance use disorder is resolved no longer applies.[19,20] Treating substance use problems without addressing comorbid mental health issues can negatively impact treatment progress and increase risk for relapse. In a similar way, leaving substance use problems untreated is associated with nonadherence in mental health treatment, poor engagement, and dropout.[21,22]

Integrated services. Due to this condition's level of clinical complexity, the optimal treatment approach is an interdisciplinary one in which integrated services are offered at a single location by a team of medical, mental health, and substance use providers (see "The case for behavioral health integration into primary care" in the June issue at http://bit.ly/2z4dwL3). An evidence-based example of such an approach is the Integrated Dual Disorder Treatment (IDDT) model—a comprehensive, integrated method of treating severe mental health disorders, including substance use disorders.[21,22] IDDT combines coordinated services such as pharmacologic, psychological, educational, and social interventions to address the needs of patients and their family members. The IDDT model conceptualizes and treats co-occurring disorders within a biopsychosocial framework. Specific services may include medical detoxification, pharmacotherapy, patient and family education, behavioral and cognitive therapies, contingency management, self-help support groups, supported employment, residential/housing assistance, and case management services.[23,24]

Medications for the mental health component. For patients who prefer medication treatment to cognitive behavioral therapy (CBT), or for whom CBT is unavailable, treat the mental health disorder per customary practice for the diagnosis (**TABLE 2**[25-30]). For psychotic disorders, use an antipsychotic, adding a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reup-

take inhibitor (SNRI) as needed depending on the presence of negative symptoms.[25,31] For bipolar spectrum disorder, start a mood stabilizer[32]; for depressive disorders initiate an SSRI or SNRI.[27] Anxiety disorders respond optimally when treated with SSRIs or SNRIs. Buspirone may be prescribed alone or as an adjunct for anxiety, and it does not cause mood-altering or withdrawal effects. Benzodiazepines in a controlled and monitored setting are an option in some antianxiety treatment plans. Consultation with a psychiatrist will help to determine the best treatment in these situations.

In all cases, treat the substance use disorder concurrently. Treatment options vary depending on the substance of choice. Although often overlooked, there can be simultaneous nicotine abuse. Oral or inhaled medications for nicotine abuse treatment are limited. The range of pharmacologic options for alcohol use disorder includes naltrexone, acamprosate, and disulfiram.[29,33] Pharmacologic treatment options for opioid use disorder include naltrexone, methadone, and a combination of naloxone and buprenorphine.[34]

Physicians who wish to prescribe buprenorphine must qualify for and complete a certified 8 hour waiver-training course, which is then approved by the Drug Enforcement Agency (under the DATA 2000 – Drug and Alcohol Act 2000). The physician obtains the designation of a data-waived physician and is assigned a special identification number to prescribe these medications.[35,36] Methadone may be provided only in a licensed methadone maintenance program. Regular and random drug urine screen requirements apply to all treatment programs.

Psychosocial and behavioral interventions are essential to the successful treatment of co-occurring disorders. Evidence-based behavioral and cognitive therapies are recommended for promoting adaptive coping skills and healthy lifestyle behaviors in co-occurring disorder populations.[23,24,37-40] Motivational interviewing enhances motivation and adherence when patients demonstrate resistance or ambivalence.[41,42] Mindfulness-based interventions have been shown to be effective and may be particularly beneficial for treating cravings/urges and promoting relapse prevention.[37,39,40,43-46]

Psychotropic medications, as with other treatment components, are most effective when used in combination with services that simultaneously address the patient's biological, psychological, and social needs.

The grassroots organization National Alliance on Mental Illness (www.nami.org) recommends self-help and support groups, which include 12-step, faith-based and non-faith–based programs.[20]

For any treatment method to be successful, there needs to be a level of customization and individualization. Some patients may respond to medication or nonmedication treatments only, and others may need a combination of treatments.

CASE

The physician recalls a past diagnosis of anxiety and asks Ms. J if there are any new stressors or changes causing concern. The patient expresses concern about an opioid use relapse secondary to her recent diagnosis of rheumatoid arthritis, which may be life altering or limiting.

Even though she has been doing well and has been adherent to her daily buprenorphine treatment, she worries for the well-being of her family and what would happen if she cannot work, becomes incapacitated, or dies at a young age. She has never considered herself an anxious person and is surprised that anxiety could cause such pronounced physical symptoms.

The physician discusses different modalities of treatment, including counseling with an onsite psychologist, a trial of an anti-anxiety medication such as sertraline, or return office visits with the physician. They decide first to schedule an appointment with the psychologist, and Ms. J promises to find more time for self-wellness activities, such as exercise.

After 3 months of therapy, the patient decides to space out treatment to every 2 to 3 months and does not report any more episodes of chest pain or shortness of breath. JFP

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