Intro to Concurrent Disorders

Presentation provided by
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“There are all kinds of addicts, I guess. We all have pain. And we all look for ways to make the pain go away.”

--Sherman Alexie
Disclosures

- I do not have any affiliations with a pharmaceutical, medical device or communications organization
- I may discuss off-label use of medications
Learning Objectives

- Recognize common presentations of co-occurring disorders
- List strategies for assessment of patients with both mental disorders and addictions
- Describe approaches to treatment for patients with concurrent disorders
Mental Illness

- Mental illnesses are neurobiological disorders characterized by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning.
Addiction

- Addiction is a neurobiological disorder characterized by behaviours that include one or more of the following:
  - Impaired control over drug use
  - Compulsive use
  - Continued use despite consequences
  - Cravings
- A chronic disorder with relapsing course
- Substance use disorder
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.

- Dual Diagnosis
- Co-occurring Disorders

- There are many combinations of psychiatric and substance use disorders and many complex presentations.
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”
Ecstacy

Fundamentals: Concurrent Disorders
What percentage of people seeking help for addiction have a mental illness?

- 5%
- 10%
- 25%
- 50%
What percentage of people with a mental illness have a substance abuse problem?

- 5-10%
- 5-25%
- 30-40%
- 30-60%
View concurrent disorders as an expectation rather than an exception.
### Lifetime Prevalence Rates

<table>
<thead>
<tr>
<th>Psychiatric Disorder</th>
<th>Rate of substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder</td>
<td>1-2%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1%</td>
</tr>
<tr>
<td>Major depression</td>
<td>15-20%</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>10-25%</td>
</tr>
<tr>
<td>PTSD</td>
<td>8%</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>2-6%</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>1-3%</td>
</tr>
<tr>
<td>ADHD</td>
<td>8%</td>
</tr>
</tbody>
</table>
# Lifetime Prevalence Rates

<table>
<thead>
<tr>
<th>Substance use disorder</th>
<th>Rate of psychiatric disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use disorder</td>
<td>22%</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>7%</td>
</tr>
<tr>
<td>Cannabis use disorder</td>
<td>18%</td>
</tr>
<tr>
<td>Nicotine use disorder</td>
<td>44% (16%)</td>
</tr>
</tbody>
</table>
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
People with Concurrent Disorders

- Seek treatment more often for either
- Have worse outcome
  - More addiction relapses
  - More non-response to psych meds
  - More hospitalizations
  - More suicide attempts and deaths
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 (ACE) – within first 18 years of life

≥ 4 ACE categories = 4-12x ↑ risk of SUD

- Emotional abuse
- Physical abuse
- Sexual abuse
- Emotional neglect
- Physical neglect
- Mother treated violently
- Household substance abuse
- Household mental illness/suicide attempt
- Parental separation or divorce
- Incarcerated household member
ACEs

- **Estimate**: ACEs responsible for ½ to 2/3 explanation for substance use disorders

- **Other factors**
  - Genetics
  - Mental health disorders
  - Environmental stressors (e.g. job loss, relationship difficulties)
  - Other environmental factors like substance social acceptability and availability
Interplay of substance use and mental health problems

Relationship not simply ‘cause and effect’, but complex mixture of:

- environmental risk factors (stressors)
- shared neurotransmitters
- genetics

Any diagnosis from either category may cause, potentiate or predispose to the other.
1. No Association Model

Psychiatric Disorder

Substance Abuse
2. Self-medication Model

Psychiatric Disorder → Substance Abuse
3. Secondary Psychopathology Model

Substance Abuse → Psychiatric Disorder
4. Common Factor Model

Common Factor

Substance Abuse

Psychiatric Disorder
5. Bi-directional Models

Psychiatric Disorder \[\leftrightarrow\]\ Substance Abuse
Interactions

- No one theory can entirely explain the relationship between mental illnesses and abuse; each fits for some presentations but not all.

- Danger is in indiscriminately applying one model to all clients – careful assessment needs to be carried out.

- Every patient is unique in their presentation and the etiology of their disorder.
Assessment

- It is difficult to be sure whether a psychiatric disorder is present when patients are actively using substances and when they are in acute withdrawal.
Post-acute withdrawal

- When a pt has heavily used addictive substances chronically, it may take > 6 mon abstinence for some substance-induced psych sx and cognitive changes to end
Presentations of Concurrent Disorders

- Intoxication or withdrawal from drugs or alcohol can mimic nearly every psychiatric disorder:
  - Cocaine Intoxication may induce symptoms similar to mania
  - Cocaine withdrawal may induce/mimic a depressive episode
  - Alcohol-Induced Mood Disorder:
  - Cannabis-induced Psychotic Disorder
- Sequential evaluations over time are essential!
Clues to distinguish between sub-induced sx and psych illness

- Use a time line to see if psych sx predated sub use
- See if psych sx present during abstinent periods (1 mon)
- Look for family hx of addiction or psych illness
Concurrent Disorders - Mania

- Intoxication with stimulants and hallucinogens can mimic symptoms of mania

- 50-60% of patients with BAD have a history of substance use disorders (Brady et. al. 1995)

- Individuals are more likely to use alcohol and drugs in a manic state

- Unfortunately, the use of alcohol or drugs is likely to disinhibit the individual and worsen the episode
Concurrent Disorders - Depression

- As many as 98% of individuals presenting for substance abuse treatment have some symptoms of depression (Jaffe et. al. 1996)

- Depressed affect and suicidal ideation are often associated with withdrawal states

- Depression is often time-limited and resolves with abstinence

- When do you offer antidepressants?
Anxiety & Substance Misuse

- Panic Disorder
- Social Anxiety Disorder
- Generalized Anxiety Disorder
- PTSD
Two Disorders that get worse with abstinence

- Social Anxiety Disorder
- Post-Traumatic Stress Disorder
What stages of substance use are associated with psychotic sx?

- Intoxication
- Withdrawal
- Substance abuse disorder
- Substance dependence disorder
How to sort out cause of psychosis?

- History
- Old records
- Physical exam
- blood tests
- urine drug screen
- time
## My favourite Self-Report Scale

### The Adult ADHD Self-Report Scale

**Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you lose track while working on a task?</td>
<td></td>
</tr>
<tr>
<td>2. How often do you make careless mistakes?</td>
<td></td>
</tr>
<tr>
<td>3. How often do you feel restless or fidgety?</td>
<td></td>
</tr>
<tr>
<td>4. How often do you have difficulty standing or remaining still?</td>
<td></td>
</tr>
<tr>
<td>5. How often do you have difficulty concentrating on what people say?</td>
<td></td>
</tr>
<tr>
<td>6. How often do you have difficulty keeping your attention on a task?</td>
<td></td>
</tr>
<tr>
<td>7. How often do you feel stressed or easily upset?</td>
<td></td>
</tr>
<tr>
<td>8. How often do you feel anxious or nervous?</td>
<td></td>
</tr>
<tr>
<td>9. How often do you feel depressed or hopeless?</td>
<td></td>
</tr>
<tr>
<td>10. How often do you feel tired or exhausted?</td>
<td></td>
</tr>
<tr>
<td>11. How often do you feel irritable or angry?</td>
<td></td>
</tr>
</tbody>
</table>

**Part B**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. How often do you feel anxious or nervous?</td>
<td></td>
</tr>
<tr>
<td>13. How often do you feel tired or exhausted?</td>
<td></td>
</tr>
<tr>
<td>14. How often do you feel irritable or angry?</td>
<td></td>
</tr>
<tr>
<td>15. How often do you feel stressed or easily upset?</td>
<td></td>
</tr>
<tr>
<td>16. How often do you feel depressed or hopeless?</td>
<td></td>
</tr>
<tr>
<td>17. How often do you feel anxious or nervous?</td>
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</tr>
<tr>
<td>18. How often do you feel tired or exhausted?</td>
<td></td>
</tr>
<tr>
<td>19. How often do you feel irritable or angry?</td>
<td></td>
</tr>
</tbody>
</table>

**Concurrent Disorders**
Ask About Trauma

- Addiction and mental health outcomes are better when trauma is treated
  - (Najavits 2013- review article)
    - Best outcomes in concurrent, combined program such as Seeking Safety
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
Where do you start

- What to treat first?
- Safety and survival
  - Suicidal ideation
  - Psychosis
  - Dangerous withdrawal
- Then addiction treatment
  - Brain must be clear from substances to learn new skills
Four Quadrant Model

Service coordination by Severity

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Locus of care</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>III</td>
<td>Locus of care: Substance abuse system</td>
<td>High severity</td>
</tr>
<tr>
<td>IV</td>
<td>Locus of care: State hospitals, jails/prisons, emergency rooms, etc.</td>
<td>High severity</td>
</tr>
<tr>
<td>I</td>
<td>Locus of care: Primary health care settings</td>
<td>Low severity</td>
</tr>
<tr>
<td>II</td>
<td>Locus of care: Mental health system</td>
<td>Low severity</td>
</tr>
</tbody>
</table>

Mental Illness

Consultation: Green
Collaboration: Yellow
Integrated Services: Red

Canadian Society of Addiction Medicine
La Société Médicale Canadienne sur l’Addiction
Quadrant model for Hamilton

Fundamentals: Concurrent Disorders
Psychiatry Clinic

? 

Addiction Service
Mental Health Clinic

Primary Care Office

Addiction Service

Fundamentals: Concurrent Disorders
Sequential Treatment

- Untreated disorder may worsen treated disorder.
- Which to treat first?
- When has 1st disorder been successfully treated to start second?
- Client ends up not referred.
Parallel Treatment

- Mental health programs and addictions treatment not integrated into cohesive treatment package.
- Treatment providers do not communicate.
- Treatment providers lack common language and treatment methodology.
- Burden of integration falls to client who must meet 2 eligibility criteria.
- No one takes final responsibility for client and they fall through the cracks.
Integrated Approach

- Same provider or team of providers provides treatment for mental illness and substance abuse disorder
- Under one roof
- Integrated assessment!
- One message
Components of Treatment

Psychosocial treatments:
- Family therapy
- Psycho-education
- Psychotherapy: individual & group counselling
- Peer support

Biological treatments:
- Medications to treat mental health problems
- Medications to treat substance abuse problems
Depression & Alcohol Misuse

- When to treat?
- Choice of medication?
- Encouraging reduction in use?
Methadone & Depression

- Consider
  - Sertraline, venlafaxine, mirtazapine, bupropion, escitalopram
- Try to avoid
  - Fluoxetine
  - Fluvoxamine
- If use antipsychotic, consider ECG
Insomnia & Substance Misuse

- Trazadone
- Doxepin (Silenor)
- Quetiapine
- Tryptophan
- Melatonin
- Zopiclone
- Zolpidem
- Benzodiazepines
What is true concurrent disorders care?

interaction between use of substances and psychiatric state.
Concurrent disorders are the rule, not the exception

Ideal: “no wrong door” when seeking treatment

Empathic, non-judgemental attitudes key in health care providers

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