Dual Diagnosis

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Overview

- Context
- Medical Illnesses
- Suicide
- Prevalence of Dual Diagnosis
- Diagnostic Difficulties
- Barriers to Recovery in Dual Diagnosis
- Broad Principles

"The AA member- medications and other drugs" pamphlet

"It becomes clear that just as it is wrong to enable or support any alcoholic to become re-addicted to any drug, it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems."

Narcotics Anonymous Fellowship Services states...

"The question of prescription medication should be decided between the member, their doctor, and the member's Higher Power.

Our pamphlet *"In Times Of Illness"* ***and our*** *10th Tradition*, ***make this abundantly clear.***

We strongly recommend telling our doctors about our history so that when prescription medication is absolutely necessary * they can prescribe it knowing that we are recovering addicts."

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State of the evidence

- **Meta analysis (Nunes & Levin) of depression treatment in patients with substance use disorders**
- **300 trials between 1973-2003**
- **Only 44 were placebo controlled**
- **Only 14 met inclusion criteria for rigor (randomized, etc)**
- **8 studies focused on EtOH**
- **In 4 of those studies, patients were drinking at the time of the study**
- **The only clear findings were that antidepressants worked better for depression if patients were sober and they didn't improve abstinence rates**

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COMBINE TRIAL
Among the largest PharmaRx addiction trials

- **Patients were not excluded for cannabis dependence**
- **Patients were not tested for cannabis use during study**
- **Visits included GGT, CDT, LFT, Renal Function but not a urine drug screen**
- **Outcomes were measured by % days abstinent or time to heavy drinking, rather than continuous abstinence.**

prior to baseline evaluation. Exclusion criteria included (1) history of other substance abuse (other than nicotine or cannabis) by *DSM-IV* criteria in the last 90 days (6 months for opiate abuse) or by urine drug screen, (2) psy-

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- Treatment Principles: Medications, Therapy, 12-step approaches

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Medical Illnesses with common depression comorbidities:

- Epilepsy
- Huntington's disease
- Infections (HIV, neurosyphillis)
- Migraines
- MS
- Narcolepsy
- Cancer
- Wilson's disease
- Parkinson's Disease
- Cushing's disease
- Menses-related
- Post-partum
- Parathyroid disorders and thyroid disorders
- SLE
- Immune/inflammatory disorders
- Certain medications

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- Specific Depressive Disorders
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Suicide

- Patients with an EtOH use disorder 20x more likely to complete suicide than general population.
- Between 18% and 66% of suicide victims have alcohol in their blood at the time of death (Roizen 1988; Welte et al. 1988, Collier et al. 1986, Berkelman et al. 1985).

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Suicide Risk Factors

- Previous suicide attempts
- History of mental disorders, particularly depression
- History of alcohol and substance abuse
- Family history of suicide
- Family history of child maltreatment
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)

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Suicide Protective Factors

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

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Prevalence

- One estimate indicates that in a given year, 10 million US residents have both a substance use disorder and mental health diagnosis
- The prevalence of depressive d/o among treatment seeking alcoholics ranges from 15-67% depending on the study
- The largest studies to address prevalence are ECA and NCS

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What conclusions about prevalence can be drawn?

- Data are conflicting d/t failure to exclude substance induced illnesses, study design, etc.
- All affective disorders are common in SUD patients, and Bipolar d/o has the highest rate of SUD of any psychiatric illness
- Depression and dysthymia are more common in opiate dep and alcohol dep.

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Diagnostic Difficulties

- **"Which came first" may not help you distinguish.**
- **Periods of abstinence, while extremely helpful in clarifying diagnosis are…**
  - Often inaccurately reported
  - Sometimes never present or too short to be useful
  - Occasionally characterized by exposure to prescription medications that further complicate diagnosis

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Diagnostic Confusion

- **Mania is generally easier to diagnose than depression in people with a SUD**
- **Manic symptoms induced by substance use tend to resolve in days; depressive symptoms can take weeks or in some cases, months**
- **Methamphetamine and hallucinogens can be the exception to this rule, as substance-induced mania with these agents can persist for weeks.**

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When to diagnose?

"The best way to clarify diagnosis is through observation during a period of abstinence"

- Diagnosing too early can lead to overtreatment and mismatching and *possibly* poorer outcomes.
- Diagnosing too late can lead to higher risk of relapse, poorer outcomes, and suicide.
- What clinical features predict comorbidity rather than substance-induced affective d/o?

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Differentiating Illnesses

- Affective symptoms that predate onset of substance use d/o
- Affective symptoms during extended periods of abstinence
- Strong family h/o affective d/o
- Positive h/o response to affective d/o treatment

"hedging your bets"

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Differentiating Illnesses... "The luxury of being a purist"

- We don't have it.
- RCTs for antidepressants exclude current or recent substance use or substance use disorders.
- The dually diagnosed are heterogeneous with respect to severity of substance use disorder, substances used, periods of abstinence, trauma history, type of affective illness

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Do treatment centers actually use medications?

- J. Clin. Psychopharm 2006; 26 supplement
- From "National Treatment Center Study"

TABLE 1. Percentage of Private-sector Treatment Programs Reporting Use of Selected Medications by Year (N = 252)

Medication	1995	2000	2004
Disulfiram	51.6	50.4	35.7*
Naltrexone	49.2	45.2	41.7*
SSRIs	77.0	73.4	68.3*

Naltrexone item specified use for the treatment of alcohol-dependent patients.
*Differences in percentages in 1995 versus 2004, $P < 0.05$.

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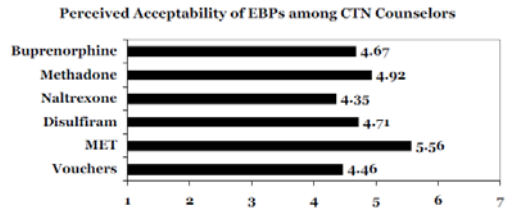
Intoxicant-based treatment remains widely acceptable



National Treatment Center Study 2004

Perceived Acceptability NTCS

OLS Regression Models of Perceived Acceptability of Medications

	Buprenorphine	Methadone	Naltrexone	Disulfiram
Specific Training	.363***	.248***	.258***	.163***
Implementation	.177***	.287***	.215***	.289***
Master's Degree	.145***	.100***	.159***	.078**
Certified	-.006	-.031	.028	-.045
Recovering	.012	.029	.034	.063*
12-Step Orientation	-.173***	-.158***	-.139***	-.160***
MMT CTP vs. Public CTP	.101**	.124**	.086*	.197***
Private CTP vs. Public CTP	.002	-.006	.012	.105**
Adjusted R^2	.335	.384	.229	.286

Significant differences, *p<.05, **p<.01, ***p<.001 (two-tailed)

Buprenorphine

- "Writing off a generation"
- Anti-buprenorphine vs "Wake up"
- State of the evidence
- Cognitive impairment (Soyka et al J. Clin Psychopharm 12/2008)
- Buprenorphine Abuse SAMHSA monograph http://bit.ly/buprenorphineabuse

Buprenorphine Abuse

The most common pattern of abuse involves crushing the sublingual tablets and injecting the resulting extract (Cicero & Inciardi, 2005).

When injected intravenously, addicts have described the clinical effects of buprenorphine as similar to equipotent doses of morphine or heroin (Sporer, 2004).

Investigators have found that the blockade efficacy of Suboxone is dose-related, and that doses of up to 32/8 mg of buprenorphine/naloxone provide only partial blockade when subjects receive a high dose of an opioid agonist (Strain, Walsh et al, 2002).

Under experimental conditions, buprenorphine has been found to be as effective as methadone in producing reinforcing and subjective effects (Alho, Sinclair et al., 2006).

Based on follow-up interviews with study subjects, researchers have hypothesized that, by suppressing withdrawal symptoms, the buprenorphine provides both positive and negative reinforcement by simultaneously producing euphoric effects and alleviating withdrawal (Comer, Sullivan et al., 2005a).

Buprenorphine diversion and abuse have been reported worldwide wherever the drug has been used for addiction treatment and, to a more limited extent, in the management of pain (Maxwell, 2006; Yeo, Chan et al., 2006; Chua & Lee, 2006; Jenkinson, Clark et al., 2005; Auriacombe, Fatseas et al., 2004).

In a study reported at the 2006 Australian National Drug Trends Conference, one percent of 914 respondents (all of whom were injection drug users) cited buprenorphine as their drug of choice, and six percent said it was the drug they had injected most often in the preceding month. Those who had injected Suboxone reported that they used it to alleviate withdrawal, to achieve intoxication, and out of curiosity (Maxwell, 2006).

From 12 studies cited in theSAMHSA monograph

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Barriers to 12-step approaches

- Increased level of social isolation
- Low energy
- Impaired concentration
- Suicidality
- Anxiety
- 12-step approaches are heavily socially driven

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The 12-step program member and medications

- Patients are told they are not different, then find that they are (e.g. dual diagnosis vs. terminal uniqueness)
- Patients are told by peers and even sponsors to discontinue medications or to seek multiple medical opinions until they find the one that states they can go without medications.
- Peers within 12-step communities have themselves been misdiagnosed as having primary affective illness and therefore mistrust doctors and their capacity to make the diagnosis.

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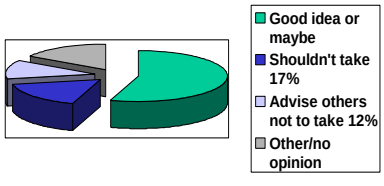
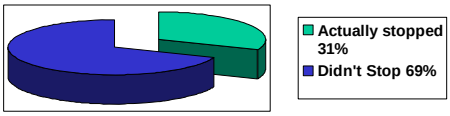
AA member attitudes towards using medications to prevent relapse



Journal of Studies on Alcohol. 61(1):134-8, 2000 Jan

Among the 29% who felt pressure to stop…



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Broad Principles

- Where possible “start low, go slow”
- Combine meds and use high doses when necessary
- Use the evidence, not the label
- Avoid / Limit PRN’s
- Re-evaluate frequently

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Broad Principles

Teach your patients:

- They are NOT unique with respect to their addiction
- Pseudomedical advice is dangerous
- Don't dose-adjust or manage your own meds
- How to handle scenarios that challenge the DD patient

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Broad Principles

- Use therapy *and* medications
- Assess ego strength carefully before using any intense psychodynamic approaches, especially with PTSD
- Attend to alexithymia
- Use but don't rely on psychological testing, delay when clinically appropriate

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Broad principles

"Hedge bets"…

Prescribe treatment when high index of suspicion exists

Clearly communicate diagnosis vs. index of suspicion

Broad Principles

- "There are no psychiatric conditions for which medication monotherapy is appropriate"
- Prescribing "therapy" as a generic recommendation can be largely worthless
- Be specific about why therapy for this individual, what modalities might be helpful and why, what might be markers of improvement, and what the goals are.
- "The goal of therapy is termination"

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