Crash Course on Co-Occurring Conditions

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Disclosure Information (Required)

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  - Dr. Fisher is a member of the US Air Force. The views expressed are those of the author and do not reflect the official policy or position of the US Air Force, Department of Defense or the US Government.

Learning Objectives

- Review common psychiatric diagnoses and evidence-based medication and therapy treatments
- Provide pragmatic tips for patient care including interview skills, clarifying diagnoses, and thinking through treatment strategies
- Apply best practices to common addiction medicine clinical cases

ICEBREAKER! What is your primary speciality?

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Nobody has responded yet.

Hang tight! Responses are coming in.

Case 1

A 35 year-old man presents as a walk-in stating he wants “to stop using.” He reports a history of alcohol, cannabis, and methamphetamine use, although in the past eight months has exclusively been using meth. He reports past diagnoses of schizoaffective disorder, bipolar disorder, schizophrenia, anxiety, and depression, with more than 5 inpatient psychiatric hospitalizations for a variety of symptoms.

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When asked if he is currently hearing voices, he hesitates and then denies. When asked about feeling safe at home, he states his neighbors have been bothering him and he wonders if they are working with the police to catch his methamphetamine dealer. He plans to move out of his apartment as soon as possible.

What else would you like to know (history and symptoms)?

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Nobody has responded yet.

Hang tight! Responses are coming in.

What would you like to know in terms of objective findings?

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Nobody has responded yet.

Hang tight! Responses are coming in.

Breakout discussion?

- Given this patient's psychosis, how specifically would you word your questions?

What is psychosis?

- Impaired reality testing (perceiving what is real from what is not)
  - Characterized by the presence of hallucinations, delusions, and the absence of normal interpersonal relatedness
- Psychosis is a symptom
  - Can be caused by primary psychiatric illness….
    - schizophrenia, bipolar disorder, or depression
  - …or secondary to another process
    - delirium, seizures, or substance intoxication or withdrawal

Primary psychiatric diagnoses with psychosis:

Schizophrenia	Schizoaffective disorder	Major depressive disorder	Bipolar 1 disorder
• Continuous positive and negative symptoms for >6 mo in the absence of other causes • Other illness on this spectrum include brief psychotic disorder and schizophreniform disorder	• Continuous psychosis + episodic mood disturbance • Can be depressive type or bipolar type	• When severe, can include psychotic features	• Can have psychosis during manic or depressive episodes

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These 4 diagnoses are mutually exclusive!

Substance-induced psychosis

- Psychotic symptoms that arise during intoxication, withdrawal, or otherwise as a result of substance use
  - Common offenders include hallucinogens, cannabis, stimulants, sedative-hypnotics, alcohol
  - Not opioids
- Not mutually exclusive with primary psychiatric illness
- Difficult, if not impossible, to distinguish based solely on symptoms

Stimulant Use Disorder and SIPD

- Stimulants include prescription stimulants, cocaine, methamphetamines, cathinones, others
- Prevalence, ~1%
- Stimulant use has ~11% conversion rate of using to developing use disorder
- ~40% of people with methamphetamine use disorder develop psychotic symptoms
- Common psychiatric comorbidities:
  - Psychotic disorders (30%)
  - Depression (70%)
  - ADHD (30%)
  - Anxiety disorders (30%)

Distinguishing primary from secondary

- Not always clear when one has crossed from “purely” substance-induced symptoms into a persistent psychotic disorder
- Clues:
  - Clear, unambiguous periods of psychosis well outside the expected time course
  - Clear, unambiguous resolution of psychosis when sober (e.g., complete return of insight)

Use of Antipsychotics in SIPD

Evidence for long-term management with antipsychotics is mixed

- Antipsychotics
  - D2 antagonism, reduced positive psychotic phenomena (hallucinations, delusions) in the mesolimbic pathway
  - First generation: haloperidol, fluphenazine
    - Increased likelihood of extrapyramidal symptoms
  - Second generation: quetiapine, olanzapine, risperidone, aripiprazole, lurasidone, ziprasidone
    - Risk of EPS
    - Metabolic syndrome
- Monitoring
  - Lipid panel, HbA1c, AIMS
  - EKG if indicated

Psychosis diagnosis

- Workup: urine drug screen, basic labs, head imaging
- Time course
- Collateral information
- Differential: consider demographics
  - Schizophrenia: presence of psychosis in the absence of other causes, typically onsets in early adulthood with prodromal period of social and functional decline
  - Mood disorder: psychosis occurs in the presence of a major mood episode (acute mania or major depression)
  - Substance induced - occurs exclusively in the expected time course of intoxication or withdrawal

Talking to people with psychosis

- Broadly: there is obvious and non-obvious psychosis
- Obvious psychosis: observable response to internal stimuli, bizarre behavior, clearly delusional content
- Practical tips for obvious psychosis:
  - Be friendly and genuine, but cautious
  - Remain grounded in reality
  - Don’t challenge delusions
  - Avoid colluding with delusions and disorganization, however…
    - Following a patient’s line of reasoning can allow to understand the history, or at least their version of it
  - Use flexibility and responsiveness
  - Recognize the limits of the interview

Non-obvious or subtle psychosis

- Subtle psychosis can be often missed for several overlapping reasons
  - Patients are guarded
  - Symptoms can be mistaken for other syndromes
  - Some content will be missed if not explicitly asked
- Eliciting symptoms through interview is important and helpful because:
  - Builds alliance and trust
  - Improved accuracy of diagnosis and therefore treatment
  - Allays anxiety in the patient

Non-obvious psychosis: building rapport

- Warmth, empathy, kindness
  - Not “overdoing it”
  - Not “over-empathizing”
- Reassurance
- Realistic limits to what you can and cannot accomplish

Non-obvious psychosis: building rapport

- Nonverbal Considerations
  - Appear non-threatening
  - Minimize staring or prolonged eye contact
  - Interpersonal distance
  - Open and relaxed posture
    - Consider where and how you sit
  - Limit intense emotional expression
- Verbal considerations
  - Soft voice, match tone, pause often
  - Avoid idioms, metaphors, sarcasm
  - Remain grounded in reality

But what do I say?

- Patients may feel safer expressing bizarre or unusual psychotic symptoms if they perceive the interviewer understands and expects them
- Normalization and expectation of symptoms
- Use phrases like:
  - “Many people feel…”
  - “When people have X, they often also report Y…”
  - “With all this stress, I wonder if…”
  - “When was the last time you hallucinated?”
  - “When you hear voices, what do they say?”
  - “When you use, does your mind play tricks on you?”
  - “How often do you use methamphetamines?”

Returning to Case 1

A 35 year old man presents as a walk-in intake stating he wants “to stop using.” He reports a history of alcohol, cannabis, and methamphetamine use, although in the past eight months has exclusively been using methamphetamines. He reports past diagnoses of schizoaffective disorder, bipolar disorder, schizophrenia, anxiety, and depression, with more than 5 inpatient psychiatric hospitalizations for a variety of symptoms.

When asked if he is currently hearing voices, he hesitates and then denies. When asked about feeling safe at home, he states his neighbors have been bothering him and he wonders if they are working with the police to catch his methamphetamine dealer. He plans to move out of his apartment as soon as possible.

What would you say to this patient?

What would you recommend next?

Summary of Recommendations

- Differentiating primary from secondary psychosis is challenging based on symptoms alone, but treatment recommendations converge.
- Antipsychotics are effective for psychosis but require cautions due to high potential burden of side effects.
- There are no FDA approved medications to treat stimulant use disorder.
- If psychosis impairs a person's ability to meet their basic needs, or places them at immediate risk of harm to themselves or others, then higher level of psychiatric care is indicated regardless of the cause.
- Speaking to patients with mild or more subtle psychosis can be accomplished with empathy and curiosity, with more attention to interpersonal cues.

Case #2 - Miss M

Miss M is a 27-year-old woman with opioid use disorder. She had been injecting opioids daily for the past two years. She is currently prescribed buprenorphine/naloxone and feels that her withdrawal symptoms and cravings are currently well managed with her current dose.

She presents today for her appointment with her care team. She requests medications for her mental health and says that she is on a waitlist to see a psychiatrist in her community, but that this could take up to six months. She says that she has a history of bipolar disorder and has been noticing an increase in symptoms since she stopped injecting opioids and started taking buprenorphine/naloxone (as prescribed).

Miss M - continued

- She reports that she has been prescribed “every medication under the sun” for her bipolar disorder, but “none of them worked”. She says that her main symptoms are “mood swings” and states that she can “wake up fine one day” and then “all of a sudden feel pissed off” and then “crash into a deep depression”. She says that this has caused problems in many of her relationships and has prevented her from maintaining employment.
  She has “manic” periods of time that last a couple of hours at most. She describes these as overwhelming emotions that are difficult to manage. These have led to her impulsively buying substances in the past.
- Miss M says that she sometimes sleeps too much and usually averages about 8-9 hours of sleep per night.
- She reports that opioids gave her energy and states that she has felt tired and sluggish for the past two weeks.

What is Miss M's most likely diagnosis?

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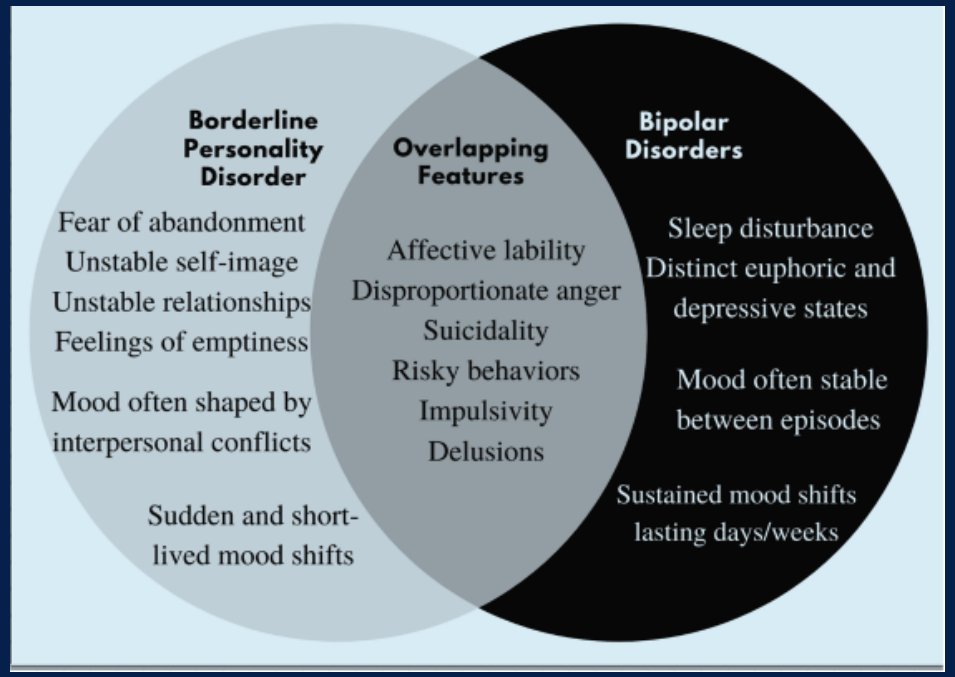
Nobody has responded yet.

Hang tight! Responses are coming in.

Ensure that you have the correct diagnosis

- Borderline personality disorder and bipolar disorder have many overlapping features and symptoms
- Patients often equate mood swings with bipolar disorder
- Obtaining an accurate time course of symptoms can be helpful



Ding J B, Hu K (July 16, 2021) Structural MRI Brain Alterations in Borderline Personality Disorder and Bipolar Disorder. Cureus 13(7): e16425. doi:10.7759/cureus.16425

DSM-5 Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, of self-image, and affects as well as marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five or more of the following:

- Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: Markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging, for example, spending, substance abuse, reckless driving, sex, binge eating, etc. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.
- Affective instability is caused by a marked reactivity of mood, for example, intense episodic dysphoria, anxiety, or irritability, usually lasting a few hours and rarely more than a few days.
- Chronic feelings of emptiness.
- Inappropriate, intense anger, or difficulty controlling anger, for example, frequent displays of temper, constant anger, recurrent physical fights.
- Transient paranoid ideation or severe dissociative symptoms.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Crash Course on BPD

- Neurobiological studies show elevated cortisol levels and opioid dysregulation
- Prevalence of Borderline Personality Disorder
  - In the US: approximately 1.6%
  - In psychiatric inpatient units: 20%
  - According to a review done in 2018, approximately half of those with BPD also have at least one current SUD, most commonly AUD. Among those with a current SUD, approximately 25% also meet criteria for BPD.
- There are a lot of empirically validated treatments for BPD and most improve without formalized therapy

Trull, T.J., Freeman, L.K., Vebares, T.J. *et al.* Borderline personality disorder and substance use disorders: an updated review. *bord personal disord emot dysregul* 5, 15 (2018).

The Role of Pharmacotherapy in BPD

- Psychotherapy is generally considered the mainstay of treatment
- Pharmacotherapy is useful as an adjunct for specific symptoms or for the treatment of other co-occurring conditions

How might BPD manifest in a SUD clinic?

- Many people with BPD are used to acting impulsively. When faced with a challenging situation, they may lash out or have difficulty regulating their own emotions.
- They may experience intense dissociation or paranoia and fear abandonment when stressed.
- It’s helpful to remember that most of these patients have experienced trauma in their past and they are usually acting out in a response to protect themselves from further trauma.

Miss M - Case Continued

- Miss M comes in for her scheduled outpatient appointment 45 minutes late. The front desk staff notify her that she cannot be seen due to her late arrival. She gets agitated and starts yelling and cursing. She demands to be seen immediately.

What is a therapeutic way to respond to patient's acting out behavior?

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Nobody has responded yet.

Hang tight! Responses are coming in.

Tips For Managing Symptoms of BPD in a SUD Clinic

- Be Active, Not Reactive: Patients with BPD need to know you are present.
- Be thoughtful in your responses. This is essential in creating a “holding environment” for individuals who have often experienced trauma in their lives.
- Maintain your boundaries. Acknowledge your mistakes.
- Convey to them that change is expected.
- Be flexible.

Summary of Recommendations

- Borderline personality disorder and bipolar disorder have many overlapping features and symptoms, but obtaining a clear timeline of symptoms can help establish a diagnosis.
- Psychotherapy is the mainstay of treatment for BPD.
- BPD and SUD commonly co-occur.
- Being active, present, thoughtful and flexible can be helpful when treating individuals who have co-occurring SUD and BPD.

Case 3

A 38-year-old man arrives in your outpatient clinic with a chief complaint, "Get my life back on track." One year ago, he was involved in a traumatic car accident. He reveals a diagnosis of GAD prior to the accident with past positive response to Xanax for anxiety symptoms. He reports that since the accident he has not kept up with mental health appointments and has had increasing alcohol use to deal with mounting pressures at work and at home. He reports many unsuccessful efforts to manage his alcohol use.

He expresses mistrust towards others, constantly being on guard, startling easily, and sometimes feeling disconnected from himself. He wants to stop this cycle of symptoms and just be able to relax again.

Initial questions for the patient?

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Nobody has responded yet.

Hang tight! Responses are coming in.

What concerns do you have as a provider?

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Nobody has responded yet.

Hang tight! Responses are coming in.

PTSD Epidemiology and Comorbidities

- 6.1% lifetime prevalence US Adults (1)
  - 8% Women and 4.1% in Men
  - Higher in Veterans, Active duty military, and some minority populations.
- 9.5% of adults in the U.S. experience a substance use disorder and a co-occurring mental illness. (2)
  - Anxiety and PTSD among the most common comorbidities
- Comorbidity rates of GAD or MDD with PTSD are as high as 91% (3)

The Wave 3 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III)

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration

Price M, Legrand AC, Brier ZMF, Hébert-Dufresne L. The symptoms at the center: Examining the comorbidity of posttraumatic stress disorder, generalized anxiety disorder, and depression with network analysis. J Psychiatr Res. 2019 Feb;109:52-58. doi: 10.1016/j.jpsychires.2018.11.016. Epub 2018 Nov 21. PMID: 30502492; PMCID: PMC6420212.

PTSD DSM 5 Criteria

A. Exposure to Trauma (actual or threatened)
    a. Directly experienced, witnessed, learned about trauma of family or close friend. Repeated exposures. Accidents or violent events.
B. Intrusive symptoms (1)
    a. Dreams, flashbacks, involuntary memories, distress with cues psychological or physiological
C. Avoidant Symptoms (1)
    a. Memories, reminders
D. Negative alterations in mood and cognition (2)
    a. Poor event recall, negative beliefs about self and the world, negative emotional state, detachment, inability to experience positive emotion
E. Arousal and Reactivity (2)
    a. Irritability, recklessness, hypervigilance, exaggerated startle, concentration changes, sleep distress
F. One month since trauma

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed Text Revision.).

GAD DSM 5 Criteria

A. Excessive anxiety or worry on most days for 6 months about different things
B. Difficulty controlling worry
C. Three of the following
    a. Restlessness, keyed up
    b. Easily fatigued
    c. Difficulty concentrating
    d. Irritability
    e. Muscle tension
    f. Sleep disturbance
D. Clinical distress, or impact on functioning
E. Not from a substance
F. Not another mental health disorder (i.e. OCD, PTSD, Anorexia, illness anxiety)

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed Text Revision.).

PTSD or GAD or Both?

- Patients with PTSD and generalized anxiety disorder have difficulty accurately determining safety from danger and struggle to suppress fear in the presence of safety cues. (1)
- PTSD symptoms
  - More connected to GAD and MDD: Negative Alterations in Cognitions and Mood and Alterations to Arousal and Reactivity (2)
  - Less connected to GAD and MDD: Intrusion and avoidance (2)

Williamson JB, Jaffee MS, Jorge RE. Posttraumatic Stress Disorder and Anxiety-Related Conditions. Continuum (Minneap Minn). 2021 Dec 1;27(6):1738-1763. doi: 10.1212/CON.0000000000001054. PMID: 34881734.

2. Price M, Legrand AC, Brier ZMF, Hébert-Dufresne L. The symptoms at the center: Examining the comorbidity of posttraumatic stress disorder, generalized anxiety disorder, and depression with network analysis. J Psychiatr Res. 2019 Feb;109:52-58. doi: 10.1016/j.jpsychires.2018.11.016. Epub 2018 Nov 21. PMID: 30502492; PMCID: PMC6420212.

Basic Pharmacology

- Paroxetine, sertraline, venlafaxine (1)
  - Monotherapies
- Prazosin as augmentation(2)
  - Higher dosing in studies with highest effect
    - ~15 mg per night for men
    - ~7 mg for women

VA/DoD Clinical Practice Guidelines. (2023). Management of Posttraumatic Stress Disorder and Acute Stress Disorder. Retrieved February 21, 2024, from https://www.healthquality.va.gov/guidelines/MH/ptsd/

Hoskins MD, Bridges J, Sinnerton R, Nakamura A, Underwood JFG, Slater A, Lee MRD, Clarke L, Lewis C, Roberts NP, Bisson JI. Pharmacological therapy for post-traumatic stress disorder: a systematic review and meta-analysis of monotherapy, augmentation and head-to-head approaches. Eur J Psychotraumatol. 2021 Jan 26;12(1):1802920. doi: 10.1080/20008198.2020.1802920. PMID: 34992738; PMCID: PMC8725683.

PTSD Therapy

- VA recommended manualized trauma-focused psychotherapies for the treatment of PTSD (1)
  - Cognitive Processing Therapy
  - Eye Movement Desensitization and Reprocessing
  - Prolonged Exposure.
  - Ehlers' Cognitive Therapy for PTSD
  - Present-Centered Therapy
  - Written Exposure Therapy

VA/DoD Clinical Practice Guidelines. (2023). Management of Posttraumatic Stress Disorder and Acute Stress Disorder. Retrieved February 21, 2024, from https://www.healthquality.va.gov/guidelines/MH/ptsd/

PTSD and Benzodiazepines

- BZDs are ineffective for PTSD treatment and prevention, and risks associated with their use tend to outweigh potential short-term benefits. (1)
- “May interfere with the natural processing of traumatic memories and emotional responses that are essential for recovery from PTSD. This interference could potentially hinder the effectiveness of psychotherapeutic treatments like cognitive-behavioral therapy (CBT) and exposure therapy, which are central to PTSD treatment.” (2)

Guina J, Rossetter SR, DeRHODES BJ, Nahhas RW, Welton RS. Benzodiazepines for PTSD: A Systematic Review and Meta-Analysis. J Psychiatr Pract. 2015 Jul;21(4):281-303. doi: 10.1097/PRA.0000000000000091. PMID: 26164054.

VA/DoD Clinical Practice Guidelines. (2023). Management of Posttraumatic Stress Disorder and Acute Stress Disorder. Retrieved February 21, 2024, from https://www.healthquality.va.gov/guidelines/MH/ptsd/

PTSD with AUD: Disulfiram and Naltrexone

- Subjects with PTSD had better alcohol outcomes with active medication (naltrexone, disulfiram or the combination) than they did on placebo; overall psychiatric symptoms of PTSD improved.

Petrakis IL, Poling J, Levinson C, Nich C, Carroll K, Ralevski E, Rounsaville B. Naltrexone and disulfiram in patients with alcohol dependence and comorbid post-traumatic stress disorder. Biol Psychiatry. 2006 Oct 1;60(7):777-83. doi: 10.1016/j.biopsych.2006.03.074. PMID: 17008146.

Challenge of PTSD/SUD Combination

- Comorbid SUD/PTSD significantly more difficult to treat than either disorder alone. (1)
- Common challenges listed in study
  - how to best prioritize and integrate treatment components
  - patient self-destructiveness
  - severe symptomatology
  - helping patients abstain from substance use
- Treat both PTSD and SUD concurrently.
- Active SUD may be barrier for therapy intake but not for initiation of treatment with medication.

Back SE, Waldrop AE, Brady KT. Treatment challenges associated with comorbid substance use and posttraumatic stress disorder: clinicians' perspectives. Am J Addict. 2009 Jan-Feb;18(1):15-20. doi: 10.1080/10550490802545141. PMID: 19219661; PMCID: PMC2845168.

Talking to patients reporting trauma (tips that helped me)

- Resisting urge to immediately reassure
  - This desire is to calm your own feelings not necessarily the patient's
- Sitting at bedside if possible
  - Patients perceive you are there longer
- Using term posttraumatic stress injury
  - Injuries are more relatable than disorders
- Normalize symptoms
  - You have had an abnormal experience that has led to an expected reaction of abnormal feeling and thoughts.

Return to Case 3

Patient reports that their most distressing symptoms are associated with reminders of the car accident. They go to great lengths to avoid dangerous situations on the road and often make excuses to avoid driving. They report not being able to watch action movies with vehicle crashes or chase scenes due to a sensation of reliving the accident.

They ask what their options are for treatment. They feel like in the past xanax helped with their anxiety and suspect that it will help again. PDMP review reveals a history of xanax at a consistent interval and dose from a single prescriber.

Breakout

How do you respond to the patient about treatment options?

Summary of Recommendations

- Be on the lookout for comorbid PTSD in SUD patients
  - Then treat BOTH SUDs and PTSD
- Avoid benzodiazepines in PTSD even with comorbid anxiety or history or positive use of benzodiazepines
- Help patients be heard without giving silver linings; sometimes things are just hard
- Use PTSD guideline approved medications first (sertraline, paroxetine, venlafaxine)

Case 4

C is a 17 y/o boy with attention-deficit hyperactivity disorder, inattentive type who recently has been reporting increasing anxiety and depression. He feels “stagnant” and “not as motivated” as his peers to work on college applications. He reports that his attention is “ok,” but that perhaps his medication is not as effective as it was in recent months and requests an increase. His medication regimen consists of lisdexamfetamine 50 mg each morning and and immediate release dextroamphetamine/amphetamine 5 mg each afternoon.

For Discussion

What else would you want to ask this patient?

Are there any labs, standardized instruments, or other tests to consider?

Are there additional diagnoses to consider?

DSM-5 Criteria: Major Depressive Disorder

1. Depressed mood
2. Anhedonia
3. Weight loss / weight gain
4. Sleep changes
5. Psychomotor changes
6. Fatigue
7. Worthlessness / guilt
8. Diminished ability to think / concentrate; indecisiveness
9. Recurrent thoughts of death / suicidal ideation

DSM-5: Other Depressive Disorders

- Disruptive mood dysregulation disorder
- Persistent Depressive Disorder (dysthymia)
- Premenstrual Dysphoric Disorder
- Substance / Medication Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorders
  - Recurrent Brief Depression
  - Short Duration Depressive Episode
  - Depressive Episode with Insufficient Symptoms
- Unspecified Depressive Disorder

DSM-5: Anxiety Disorders

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Substance/Medication Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
  - Limited Symptoms Attacks
  - Generalized Anxiety Disorder Not Occurring More Days Than Not
  - Culturally bound syndromes
- Unspecified Anxiety

Screen for Trauma; Screen for PTSD

1. Intrusion symptoms
2. Avoidance symptoms
3. Negative alterations in cognitions / mood
4. Hyperarousal / reactivity symptoms

Case 4 - Continued

Urine drug screen is performed during C's visit and the test results are positive for amphetamines and THC. When asked C reports that he initially used cannabis a couple of times with his cousins though recently progressed to daily use citing the perceived benefit in his attention and stress.

In response to his complaints of feeling "stagnant" you administer a PHQ-9 and his score is 7 (see next slide for specific results).

He denies trauma– historical or ongoing.

He reports that his issues with attention "have been bad all school year" and that he has only started using cannabis regularly in the past couple months.

He denies symptoms of anxiety including dread, rumination, and panic. He reports he "feels bad when he gets behind in school and recently had difficulty with a group project, resulting in feelings that he "let his group down"

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 in some way	0	1	2	3

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How do we counsel C and his family?

- Risk of psychosis
  - Well established
  - Dose dependent
  - Heightened vulnerability in teenage years
- ADHD is a risk factor for substance use
- Risks of treating versus not treating ADHD symptoms

Solmi M, De Toffol M, Kim J Y, Choi M J, Stubbs B , Thompson T et al. Balancing risks and benefits of cannabis use: umbrella review of meta-analyses of randomised controlled trials and observational studies *BMJ* 2023; 382 :e072348 doi:10.1136/bmj-2022-072348

For Discussion

What do we make of request for increase dose of stimulants in context of cannabis use?

What are the considerations for prescribing stimulants medications to a teenage patient actively using cannabis?

What is the relationship between ADHD and Cannabis Use Disorder?

Discussing our Fears and Concerns

- Fear of “cannabis cancelling out our ADHD meds”
  - Psychostimulants and cannabis do not have directly opposing mechanisms, though cannabis use can impair attention
- Fear of diversion
  - Not all people who use drugs engage in other deviant behavior. While cannabis use might increase our concern for diversion it should not alone lead to the conclusion that a patient cannot be trusted with controlled substances
- Fear of “enabling a patient”
  - Many people sample cannabis or use it regularly; this is beyond our control as physicians. Providing suboptimal treatment for ADHD is not a viable solution to promote abstinence from cannabis if that is a treatment goal

Factors to Consider When Treating Co-occurring CUD and ADHD

- Confidence in diagnosis of ADHD
- Relationship of ADHD symptoms and cannabis use
  - Cannabis impairs attention though can be perceived as helpful
  - The negative affective state of addiction disorders can impair attention
- Optimizing ADHD treatment is associated with reduced drug use and improved outcomes (overall data is discordant on this)

Özgen H, Spijkerman R, Noack M, Holtmann M, Schellekens A, Dalsgaard S, van den Brink W, Hendriks V. Treatment of Adolescents with Concurrent Substance Use Disorder and Attention-Deficit/Hyperactivity Disorder: A Systematic Review. J Clin Med. 2021 Aug 30;10(17):3908. doi: 10.3390/jcm10173908. PMID: 34501355; PMCID: PMC8432200.

Summary - Key Takeaways

- It is important to optimize the treatment of ADHD in patients who are using cannabis or other substances.
- It is important to counsel kids, adolescents, and young adults (and their families) about the risks of cannabis use
- It is possible to mitigate the misuse potential of stimulant medications with certain long-acting formulations– these should be considered first-line in treating co-occurring ADHD and SUDs

Final Takeaways/Summary

- Don’t let the perfect be the enemy of the good
  - Beginning management of psychiatric conditions while awaiting referral (or in the absence of available options) is usually the right move.
- Human first, physician second, psychiatrist* only third
  - Most appropriate strategies for approaching patients with psychiatric illness boil down to empathy, compassion, and professionalism
- Know your limits
  - Complicated psychiatric cases may require transfer of care, such as OCD, eating disorders, refractory mood and psychotic disorders

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