Introduction to Concurrent Disorders

Fundamentals of Addiction 2021

CSAM – SMCA Fundamentals

Disclosures

- No support from commercial sources
- Financial conflicts of interest — none

Learning Objectives

- By the completion of this presentation, attendees will be able to describe:
  - models of and risk factors for concurrent disorders
  - an approach to the assessment and treatment of concurrent disorders
  - Common patterns of psychiatric and substance use disorders

Definition: Concurrent Disorders

A condition in which a person has both a mental illness and is experiencing harmful involvement with alcohol, other drugs and/or gambling.

―CMHA

Concurrent disorders
Mental health
Use disorders
Substance-induced disorders
What percentage of people seeking help for addiction have a mental illness?

a. 5%

b. 10%

c. 25%

d. 50%

What percentage of people with a mental illness have a substance abuse problem?

a. 5-10%

b. 5-25%

c. 30-40%

d. 30-60%

What percentage of patients in an opioid agonist therapy clinic meet criteria for another DSM 5 Disorder?

a. 20%

b. 40%

c. 60%

d. 80%
View concurrent disorders as an expectation rather than an exception.

Major depression
Bipolar disorder
Panic disorder
PTSD
Social anxiety disorder
Schizophrenia
Eating disorder
Borderline personality disorder

Alcohol
Crack cocaine
Marijuana
Morphine
Dilaudid
Crystal meth
Nicotine
“Bath salts”
Ecstasy

Lifetime Prevalence Rates

<table>
<thead>
<tr>
<th>Substance Use Disorder</th>
<th>Bipolar Disorder</th>
<th>Schizophrenia</th>
<th>Major Depression</th>
<th>Any Anxiety Disorder</th>
<th>PTSD</th>
<th>Borderline Personality Disorder</th>
<th>Eating Disorder</th>
<th>ADHD</th>
<th>Rate of Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2%</td>
<td>1%</td>
<td>15-20%</td>
<td>10-25%</td>
<td>10-25%</td>
<td>8%</td>
<td>2-8%</td>
<td>1-3%</td>
<td>8%</td>
<td>10-45%</td>
</tr>
</tbody>
</table>
Risk factors for Concurrent Disorders

- Family problems
- Past or ongoing abuse or trauma
- Family history of concurrent disorders
- Discrimination
- Genetic factors or predisposition
- Unemployment, poverty or unstable income
- Lack of social network
- Stress related to work or school
Adverse Childhood Experiences Study

Dr. Daniel Sumrok: It’s not the drugs. It’s the ACEs – adverse childhood experiences.

Addiction: ritualized compulsive comfort-seeking

Between the substance use and mental health problems

- Complex interplay of different factors
- Any diagnosis from either category may cause, potentiate or predispose to the other.
- Different models developed to explore the complexity of CD
People with Concurrent Disorders

Overall:
- prognosis is more guarded
- use more services
- feel like “system misfits”
- are highly crisis prone
- are more difficult to engage in a positive and hopeful way

Assessment

- Challenges in assessing for a primary disorder versus secondary to the effect of a substance
  - Intoxication
  - Withdrawal
  - Substance-induced

A dimension approach to mental illness

- MOOD: depression, mania & affective instability
- ANXIETY: inhibited responses
- IMPULSIVITY: anger & aggression
- PSYCHOSIS: cognitive & perceptual disorganization

SUBSTANCE USE

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Psych Symptoms: Primary or Substance-induced?

- Depression
- Mania
- Anxiety
- Insomnia
- Anger
- Psychosis
- Cognitive problems (memory, attention)

Substance-Induced Disorders

- Mood Disorders
- Anxiety Disorders
- Neurocognitive Disorder
- Psychotic Disorder

Substance Induced Disorders

- acute intoxication or withdrawal
  - During or within 1 month of intoxication
  - Involved substance is capable of producing the mental disorder
  - Anxiety and psychosis usually ameliorate within 2 to 3 weeks

- With heavy and chronic use
  - > 6 month abstinence for some substance-induced psych sx and cognitive changes to reverse
Substance-induced or Not?

- Use a timeline to assess mental health symptoms and substance use
- Look for psychiatric symptoms before the onset of substance use AND during periods of abstinence

When psychiatric symptoms and substance use or withdrawal co-occur, a primary psychiatric condition may or may not be present. Time will tell.

--Beth Reade

Which do you treat first? Addiction or mental illness?

Concurrent Disorders--What to treat first?

- Safety and survival
  - Suicidal ideation
  - Psychosis
  - Risk of violence
  - Dangerous withdrawal
- Then addiction and mental health treatment
  - Brain must be clear from substances to learn new skills
### Barriers to Treatment

- Stigma and denial
- All diagnoses not identified
- Complexity of presentation
- Not aware of treatment options
- Challenges in navigating addiction and psychiatric systems
- Difficulty affording treatment or time off work
- Non-supportive spouse or partner
- Other responsibilities

### Approaches to treatment of addictions and psychiatric illness

- Sequential treatment
- Parallel treatment
- Integrated treatment

### Integrated Approach

- SAMHSA supports an integrated treatment approach to treating co-occurring mental and substance use disorders:
  - Collaboration across disciplines
  - Client-centered, patient's goals
- Integrated treatment associated with lower costs and better outcomes:
  - Reduced substance use
  - Improved psychiatric symptoms and functioning
  - Decreased hospitalization
  - Increased housing stability
  - Fewer arrests
  - Improved quality of life
Conclusion: Emergent models of coordinated care were found to include
- collaborative care,
- regional networks with centralized access to care,
- clinical information-sharing,
- cross-training,
- improved scope of care to include psychologists,
- alignment of physician incentives with patient needs to better support patient care.

5 CD Subgroups

1. Stress, Trauma & Substance Use Disorders
2. Anxiety Disorders & Substance Use Disorders
3. Mood Disorders & Substance Use Disorders
4. Psychosis & Substance Use Disorders
5. Impulsivity & Substance Use Disorders
Talk therapy

- Individual vs group
- In person vs online
- Mutual support groups
- Motivational enhancement
- Skills in distress tolerance and emotion regulation
- Relapse prevention
- Acceptance and Commitment Therapy
- CBT for depression, anxiety, insomnia
- CRAFT—Community Reinforcement and Family Training

PTSD & Alcohol Use Disorder

- Gets worse with abstinence
- Trazadone
- Prazosin
- Gabapentin
- Cognitive Processing Disorder when ready

Social Anxiety Disorder & Opioids or Alcohol

- Self-treating
- Gets worse with abstinence
- SSRI early
- ? quetiapine
- ? gabapentin
- ? benzo’s
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Description of slide:

**Depression & Alcohol Use Disorder**

- A total of 32 studies met systematic review inclusion criteria.
- Pharmacological treatments were significantly better than placebo in improving manic symptoms, MDD depressive symptoms, and alcohol abstinence but were not better for bipolar depression symptoms.
- Importantly, quetiapine was not more effective than placebo in improving bipolar depression symptoms nor were SSRIs for the treatment of MDD depression.
- Our findings highlight the need for further high-quality clinical trials of treatments for mood disorders and comorbid addictions.

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Description of slide:

**Methamphetamine & Psychosis**

- Qualitatively different than primary psychosis
- Patient often aware they are psychotic
- Persists after abstinence achieved for 6 mon
- Recurs with re-exposure
- Antipsychotics
- Topiramate XL and mirtazapine
- Stimulants

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Cannabis & Psychosis in Youth

- Increases risk of psychosis, but modest
- Amotivation syndrome
- Antipsychotics
- Engage in meaningful activities

ADHD & Addictions

- Risk factor
- Assessment: Adult ADHD Self-Report Scale (ASRS) or neuropsych testing
- Do you treat?
- Atomoxetine
- Long-acting stimulants

Borderline Personality Disorder

- Use substances to cope with strong emotions
- Hx of self-harm, impulsivity
- Few supports due to hx of conflict in relationships
- Need skills in distress tolerance and emotion regulation in order to succeed in maintaining abstinence
Insomnia & Substance Abuse

- Sleep hygiene
- Exercise
- Trazadone
- Quetiapine
- Mirtazapine
- Gabapentin
- ? Benzos or zopiclone

Concussions

- Risk factor for addictions!!!
- Patient appears “non-compliant” but due to traumatic brain injury has an “inability” to comply—it is NOT lack of motivation


CD Clinic at St Joe’s Hamilton

- Groups: now virtual
  - Motivational enhancement (4 sessions, drop-in)
  - Basic DBT skills (6 sessions, drop-in)
  - SMART recovery (drop-in, 6pm)
  - Acceptance & Commitment Therapy (drop-in AND closed)
  - Post-acute withdrawal syndrome group (drop-in)
  - Friends & Family psycho-ed group (once/month)
  - www.cdcapacitybuilding.com—non-live group link

- Clinicians identify clients needing a psych assessment
There is no one correct approach to individuals with concurrent disorders.

What is true concurrent disorders care?

When a client can talk openly about the interaction between their use of substances and their psychiatric state.

Thank you jbrasch@stjoes.ca
Resources

- Concurrent Disorders resources (Hamilton based)
  www.cdcapacitybuilding.com
  - Source for some diagrams in presentation, available in "articles" tab

- Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration [META PHI] https://metaphi.ca/ (if you look at only 1 resource, make it this one)

- Medications for the treatment of Alcohol Use Disorder (2015)

- Low-risk Alcohol Drinking Guidelines
  http://www.ccdus.ca/Eng/topics/alcohol/drinking-guidelines/Pages/default.aspx

- APA Guidelines for Alcohol Use Disorder Treatment

- Ashton Manual
  https://www.benzoinfo.com/
  Deprescribing guidelines: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5951648/
  SBIRT http://www.sbir-dba.ca/

- Canadian Society for Addiction Medicine https://csam-smca.org/