Treatment of Concurrent Disorders and Stimulant Use Disorder in RAAM Clinics, Outpatient Settings and Bed-Based Programs

Rationale and Approach

Mental health disorders are very common in people with substance use disorders; yet patients in emergency departments with these co-occurring disorders are less likely to receive psychiatric care than patients without a substance use disorder. This gap in care is compounded by long wait lists for community-based services that include psychiatric consultations and Assertive Community Treatment for people with serious mental illness.

RAAM clinics and other addiction services give people quick access to addiction and mental health care without a referral or appointment. Concurrent treatment improves outcomes.

Clinicians must practise within their area of competence and seek support or consultation when needed for diagnosis and treatment. E-consultation is available through the Ontario Telehealth Network. Psychotherapy is an essential part of treatment (in addition to substance use counselling) not covered in this guide.

Assessment and Treatment of Psychiatric Disorders Common in Substance Use

DIAGNOSIS	ASSESSMENT TOOLS	TREATMENT GUIDELINES	FIRST-LINE MEDICATION
Posttraumatic stress disorder	PTSD Checklist for DSM-5 (PCL-5)	Canadian Clinical Practice Guidelines for the Management of Anxiety, Posttraumatic Stress and Obsessive-Compulsive Disorders[a]	Fluoxetine, sertraline, venlafaxine XR, paroxetine Prazosin for nightmares and alcohol use disorder[b]
Major depressive disorder*	Patient Health Questionnaire (PHQ-9) Beck Depression Inventory (BDI)	CANMAT 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults[c]	Escitalopram[d], sertraline, duloxetine, mirtazapine, bupropion or others[c] Augmentation with aripiprazole, brexpiprazole, bupropion
Generalized & social anxiety disorder*	General Anxiety Disorder-7 (GAD-7) Liebowitz Social Anxiety Scale (LSAS)	Canadian Clinical Practice Guidelines for the Management of Anxiety, Posttraumatic Stress and Obsessive-Compulsive Disorders[a]	Escitalopram[d], sertraline, venlafaxine XR, paroxetine, pregabalin, gabapentin[e]
Substance-induced psychosis/ schizophrenia	Clinical assessment	Canadian Guidelines for the Assessment and Diagnosis of Patients with Schizophrenia Spectrum and Other Psychotic Disorders[f]	Antipsychotics such as risperidone, olanzapine. paliperidone, aripiprazole,[g] and long-acting injectable formulations (aripiprazole, paliperidone)

[a] Katzman et al., BMC Psychiatry, 2014; 14. [b] Prazosin has some off-label evidence for alcohol use disorder; see Simpson et al., Am J Psychiatry, 2018; 175, 1216–1224. [c] Lam et al., Can J Psychiatry, 2024; 69, 641–687. [d] Escitalopram and citalopram have advisories about QT prolongation, particularly if combined with methadone. [e] Pregabalin and gabapentin have misuse potential and should be monitored and not prescribed in large amounts. [f] Addington et al., Can J Psychiatry, 2017; 62, 594–603. [g] Aripiprazole labels now warn about risk of pathological gambling, hypersexuality and other impulsive behaviours.

* Recent guidelines for treating alcohol use disorder warn against regular use of SSRIs for depression or anxiety without careful consideration. Wood et al., CMAJ, 2023; 95, E1364–E1379.

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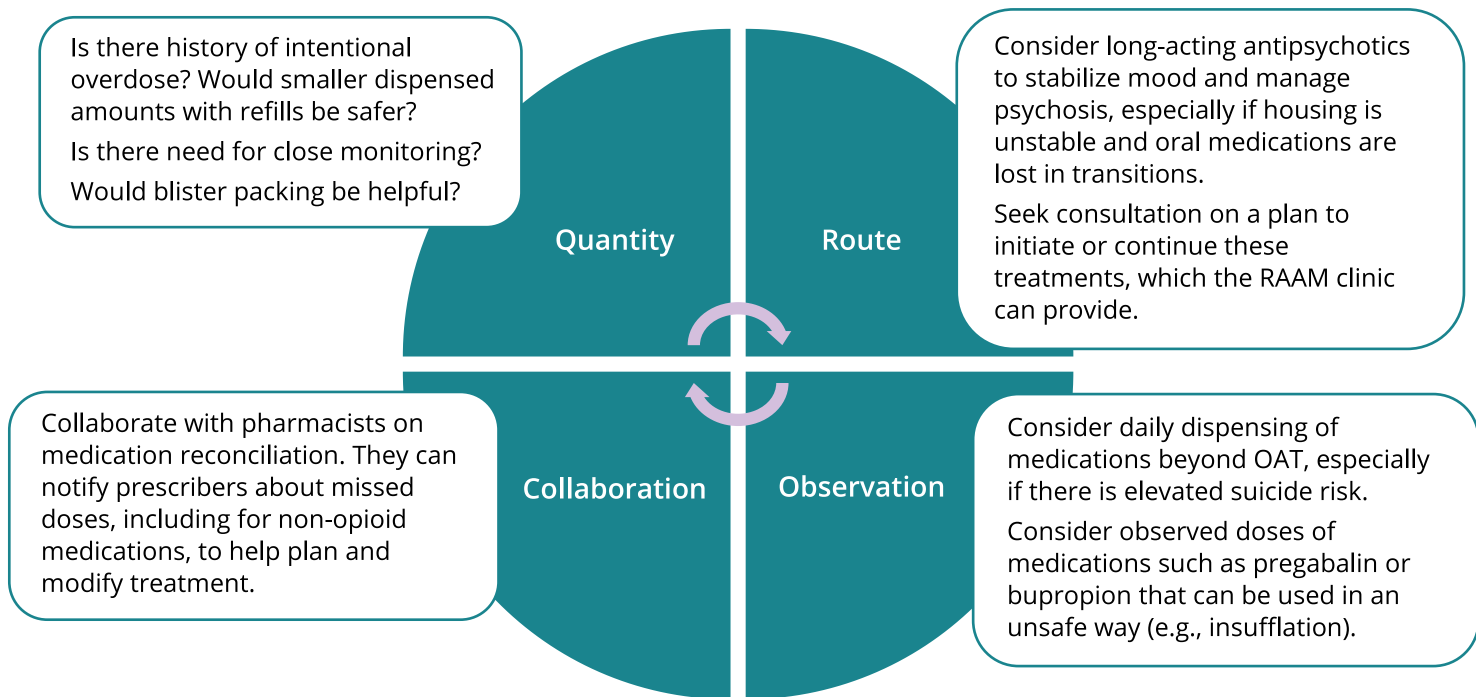
General Prescribing Considerations



Medical Considerations in Prescribing Psychiatric Medication

Consider medical conditions, risk factors and drug-drug interactions when prescribing medication for mental health disorders in patients with co-occurring substance use disorders.

CONCERN	TREATMENT CONSIDERATIONS
QT prolongation	Consider QT prolongation risk and relative benefits of medications, particularly when combining high-dose methadone (>150 mg) with QT-prolonging agents such as antipsychotics or antidepressants, or when patients are in alcohol withdrawal, or use cocaine or methamphetamine. Provide psychoeducation, monitor ECG (especially before and after initiating medication) and consider cardiology referral if there is QTc prolongation or a complex cardiac history.
Bipolar disorder	Avoid antidepressants or consider them only after comprehensive psychiatric assessment because they can precipitate mania in bipolar disorder. Mood-stabilizing medications such as valproate or lithium require careful monitoring and psychiatric assessment. Consider a medication that is safe for both prevention/treatment of mania and depression such as quetiapine or aripiprazole if mania is a concern.
Renal function	Adjust doses of medications such as lithium and pregabalin in patients with renal impairment because they undergo renal clearance.
Hepatic function	Remember that certain medications (e.g., duloxetine, valproate) undergo hepatic metabolism and are contraindicated in hepatic impairment or require dose adjustment (e.g., fluoxetine).
Drug-drug interactions	Work with the pharmacy team/pharmacist to identify drug interactions, including those related to cytochrome P450 enzyme inhibition or induction (e.g., vortioxetine, bupropion).

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Metabolic monitoring	Monitor for metabolic side effects in patients on antipsychotic medications for any indication (e.g., psychosis, mood augmentation). Manage cardiometabolic risks. Metabolic monitoring tools from the Early Psychosis Intervention Ontario Network
Safety assessments	Develop a safety plan because patients with mental health and substance use disorders are at risk of self-harm, harm to others and reduced self-care. The plan should include reducing the patient's access to means such as medications that have overdose potential. Free CAMH Safety Planning mobile app
Neurocognitive disorders	Recognize that patients may have neurocognitive disorders (dementia) due to use of substances such as alcohol, or they may have other concurrent disorders (traumatic brain injuries, cardiovascular disorders). Refer these patients to primary care or a memory clinic and ensure reversal of treatable causes (e.g., thiamine replacement). Consider the need for medication reconciliation and discontinuing or tapering medications such as benzodiazepines or anticholinergic medications that increase delirium risk. Older adults' mental health and medication resources: CCSMH and GeriMedRisk
Seizure history	Do not use bupropion in patients with elevated risk of seizures (significant alcohol use, sedative or hypnotic use disorder/withdrawal, history of seizures such as from fentanyl).
Pregnancy	Ensure informed consent in discussions about psychopharmacology in pregnancy. Risks of treatment versus risks of untreated mental health disorder must be carefully considered. Consider referral to perinatal mental health services and coordination of care with pregnancy care providers. Some medications have serious risks and are contraindicated in pregnancy (e.g., valproate). Pregnancy and medication resources: Best Use of Medicine in Pregnancy and LactMed
Polypharmacy	Conduct medication reconciliation and ensure strong communication with primary care providers and other prescribers. Polypharmacy can lead to serotonin syndrome with many classes of medications (SSRIs, opioids, TCAs). CredibleMeds medication safety resource

When to Consider Referral to Psychiatry

- Youth under age 18, especially under 16; patients over 65 or with neurocognitive disorders (or refer to memory clinic/geriatrics)
- Consideration or modification of medications such as valproate, clozapine, lithium; initiation of long-acting antipsychotics
- Community Treatment Orders or Assertive Community Treatment, usually for patients with psychotic disorders and repeated hospitalizations, to support community living and prevent rehospitalization
- Subspecialty care such as for obsessive-compulsive disorder that has not responded to first-line management
- Perinatal mental health care (planning pregnancy, during pregnancy, postpartum mental health concerns)

How to Address Acute Psychiatric Emergencies and Safety

- Consider driving safety, including mandatory reporting for psychiatric symptoms or diagnoses (e.g., acute psychosis).
- Consider the need for a Form 1 (Ontario). Physicians should complete this Application for a Psychiatric Assessment if there is a safety concern with a patient (e.g., threats to self/others, failure to care for self).

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- **Past/present test**: What is the *safety issue* (e.g., ran into traffic, attempted overdose, waved knife in clinic)?
- **Future test**: What are the *symptoms of a mental health disorder* (e.g., yelling at wall, demonstrating a thought disorder, feeling hopeless)?

- Consider the need for emergency services (EMS/police) if there is a risk to staff or other patients. A police wellness check is an option if a Form 1 is not possible or appropriate.

Pharmacological Treatments for Stimulant Use Disorder

The below off-label treatments have evidence in reducing stimulant use (primarily cocaine and methamphetamine).

MEDICATION	ADVANTAGES	CONCERNS	DOSING
Naltrexone	Alcohol use disorder treatment (first-line)[a] Can cause weight loss May prevent accidental opioid overdose	Contraindicated in opioid use disorder / opioid agonist treatment or any use of opioids (surgery, dental pain) Can cause weight loss and nausea Liver enzyme elevation, requires monitoring[a]	Start at 25 mg daily PO with food. Increase to 50 mg after one week. Consider off-label dosing 100–150 mg daily if helpful.[a]
Bupropion	ADHD treatment (off-label) Can cause weight loss Effective antidepressant Smoking cessation treatment	Seizure risk Mania risk in bipolar/schizoaffective disorder Misuse/insufflation/injection risk Can cause weight loss	Start at 150 mg daily, XL formulation preferred. Increase to 300 mg after a few weeks. Can increase to 450 mg if tolerated (increased seizure risk).
Mirtazapine	Insomnia treatment (off-label) Effective antidepressant Risk of weight gain or appetite increase	Mania risk in bipolar/schizoaffective disorder Risk of weight gain and sedation	Start at 15 mg QHS. Increase to 30 mg QHS after a few weeks. Max dose 45 mg QHS.
Topiramate	Seizure prophylaxis benefit Alcohol use disorder treatment (off-label)[a] Risk of weight loss	Cognitive side effect risk Teratogenic risk Adherence/discontinuation risk (seizures) Risk of weight loss	Titrate gradually starting at 25 mg once daily. Increase total daily dose gradually (by 25–50 mg weekly) to max 300 mg/day. Doses over 50 mg/day should be in two divided doses.
Psychostimulants (methylphenidate, amphetamine-type stimulants, modafinil)	Concurrent ADHD treatment Risk of weight loss Likely more effective for cocaine than amphetamine-type drug **Long-acting formulations are recommended*	Contraindicated in psychosis or mania, even if induced by substance use[b] Misuse – consider duration of prescription, or observed doses at pharmacy Cardiac arrhythmia risk	Depends on specific formulation. Start low and increase as tolerated.

[a] META:PHI Clinical Best Practices in Addiction Medicine, 2019. [b] ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder, 2024.

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