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SERIOUS MENTAL ILLNESS
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# Opioid Use Disorder Treatment and Concerns with Co-Occurring Psychiatric Conditions

The presence of co-occurring mental health disorders (such as mood, anxiety, PTSD, personality disorders, and serious mental illness) is highly prevalent among individuals with opioid use disorder (OUD) and other substance use disorders (SUD). This high rate of dual diagnosis significantly complicates clinical assessment, treatment planning, and overall prognosis.

## Foundational Principles

- **Medications for OUD (MOUD)** are evidence-based treatments (e.g., buprenorphine, methadone, and naltrexone) to treat individuals with opioid use disorder as part of a comprehensive treatment approach. It is evidence-based to initiate and continue the MOUD even when significant psychiatric comorbidity is present.
- **Integrated Care** is essential for optimizing patient outcomes. This model combines behavioral and psychiatric health services, MOUD, and general medical care into a comprehensive, coordinated approach, leading to improved adherence, reduced substance use, and better mental health stability.
- **Pain Management** should be evaluated in detail in patients with opioid use disorder and co-occurring psychiatric conditions. For more information on pain management, please see the PRN guidelines.

## Common Co-Occurring Psychiatric Disorders

- **Other SUDs:** Alcohol, stimulants, sedatives, cannabis, tobacco
- **Mood Disorders:** Major Depressive Disorder, Dysthymia, Bipolar Disorder
- **Psychotic Disorders and Serious Mental Illness:** Schizophrenia Spectrum and Other Psychotic Disorders, Schizoaffective Disorder
- **Anxiety Disorders:** Generalized Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, Post-Traumatic Stress Disorder
- **Personality Disorders:** Borderline and Antisocial Personality Disorders

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## Characteristics of Presentation

- Overlapping Symptoms: Sleep disturbance, concentration problems, irritability, and affective lability occur in both withdrawal and primary psychiatric disorders- this complicates diagnosing.
- Temporal Patterns Matter: Psychiatric symptoms that predate sustained opioid use or persist after weeks/ months of abstinence are more likely to be independent disorders. Substance-related symptoms frequently change with intoxication and withdrawal.
- Functional Impact: Comorbidity is associated with a higher risk of overdose, poorer retention in treatment, higher hospitalization and suicide risk, and lower rates of MOUD use in some subgroups.

## Disentangling OUD and Mental Health Diagnoses: Screening and Diagnostic Approach

1. **Initial Triage (first visit/intake)**
    a. Safety first: assess suicidality, homicidality, acute psychosis, severe withdrawal (and manage each of these symptoms per emergency/medication protocols).
    b. Use Brief Standardized Screening Tools for Triage:
    c. Offer MOUD on the first day if appropriate.
2. **Diagnostic Formulation (within first 1-4 weeks)**
    a. Gather timeline data: onset of psychiatric symptoms relative to first regular opioid use, periods of abstinence, and changes during intoxication/withdrawal.
    b. Observe during stabilization on MOUD (when possible): many substance-induced symptoms remit with stabilization and reduction of use; reassess after 2-8 weeks of reduced use/engagement in treatment.
    c. Do not delay life-saving MOUD while starting any psychiatric treatment.
    d. Use structured or semi-structured instruments (e.g., MINI, SCID, or similar) for formal diagnosis when clinical uncertainty remains, or for SMI evaluation.
    e. If severe psychiatric illness is suspected, initiate/coordinate urgent care; consider inpatient stabilization if needed.
3. **Criteria to Favor a Primary Psychiatric Disorder**

- Symptoms clearly precede sustained opioid use
- Psychiatric symptoms persist during sustained periods of abstinence or after stable MOUD for several weeks
- Family history or prior episodes when not using substances
- Response to standard psychotropic treatment independent of changes in substance use

## Ongoing Care

- Integrate behavioral health visits into MOUD follow-ups or provide warm handoffs
- Use measurement-based care to track response
- Coordinate prescriptions (avoid unsafe sedative combinations; when benzodiazepines are necessary, use careful risk mitigation

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## Role of Integrated Care

- Coordinated, co-located, or closely linked services where addiction treatment, mental health care, primary care, and social supports function together with shared treatment goals and communication is ideal
- Integrated care improves access to MOUD, increases retention, reduces fragmentation (which causes treatment gaps), and supports simultaneous management of psychiatric disorders and OUD. Guidelines emphasize integrating pharmacotherapy for OUD with psychosocial and mental health interventions
- Core components include shared screening at intake, case management/care coordination, team-based medication management (MOUD + psychotropics), psychotherapy options on site (or via warm handoffs), harm reduction services (naloxone distribution), and data sharing/joint treatment plans

## Interventions

1. **Pharmacologic Treatment for OUD**
    - Evidence-based treatments (e.g., buprenorphine, methadone, and naltrexone) to treat individuals with opioid use disorder as part of a comprehensive treatment approach. It is evidence-based to initiate and continue the MOUD even when significant psychiatric comorbidity is present. These treatments work substantially better than other treatments particularly NA and AA.
    - Offer MOUD to all eligible patients; comorbid psychiatric disorders are not routine contraindications to MOUD. Choose medications based on clinical factors and access. Continue or initiate MOUD even while psychiatric diagnoses are being clarified.
2. **Psychotropic Medications for Comorbid Psychiatric Disorders**
    - Treat primary psychiatric disorders per standard guidelines, while monitoring interactions and adherence. Many psychotropics are safe with MOUD; be mindful of sedative combinations, which increase overdose risk. Coordination between prescribers is essential.
3. **Psychosocial Interventions**
    - Evidence-based therapies useful with OUD + psychiatric comorbidity: motivational interviewing, contingency management, CBT, dialectal behavior therapy and trauma-focused therapies. Integrate these with MOUD rather than using them on their own for OUD.
4. **Harm Reduction and Crisis Management**
    - Naloxone distribution, overdose education, safe prescribing practices, and management plans for suicidality. For patients on MOUD, ensure protocols for ongoing monitoring and accessible crisis response.

## Practical Tips for Challenging Scenarios

1. **New Psychosis in Active Opioid Use:** Stabilize on MOUD if possible, treat psychosis per emergency guidance, and re-evaluate after intoxication/withdrawal resolves to determine if diagnosis is substance-induced.
2. **Severe Depression with Suicidal Ideation:** immediate risk management (safety plan/hospitalization if needed), start MOUD if appropriate, start antidepressant, with close follow-up.

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