

Concurrent Disorders: A Model for Treatment

Dr. Laura Chapman, VIHA & NHA
MD FRCPC ASAM
Clinical Assistant Professor
UBC Psychiatry

Learning Objectives

1. Identify screening techniques
2. Discuss brief treatment strategies
3. Review treatment resources

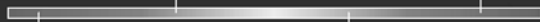
Spectrum of Psychoactive Substance Use

Non-problematic

• recreational, casual or other use that has negligible health or social impact

Dependent

• use that has become habitual and compulsive despite negative health and social impacts

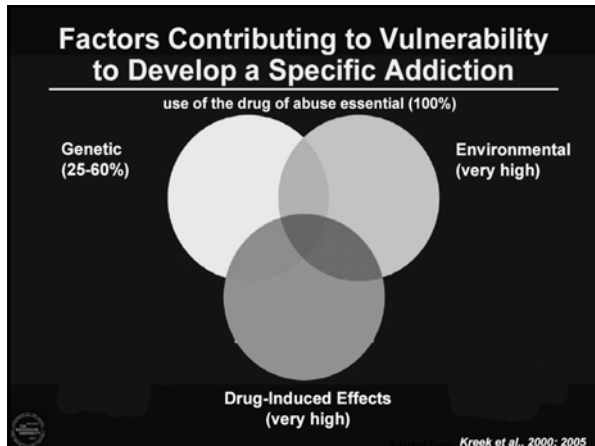


Beneficial

• use that has positive health, spiritual or social impact
• e.g. medical psycho-pharmaceuticals; coffee to increase alertness; moderate consumption of red wine; sacramental use of ayahuasca or peyote

Problematic

• use that begins to have negative health consequences for individual, friends/family, or society
• e.g. impaired driving; binge consumption; harmful routes of administration



Prevalence of Concurrent Disorders in the Community

- 19% of the general population in Ontario aged 15-54 met criteria for CD in the past year (Offord et al 1996)
- 55% of people with an alcohol use disorder at some point in their lives also had a MHD (Ross 1995)
- NCS (1992) 28% general population had CD
- Treatment seeking populations have higher rates

Lifetime Prevalence of SUD in Specific MHDs

| | | |
|------------------------|----------|-----------|
| Bipolar Disorder | 56% | Gen Pop |
| Schizophrenia | 47% | AUD = 10% |
| Major Depression | 27% | DUD = 6% |
| Any Anxiety Disorder | 24% | |
| PTSD | 30 - 75% | |
| Borderline Personality | 23% | |
| Eating Disorder | 23 - 55% | |

Kessler NCS 1992

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Screening for SUD – Level 1

- Single question, all patients, annually
- Integrate into general medical care
- Positive = within the last 12 months
- Sensitivity = 80%
- Specificity = 74%

**“When was the last time you had more than
___(4 for women, 5 for men) drinks in 1 day?”**

Seale JP et al J Stud Alcohol. 2006 Sept;67(5):778-84

Screening for SUD – Level 2

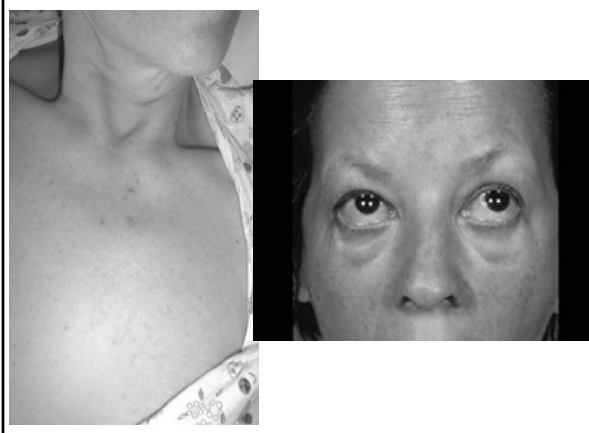
- **AUDIT**
www.smartrecoveryaustralia.com.au/HealthProviderAUDIT.pdf
- **CUDIT** or **DUDIT**
www.chmeds.ac.nz/departments/psychmed/treatment/pdfs/cudit.pdf
- **ASSIST** –
www.nida.nih.gov/nidamed/screening/
- Stratify to low, moderate or high risk
- Screening is most effective when done with brief intervention

Screening for Mental Health Disorders (MHD) – Level I

- “Have you ever been given a mental health diagnosis by a qualified professional?”
- “What were the circumstances?”
- “Have you ever been hospitalized for a mental health illness?”
- “Have you ever harmed yourself or thought of harming yourself but not as a direct result of drug or alcohol use?”
- **ABC Checklist** – Appearance/Affect/Anxiety, Behaviour, Cognitive
- PHQ-2, PHQ-9

Screening for MHD – Level 2

- **Psychiatric Review of Symptoms (PROS)**
(Carlat DJ Amer Family Physician Nov 1998)
- SIGECAPS, DIGFAST, ‘I DESPAIRR’, ‘Recipe4Pain Convert 2 Stomachs to 1 Sex’, Anxiety/Panic, Ob/Comp, Eating Disorders, Memory impairment
- **BC Practice Support Program:**
<http://www.impactbc.ca/practicesupport/mentalhealth>
‘S2IGECAPS A2GS P3OMP2 (CAGES)’
- GAD-7, Mood Disorders Questionnaire (MDQ), MOCA, MMSE, Beck Depression Inventory
- **Focus on symptoms prior to onset of SUD, during abstinence, order of onset**









Children found in homes with meth labs

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Using the NIAAA Clinician's Guide (Updated 2005 Edition)

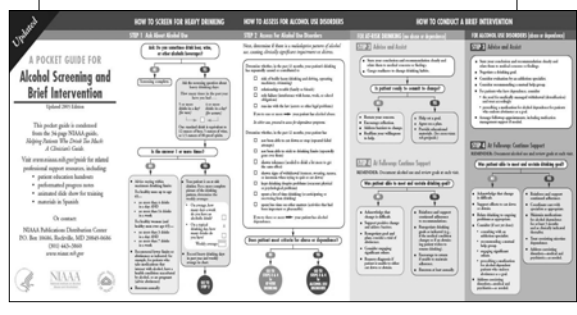
To order free copies of the
Clinician's Guide, contact
NIAAA...

Online
www.niaaa.nih.gov/guide



POCKET GUIDE

NIAAA also offers a condensed Pocket Guide
that features the same steps and many of the
supporting materials.



www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf



THE ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (ASSIST): GUIDELINES FOR USE IN PRIMARY CARE

Draft Version 1.1 for Field Testing



World Health Organization

<http://nida.nih.gov/nidamed/resguide/resourceguide.pdf>

SCREENING FOR DRUG USE IN GENERAL MEDICAL SETTINGS
Resource Guide

NIDA

www.kap.samhsa.gov/products/brochures/pdfs/bmdc.pdf

Brief COUNSELING for MARIJUANA DEPENDENCE

A Manual for Treating Adults

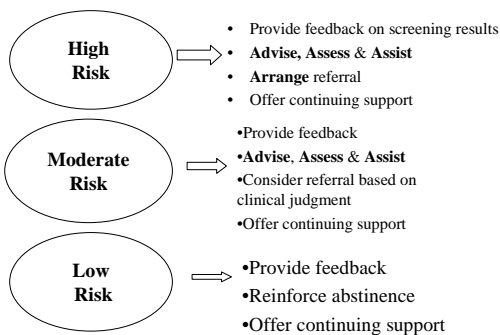


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Brief Treatment – 5A’s

- **Ask** – about substance use and effects
- **Advise** – patient to make a change according to screening result
- **Assess** – readiness to change and confidence to change
- **Assist** – in making the change
- **Arrange** – specialty referral, follow up visit

Brief Treatment



Process of Addiction Treatment

| Phase of Treatment | Stage of Change |
|--------------------------------------|-------------------------------|
| • Screening | • Precontemplative |
| • Engagement | • Contemplative / Preparation |
| • Withdrawal Management | • Action |
| • Stabilization: | • Action |
| – +/- Residential Treatment | • Action |
| – +/- Intensive Outpatient Treatment | |
| • Relapse Prevention | • Maintenance |
| • Re - engagement | • Relapse |

Comparing Traditional & Motivational Approach

Traditional Approach

- Focused on fixing the problem
- Paternalistic relationship
- Assume patient is motivated
- Advise, warn, persuade
- Ambivalence means patient is in denial
- Goals are prescribed
- Resistance is met with argumentation, persuasion, correction

MI Approach

- Focused on patient concerns and perspectives
- Egalitarian partnership
- Match intervention to patient
- Emphasizes personal choice
- Ambivalence normal part of change process
- Goals are collaboratively set, patient given a menu of options
- Resistance influenced by provider behaviour

Motivational Interviewing: Techniques

- Open-ended questions
- Affirmations
- Reflective listening / Roll with Resistance
- Summarize

www.motivationalinterview.org

Motivational Interviewing: Techniques

- Feedback
- Responsibility for change rests with the patient
- Advice regarding risk to health
- Menu of change options developed
- Empathic listening
- Self-efficacy is enhanced

Motivational Interviewing: Stage of Change

- **Precontemplation stage**

Goal: patient will begin thinking about change.

- "What would have to happen for you to know that this is a problem?"
"What warning signs would let you know that this is a problem?"
"Have you tried to change in the past?" "What was it like?"

Zimmerman GL Amer Family Physician March 1, 2000

Motivational Interviewing: Stage of Change

- **Contemplation stage**

Goal: patient will examine benefits and barriers to change.

- "What are the reasons you want to change at this time?"
"What were the reasons for not changing?"
"What would keep you from changing at this time?"
"What are the barriers today that keep you from change?"
"What might help you with that aspect?"
"What things (people, programs and behaviors) have helped in the past?"
"What would help you at this time?"
"What do you think you need to learn about changing?"

Zimmerman GL Amer Family Physician March 1, 2000

Action Stage: Change Plan Worksheet

www.motivationalinterview.org/clinical/change

The changes I want to make are:

The reasons I want to make these changes are:


The steps I plan to take in changing are:

The ways other people can help me are:


I will know that my plan is working if:

Some things that could interfere with my plan are:

What I will do if the plan is not working:



Screening, Brief Intervention, and Referral to Treatment



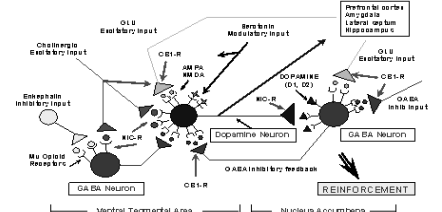
SAMHSA
CSAT
Center for Substance Abuse Treatment

On-line training for Brief Intervention:
<http://sbirt.samhsa.gov/>

Addiction Pharmacotherapy

5/26/2015
LI-NAATP

Neurotransmitter/Modulator Relationships in Reinforcement



Addiction Pharmacotherapy

- Combine with standard behavioural treatments
- Consider for patients with high cravings
- Consider for patients who have limited success with standard therapies
- Integrate urine drug testing with feedback, document improvement, consider as a trial
- **Model:** Tobacco treatment
 - NRT, Bupropion, Varenicline, combinations + behavioural treatments

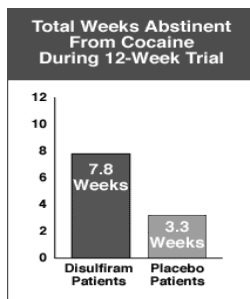
Cocaine



Pharmacotherapy - Cocaine

- All are off-label
- Disulfiram (Antabuse)– 250 mg daily
Gossop M & Carroll KM *Alcohol & Alcoholism* 2006;41(2);119–120
- Modafanil (Alertec) – 200 mg BID
Anderson AL et al *Drug & Alcohol Depend* 2009,104:133-139
- Topiramate – titrate up to 200mg daily
Kampman KM et al *Drug Alcohol Depend* 2004,75:233–240
- Tiagabine (Gabitril) - 24 mg/day
Gonzalez G et al *Drug & Alcohol Dependence* 2007;87(1):1-9

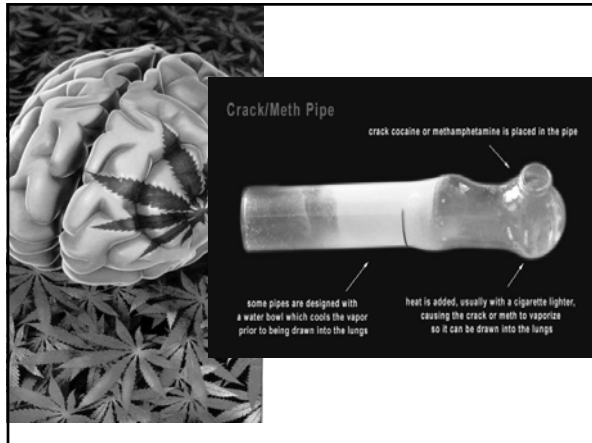
Disulfiram for Cocaine



•Carroll, K.M., et al. Efficacy of disulfiram and cognitive behavior therapy in cocaine-dependent outpatients: A randomized placebo-controlled trial. *Archives of General Psychiatry* 61(3):264-272, 2004.

Pharmacotherapy – Cocaine

- **Vigabatrin (Sabril)** – 1-3 grams/day
(Brodie JD Am J Psychiatry online epub Aug 3,2009)
- **Baclofen** – 20 mg TID
(Shoptaw S J Clin Psychiatry 2003;64:1440-1448)
- **??Dextroamphetamine (Dexedrine)** – 15 – 30 mg/day; improved treatment retention only
(Grabowski J Jour Clin Psychopharm2001;21:522-526 & Myles J Evidence-Based Mental Health 2002;5:47)



Pharmacotherapy – Cannabis and Methamphetamine

- **All are off-label**
- **Cannabis:**
 - Dronabinol – reduces cravings, withdrawal discomfort, insomnia, irritability
(Haney M 2004, Budney AJ 2007)
 - Empirically : Quetiapine and Trazadone for withdrawal symptoms
- **Methamphetamine:** - Empirically: antipsychotics
 - ??Dextroamphetamine – 15 – 60 mg/day
(Grabowski J Jour Clin Psychopharm 2001;21:522-526)
 - Viagabatrinn (Sabril) – 1-3 g/day
(Brodie DJ Synapse 2005;55:122-125)

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BC Treatment Resources: Addictions

- Local HA Mental Health & Addictions Clinics
- Withdrawal Management Services – Out patient and inpatient
- **Residential** Treatment facilities: (not a complete list)
 - **Co-Ed**: Crossroads (Kelowna), Pacifica (Vancouver), Phoenix (Surrey)
 - **Women only**: Aurora (Vancouver), Ellendale (New West)
 - **Men only**: Kinghaven/Pearndonville (Abbotsford), Surfside (Nanaimo), Central City Lodge (Vanc), Last Door (Vanc)
 - **Youth**: The Crossing (Keremeos), Atlas (Terrace), Waypoint (Vanc)
 - **Aboriginal**: North Wind (Dawson Creek), Round Lake (Armstrong), Tsow-Tun Lelum (Lantzville)

BC Treatment Resources Addictions

- **Private Residential Treatment Facilities**:
 - Cedars at Cobble Hill, Edgewood (Nanaimo), Orchard (Bowen Island), Sunshine Coast (Powell River), Sage Healing Centre (Kamloops), Women Into Healing (Maple Ridge), Inner Visions (Surrey)
- **Support, Recovery & Stabilization Housing**:
 - Eg. Turning Point (Richmond)

Long Term Treatment: Burnaby Centre for Mental Health & Addictions

Patient Resources - SUD

Alcoholics Anonymous – www.aacanada.com
Narcotics Anonymous – www.na.org or
www.bcrsna.bc.ca
Smart Recovery – www.smartrecovery.ca
Life Ring – www.unhooked.com
Dual Recovery Anonymous – www.draonline.org
Gamblers Anonymous – www.gamblersanonymous.org
Overeaters Anonymous – www.oa.org
Al-Anon (substance affected) –
www.al-anon.alateen.org

Treatment Can Work!

NIDA's Principles of Treatment

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Treatment must attend to multiple needs of the individual, not just drug use.
- Multiple courses of treatment may be required for success.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.



NIDA



Cost-Effectiveness of Drug Treatment

- Treatment is less expensive than not treating or incarceration (1 yr methadone maintenance = \$4,700 vs. \$18,400 for imprisonment)
- Every \$1 invested in treatment yields up to \$7 in reduced crime-related costs
- Savings can exceed costs by 12:1 when health care costs are included
- Reduced interpersonal conflicts
- Improved workplace productivity
- Fewer drug-related accidents

NIDA

www.drugabuse.gov

Patient and Practitioner Resources MHD

- Fact Sheets:
www.heretohelp.bc.ca/publications/factsheets
- Skills:
www.heretohelp.bc.ca/skills
www.comh.ca/selfcare
www.dbtselfhelp.com
www.behavioraltech.com/index.cfm (BPD resources)
www.moodgym.anu.edu.au/moodgym

Support Groups MHD

- Mood Disorders Association of BC
– www.mdabc.net
- Anxiety Disorders Association of BC
– www.anxietybc.com
- Schizophrenia Society of BC
– www.bcsm.org

Summary

1. Screening is effective and many easy to use tools are available
2. Brief treatment is effective for patients at low to moderate risk and can be integrated into general medical practice
3. There are many resources available for directed self-help through intensive inpatient treatment

Treatment is effective!

Thank you!
Questions?