Welcome! In this module, we’re going to discuss some of the important relationships between mental health and substance use that clinicians may encounter when applying the SBIRT process in practice.
Psychiatric illness can be a major contributory and interactive factor in substance use. In this module, we’ll consider some of the most common mental disorders that occur concurrently with substance use – both “risky” drinking that is the focus of the SBIRT process, and also substance use disorders.

In that context, we’ll review common screening tools for anxiety and depression that you may consider using. These are often valuable in planning more comprehensive assessment and treatment of concurrent conditions.
Let’s start with the important relationship between substance use and psychiatric illness.

Alcohol and drugs may be used to deal with distressing symptoms of mental disorders – for example, alcohol use to reduce impairing anxiety – but they can also trigger the onset of mental illness and make existing symptoms worse.
People who have a mental disorder and also use substances are at high risk for having a downward spiral in their health. As a result, assessing and treating both conditions at the same time is essential.

Building a strong base of objective data to support symptom presentation – including standardized scale scores, lab values, and physical assessment findings – is essential to adequately treat both conditions.

For most people with co-occurring substance and mental disorders, integrated treatment that offers health, mental health, and substance use treatment in the same clinic is optimal. That way they get the best of primary care and specialty treatments working as a team.
Both clinical and sub-clinical depression is widely associated with substance use, particularly drinking. Of importance, the relationship goes both ways: Drinking can lead to depression, and depression can lead to drinking.

And it’s not just drinking. Use of other substances, including both prescription and illicit drugs, may also be used to “self-medicate” the distressing thoughts and feelings that clinical depression can trigger.

If you suspect a client has depressive symptoms along with substance use, be sure to assess their depression symptoms using a standardized scale.

Reference: Depression and the Connection to Substance Abuse (https://www.futuresofpalmbeach.com/addiction-treatment/co-occurring-disorders-overview/depression-drug-abuse/)
The Patient Health Questionnaire 2-item and 9-item scales are widely used in clinical settings to assess depressive symptoms.

Just like we use the 2-item annual screen for substance use, the PHQ-2 can be used to detect clinical depression. This is because it rates the two hallmark symptoms of clinical depression: loss of ability to experience pleasure in usual activities and prominent dysphoria or sadness, feeling blue and down.

The PHQ-9 is equally easy to use and score, making it another popular alternative. For 12 to 18 year olds, screening for depression is recommended at every routine visit, so consider using the PHQ-A.
Each symptom is rated on a four-point scale. First you total the columns, then add the results to get a total score of 0 to 27. A score of 10 or greater indicates clinically significant depression – depression that deserves further assessment and treatment.

Using the PHQ-9 or the PHQ-A is just the first step toward a more comprehensive assessment and decisions about treatment. However, quantifying the number and intensity of depressive symptoms can help guide decision-making about possible treatments. This can include medications, psychosocial therapies, and increased physical activity for those with milder depressions.
Like depression, anxiety-related disorders can be the reason for substance use, but substance use also worsens symptoms of anxiety-related disorders. For example, individuals with social anxiety disorder may experience temporary relief from distressing symptoms of the disorder when drinking alcohol, but ultimately alcohol will intensify their anxiety symptoms.
When you detect anxiety-related symptoms in a client that is using a substance, we highly recommend that you quantify them using a standardized scale. A good starting point is the GAD-7, which will give you a foundation for understanding the frequency and intensity of anxiety-related symptoms.
The GAD-7 is scored just like the PHQ-9, and uses similar cut points that can help direct treatment decisions.
When screening for anxiety in children and adolescents, you may want to consider using the “Severity Measure for Generalized Anxiety Disorder—Child Age 11-17” or the “Screen for Child Anxiety Related Disorders,” known as SCARED.
Note that the scoring of the GAD for children age 11 to 17 is different than the scoring of the GAD-7.
When scoring the SCARED screening tool, a total score of 25 or higher may indicate the presence of an anxiety disorder. Scores higher than 30 are more specific, with total scores for specified items possibly indicating other disorders.
Several studies have shown a strong connection between ADHD and substance use. This evidence suggests that adolescents with ADHD are at a higher risk to start using alcohol during their teenage years. Of equal importance, ADHD is a predictor of alcohol and substance use as an adult. In short, there are many reasons to include substance use in discussions with youth who have ADHD.

A couple of tools available to screen for ADHD are the Conners-Wells’ Adolescent Self-Report Scale for teenagers and the Vanderbilt ADHD Rating Scales for teachers and parents.

Reference: ADHD and Substance Abuse (http://www.webmd.com/add-adhd/adhd-and-substance-abuse-is-there-a-link#1)
The risks of substance use continue into adulthood for individuals with ADHD. In adults, substances are often used to improve their mood or help them sleep better. Of note, substance use is also common among individuals with undiagnosed ADHD or those who have not received treatment. The “Adult Self-Report Scale” – or ASRS – can be used to screen for ADHD in adults.

Reference: ADHD and Substance Abuse (http://www.webmd.com/add-adhd/adhd-and-substance-abuse-is-there-a-link#1)
Individuals with serious and persistent mental disorders are also more likely to use alcohol and drugs. As noted earlier, alcohol or drugs may be used to reduce distressing symptoms, including psychotic symptoms like auditory hallucinations.

If you are treating individuals with existing mental disorders like ADHD, bipolar disorder, schizophrenia, and personality disorders, think carefully about the potential that they are also using one or more substances – and work toward concurrent treatment of both conditions.

References:
Bipolar Disorder and Addiction (http://www.dualdiagnosis.org/bipolar-disorder-and-addiction/)


Borderline Personality Disorder and Addiction (http://www.dualdiagnosis.org/borderline-personality-disorder-and-addiction/)
With a dual diagnosis – substance use disorder and a mental disorder – treatment can be a challenge. As noted earlier, collaborative, integrated approaches to treatment are ideal. However, the starting point is first understanding that more than one illness is affecting your patient. Only then can you work toward developing an effective treatment plan.
In summary, concurrent mental and substance use disorders require thoughtful assessment and treatment. Using standardized scales can help clinicians determine therapeutic “next steps.”

Understanding the complexity of the issues is critical in providing comprehensive and competent care and treatment.
Screening, Brief Intervention, and Referral to Treatment (SBIRT): Mental Disorders