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ASAM Practice Pearls Transcript

Optimizing Treatment for Co-occurring Psychiatric and Substance Use Disorders

Dr. Stephen Taylor: Welcome back to *ASAM Practice Pearls*, where we turn clinical expertise into everyday addiction care, one conversation at a time. I'm your host, Dr. Steven Taylor, and today I'd like to reflect on two patients that I've seen in the past month. The first is a female patient in her thirties who has schizoaffective disorder, bipolar type, and also has complicated PTSD and has a borderline personality disorder and also has a stimulant use disorder with respect to methamphetamine and opioid use disorder and a severe addiction to benzodiazepines. This patient has struggled with homelessness, with numerous crises of both mental health conditions, as well as struggling to achieve recovery from addiction, and has been a very unstable person for a long time, until recently, when she has begun to get into stable recovery and to enjoy some relative remission of her general psychiatric conditions. This is the kind of patient that we would have admitted to the dual diagnosis unit, as it was referred to back in the nineties at Bellevue Hospital, when I was doing my fellowship there in the 1990s.

The other patient is a male patient in his forties who has an alcohol use disorder, and this patient is married and has children, and has suffered some consequences from his alcohol use disorder, such as a divorce and some employment losses, but is a much more typical person that folks would think of with an alcohol use disorder. But he also has a major depressive disorder and a generalized anxiety disorder. And he will tell you that the only reason he has been able to get into stable recovery so far is because his major depressive disorder and generalized anxiety disorder were treated from the time he first entered inpatient treatment for his alcohol use disorder. And at the same time as treating his alcohol use disorder, his co-occurring general psychiatric conditions were treated. And as a result, he is doing well now.

Both of these patients are doing well now. Both of them have both general mental health conditions and severe addiction disorders, and yet, generally, people would think of the first patient as a dual diagnosis patient, and the second patient as more of a typical patient with alcohol use disorder. And yet, it dawns on me that both of these folks needed to be treated with an understanding of treating co-occurring general mental health conditions and substance use disorder.

And so, with that as an introduction, with that recognition that patients like these are more the rule than the exception, I want to introduce the expert who would be the ideal person for us to discuss this topic with, the topic of today being optimizing treatment for co-occurring psychiatric and substance use disorders, and that expert is none other than Dr. Smita Das. Dr. Das, thank you so much for joining us, for lending us your expertise, and please say hello to our audience.

Dr. Smita Das: Thank you so much for having me on the podcast today, and also for that wonderful tee-up of the introduction of those two patients, really nuanced cases, and really brings to light what we're going to be discussing hopefully here today.

Dr. Stephen Taylor: Thank you. So, let's jump right into it. What psychiatric conditions do you see most often alongside substance use disorders?

Dr. Smita Das: That's a great question, and I think your cases at the beginning really tee up some of this. So, probably the top two that we have tend to be also the top two most prevalent mental health conditions in addition to substance use disorders, but those are mood disorders, primarily, major depressive disorder, as well as generalized anxiety disorder.

In the category of anxiety, I think it's also very important to mention trauma and trauma-related disorders, things like PTSD. There is a high rate of co-occurrence, and oftentimes, with any of these conditions, individuals are in a really difficult cycle where they may be experiencing these mental health conditions and not having their symptoms improve. And so, they may be using substances or increasing use of substances as a way to cope. So those are definitely a few of the main ones that I would think about.

Another couple that come to mind that have kind of specific substances that they generally tend to have co-presentations with are ADHD, as well as some psychotic disorders or psychotic presentations. And so, these are very common.

I love the statistic that I always use from SAMHSA and NSDUH, the National Survey on Drug Use and Health, which is that, in general, over and over again, we have seen that about half of people with a substance use disorder have another mental health condition. So, definitely something, as you said, that is not the exception. It is very common.

Dr. Stephen Taylor: Thank you for that. And you're absolutely right. That is a statistic that, frankly, I have been hearing for many years, that it's roughly 50%. In terms of looking at some of the nuances of this, how would you say that the prevalence of a co-occurring psychiatric disorder may change depending on the substance? Well, for example, I presented two different patients with addiction disorders with respect to many different substances. You know, one with stimulants and opioids and benzos, the other with alcohol. How does the prevalence of the co-occurring psychiatric disorder change? Depending on the substance, or does it change?

Dr. Smita Das: Yeah, so we do have some good data that look at how that changes. And again, it's a bit of chicken-and-egg depending on how the co-occurrence happened. Did somebody have a substance use disorder and had worsening of another mental health condition? Or do they have, as I mentioned earlier, mental health condition, and the substance use disorder is exacerbated by that because of trying to relieve the symptoms?

And so, with that in mind, I'll point out a few here. So, alcohol use disorder is generally found very often with depressive disorders. Alcohol itself is a depressant, and the interesting thing is, many of them are using alcohol in a way that they feel like it helps reduce their symptoms of depression, temporarily. And at the same time, the alcohol itself is a depressant. So, that's a really an interesting discussion to have clinically with patients.

And then with opioid use disorders, of course, we do see also depression, chronic pain, and, while not a usual DSM diagnosis in the area of mental health conditions, is a very common co-occurring diagnosis, of course. And a lot of PTSD, when we're looking at the statistics of opioid use disorder and PTSD.

You mentioned in one of your cases as well, the, you know, benzodiazepines, and that also would generally fall under the co-occurring with anxiety disorders. It's unfortunately one of those things where somebody may have had anxiety, they have used a benzodiazepine to try to relieve that in the short term, but then, unfortunately, develop a benzodiazepine use disorder.

Stimulant use disorders. This is something that is interesting in the area of mood disorders—that are bipolar, as well as psychotic disorders. So bipolar can also present with psychotic symptoms. Stimulants can induce things like paranoia and hallucinations. And so, there can be some overlap there.

And then finally, cannabis use disorder, which is a topic I like to talk about a lot on the rise. We have really excellent data now that is showing this increased concern that cannabis use, and early cannabis use and high potency cannabis use, is contributing to the earlier onset of psychotic disorders. So, a lot of different points here with the different substances and the co-occurring presentations.

And so, again, there is very good reason to be screening for mental health concerns when seeing somebody who has a substance use disorder.

Dr. Stephen Taylor: That is so true. Thank you for that. And you mentioned in part of your comments, the chicken-or-egg issue. And so, I want to pick up on that because that's an issue that our colleagues will address time and time again. And what is the situation that we're dealing with, with an individual patient? Is it a substance-induced symptom or is it a symptom that is a primary psychiatric symptom? And how do you distinguish, and is it even that important to distinguish between the two?

Dr. Smita Das: Yeah, so I'll address your second question first. Is it important to distinguish the two?

In practice, when I'm working with patients, and they are suffering, I, in that visit, in that encounter with them, in that very human moment where they are suffering from, you know, both of these conditions, I am less interested in kind of that given moment

of was it the chicken or the egg. I am most interested in trying to help relieve their symptoms and help them find their path for recovery.

However, it is very important to, over time, and this might take some time, to understand how that relationship evolved. So, a good thing to do is to go over the history and take a really thorough history.

I'll take a good patient case that I have right now, a young person who has had a lifelong diagnosis of bipolar I. However, every episode of mania occurred with very, very heavy substance use. And so, they came to me for several substance use disorders, and they're on many, many medications for bipolar I, and yet we didn't have a clear history ever because they would present to the hospital, they would get started on a medication. There hadn't been a conversation about the temporal relationship in the course of their symptoms. And so, we've had many months now to try to understand when did symptoms of bipolar I start occurring? And was there actually a time where they weren't using substances, that they had those symptoms?

And so, you know, taking a really thorough history, kind of the essence, of the art of medicine. I always think about, as we're getting into an age of technology, how, as physicians/clinicians, we really are practicing the art of medicine. Part of that is thinking about that history, thinking about that time course, really going into detail with the patient when they're not intoxicated or actively withdrawing.

The other things to think about are family history. And then also, just as I said, thinking about what their clinical presentation looks like at the very moment, too.

Dr. Stephen Taylor: It's so true, getting us right back to the basics. Back to medical school, preclinical years, first days of school, where we're taught the key to diagnosis is a careful, thorough history. And it's very often important to revisit the history when you have a question, a difficult clinical question. Very often, the first steps to answering that question are revisiting the history, retaking it if necessary, being more thorough with it, if necessary. I couldn't agree more. That said, are there any specific screening tools or other approaches that you would recommend, or that you generally use in your clinical work?

Dr. Smita Das: A hundred percent. So, my background is in public health, and as part of that, I feel very strongly about screening and medicine in general. You know, when we go to our primary care doctors, we're screened for all sorts of things. And we don't always do that in mental health and in addictions. And so, the example of, say, measurement-based care, is very important to me, being able to screen and then follow symptoms over time so that we have more of an objective measure. Because so often our patients, unfortunately, are started on treatments and started on medications, and then we're not continuing to monitor that.

So, on the screening side, that's a kind of upfront. I'm a huge proponent of screening for all the most common mental health concerns, as well as addiction. And so, what

those tools would look like in psychiatry, very commonly, we are always screening for depression and anxiety.

The most common tools that are used in measurement-based care, that are also recommended by the creditors of healthcare organizations, are the PHQ-9, the Patient Health Questionnaire-9, as well as the GAD-7, and that's for anxiety. So, depression and anxiety, these are the two most common screeners that are used in measurement-based care. And it's important to mention for the PHQ-9, that does have the question about suicidality.

And so, that's another topic that I think is really important when we're thinking about co-occurring psychiatric disorders, is that people with substance use disorders are at higher risk for suicidality as well as a suicide. So, we want to make sure that we're screening there.

And then of course, when I'm meeting with non-addiction psychiatrists and clinicians, I will say, let's make sure that we're screening for substance use, and that can be starting as simple as things like the NIDA or National Institute of Drug Abuse 3-question screeners that then expand into more expansive screeners to measurement-based care screeners such as the BAM or the Brief Addiction Monitor.

Dr. Stephen Taylor: Yes, and there are some really good screening tools out there. I know in my practice, we use the Columbia Suicide Scale as well to screen specifically for suicidality. Because as you point out, that is an extremely important issue, particularly with patients with co-occurring disorders, because they're at an even higher risk than people who have either type of disorder alone.

You know, in your comments about the patient that you outlined for us, you mentioned that that patient had been treated with many, many different medications for bipolar disorder, and that's so often what we see, right? But that's because people want to try to provide good treatment for folks with these conditions. And so, it's important to think about the pharmacological management for SUDs and for the co-occurring psychiatric disorders. So, what would you say are the concerns or the challenges or the interactions that clinicians need to be thinking about when it comes to the pharmacological management of folks with these co-occurring conditions?

Dr. Smita Das: So, it's a really good question. I think that it is important to properly interpret the symptoms that we're seeing. So, for example, when somebody is experiencing withdrawal from a substance, they may be exhibiting signs of common psychiatric conditions.

So, another one that I'm very passionate about is tobacco. When somebody is withdrawing from cigarettes, the most common symptoms include slow mood, anxiety, tension, irritability, and those look a lot like other psychiatric conditions. And so, you know, a good question is if we're treating and we're thinking about medications, I do try very hard to see when someone's presenting to my tobacco

clinic at my university practice, I do want to make sure that I am screening for whether they had depressive symptoms prior to their tobacco use. Sometimes it's really hard because they have been using tobacco since they were 15. And so, they don't know what it feels like to not be using tobacco and to try to use clinical judgment to decide, okay, do I start them on what would be an evidence-based treatment from a pharmacologic point of view of an SSRI for depression? Or am I only treating the nicotine withdrawal, which may also calm down some of those symptoms? And so, that's again, where I think you said it best, like going back to the basics and reassessing regularly that history is going to be very important.

And the other example I'll give briefly is just psychotic symptoms that patient that I was mentioning earlier, the psychotic symptoms, are they intoxicated? And so, oftentimes there is the wait-and-see strategy. I think that it's very important though, if folks are using that strategy to document and document well and make sure that follow-up is done because it can be very easy to forget to treat the primary condition once the substance use disorder is more resolved because the patient's feeling better, but they're still suffering in a different way.

Other things that I would add, though, have to do with drug interactions. If there's medications that can worsen risk of something. So, for example, benzodiazepines and opioids. If there is a risk of providing somebody with benzodiazepines and opioids, for example, for risk of respiratory depression, then that should be considered.

Another thing to consider, when treating with multiple medications, if somebody is using stimulants and we're treating them for depression, then serotonin syndrome is something we always should be thinking about but should be thinking about a little bit more because of the concerns of hypertension.

And then of course, there's very basic things like if we have somebody on naltrexone and they are suffering from a chronic pain disorder and they need opioids, then I am thinking about the risk there, as well as how sensitive somebody might be to opioids after stopping naltrexone. So, all of these are very relevant when it comes to the medication challenges. A couple of others, misuse and diversion, that's something that we're often thinking about when it comes to psychotropic medications for primary mental health concerns. And then all this coming back to what we already discussed: the symptom overlap.

Dr. Stephen Taylor: First of all, I'm going to take a time out here just to say kudos to you for having a tobacco clinic. It's the kind of thing I would expect from a public health specialist who understands that tobacco actually kills more people per year than all of the other substances combined. And yet, we, as a field, so often pay far too little attention to tobacco, is something that more of our colleagues need to take seriously and really think about in our patients.

But then the other thing that I thought about, as you were speaking, was that there's this challenge of where folks get care. Not everybody's going to have the opportunity

to get to Dr. Smita Das and have their tobacco use disorder addressed, as well as their general psychiatric condition, and their other substance use disorder.

And what we find all too often is patients who are admitted to a setting that says that they treat folks for general psychiatric illness. And the folks there say, "Well, but we don't deal with substance use disorder." Or they're treated in a setting that takes care of people that specializes in treating people with substance use disorder, and they say, "Hey, but you got too much of a severe psychiatric problem going on. We really can't handle you."

What would you say are the recommendations you would have to break through these kinds of barriers that our patients so often face, and that therefore we, clinicians who take care of them, so often face?

Dr. Smita Das: Thank you for the kudos for having the tobacco clinic. And yet, having the tobacco clinic, I think, highlights part of this issue. Is that there is a clinic specifically for smoking cessation, where, kind of, every clinician, because this is the leading, preventable cause of death in this country, and when it comes to addiction, it causes more death and dying than alcohol in all other drugs combined. Every clinician, psychiatric addiction, general medicine, should be treating this. And yet, in the university system, when, for example, a cardiologist has a patient with a tobacco use disorder, rather than treating it within that cardiology visit, they come to my tobacco clinic. I think it's reflective, unfortunately, of the silos.

Now I'm glad to have the clinic because I need these patients to go somewhere. And so, because of the way the system is, for example, really stringent times and caseloads and RVUs, all of the things that we face as clinicians, if their kind of primary clinician is unable to treat the substance use disorder, I want them to come to my tobacco clinic or to my addiction clinic.

So, I think that is part of the issue, is that there are a lot of silos. You know, one hand thinks the other hand is taking care of things, and then nobody takes care of things. I think that there's challenges, and this is where I really appreciate, for example, ASAM on all of their advocacy in the area of parity and covering addiction and mental health in the same way that everything else is covered and covering them together.

So, I think that is a challenge coming back to the clinician. There's more that can be done to increase knowledge. That's why I'm thrilled to do this podcast, and I'm thrilled to be involved in all things education-related at ASAM, because that clinician knowledge is very important to increase how often people are just treating, again in their primary settings.

Another piece has to do with communication, and we know that there's lots of rules about communication regarding substance use disorders. For example, 42 CFR Part 2. And so, the more that we can do to help safely communicate and protect our patients, at the same time, will help us with that coordinated care.

And then of course, all of the barriers our patients face, for example, not having access, feeling stigma, trying to go to two appointments because, you know, again, they're having to split up their care. Those are all structural issues. And so, I said a whole lot of things that are difficult, but I will say that I think that conversations, like this education that is put out, will help reduce some of those structural issues that our communities and patients face.

Dr. Stephen Taylor: Absolutely. And that's why it's so important to have conversations like this with experts like yourself. I'm going to throw one more question at you because I know you can handle it, and I know that it will be helpful for our listeners.

My ears perked up when you mentioned cannabis use disorder, and you mentioned the psychosis caused by cannabis use disorder, because that's something that we particularly tend to focus on adolescents, the increased risk for adolescents. So often, that's the age range where cannabis use disorder, even more so than a lot of the other substance use disorder drugs get started. And so, I guess, what I'd like to ask you is the presentation and management of co-occurring disorders, how does it change in adolescents and frankly in other so-called special populations, older adults, peripartum patients?

What would you say are the ways that we need to think about these particular populations in terms of co-occurring disorders?

Dr. Smita Das: That's a great question, and I'm so delighted to have the conversation with you because I know I can count on my hand the number of addiction and child adolescent specialists that I know. It is like the unicorn in medicine, and it is the super-specialized individual that we need, and we need more of you.

What I'm seeing most often in children and adolescents is that the presentation may come along as being kind of one of two flavors. Either the parents are showing up with the child, and they are finding that they're irritable, that they're having difficulty in school, that they are kind of having difficulty with behavior at home, and they may not know about the cannabis.

On the other hand, I am seeing parents who bring in their child because all they're focused on is the drug, for example, the cannabis. But there's been this longstanding set of depressive symptoms before the cannabis use. Or last week, I had another family come in with, kind of, a gaming use, which isn't an official diagnosis, but concerns of addiction to gaming. But that, again, was preceded by depressive symptoms.

And so, I find it very helpful to really engage. And we haven't talked about the psychotherapeutic approaches, but motivational interviewing, and not just for the child, but also for the parent, in terms of trying to kind of have a more broad understanding of the disorders and how they may present.

In older adults, I think oftentimes depression, anxiety, they're just mistaken for just aging or being quiet. I think in older adults, the importance of looking at polypharmacy is also really relevant. And there, I think a lot of my strategy has been to implement things like trying to combat loneliness and isolation and thinking about community resources to help that.

And then the last group that I'll talk about, really briefly, are peripartum patients or patients that may be in stages of pregnancy or postpartum. This is a whole topic, and so, in one minute, I can't do it justice, but I think that it is very important to screen for both substance use disorders, as well as mood disorders.

I think a lot of women are trying to just kind of push through things and be okay. And I remember getting the PHQ-9 when I had just delivered, or when I was coming up to delivery, and thinking, "Goodness, this is so needed," because there's a whole lot that is going on physically, and we need to treat the primary mental health concerns in addition to the substance use disorder, both of which are probably underdressed in this population.

Dr. Stephen Taylor: So true. Thank you for handling that very tough question in a very nice fashion, in a short period of time. We're at the point now where I'm going to just ask you for your idea of the key takeaways. What is the most important thing or couple of things that you want our listeners to come away from this podcast with, if you had to distill it down, what's the one or two most important key takeaways for our listeners?

Dr. Smita Das: Yeah, I think one is screening and having that conversation, even if somebody doesn't feel comfortable treating all of the things. And then referring a patient to the right place. And of course, using resources like these to increase knowledge to be able to treat yourself. So screening is very important.

And then that leads into the concept of treating together. There's this social media advertisement that I saw for a place that said that only 50% of people with an addiction have another mental health concern. And I was like, yes, but then there's still another 50% that do have a mental health concern because they were trying to propose that addiction should be treated first and in addiction-specific ways as opposed to integrating.

And so, I would push back against that. We know that the research and the data say that treating both together produces the best outcomes. We see this across the board for various substances and various mental health conditions. And so, very important to do that. We need to do just by our patients and give them the full care in any other area of medicine. If we just ignored one of their health concerns, that would be wrong. And so, the same applies to addiction and mental health.

Dr. Stephen Taylor: So, so true. Thank you so much. That's exactly right, and let me just say, for more information on co-occurring psychiatric and substance use

disorders, check out ASAM's 2025 Review Course, Psychiatric Comorbidities: Complexities of Diagnosis and Care. You can find a link to the course in today's show notes.

I want to thank our expert, Dr. Smita Das, for sharing her incredible insights on treating co-occurring psychiatric disorders and SUD.

Remember, you've got to visit ASAM's e-Learning Center to claim your CME credits for this episode. And yes, we are providing CME credits for this episode.

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Thanks for listening, and we'll see you next time on *ASAM Practice Pearls*, where we turn clinical expertise into everyday addiction care one conversation at a time.