MENTAL HEALTH PROBLEMS CO-OCCURRING WITH SUBSTANCE USE DISORDERS

AND HOW TO TREAT THEM

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Dual Diagnosis: The Interface Between Substance Abuse and Mental Health

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Dual Diagnosis: The Interface Between Substance Abuse and Mental Health

- I have no conflict of interest to disclose.
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Learning Objectives

- Describe the prevalence of mental health conditions commonly co-occurring with substance use disorders
- Evaluate current gaps in the treatment of co-occurring mental health and substance use disorders
- Describe therapeutic interventions helpful for the treatment of mental health conditions in individuals with substance use disorders

Almost always underlying substance use….

- Anxiety
- Trauma
- Depression
- Insomnia

WHY?

- GENETIC VULNERABILITY

  +

- STRESSOR

Conditions Leading to Substance Abuse

- Depression

  --Still underdiagnosed

  --May present as behavior problems in teens

  --Alcohol acts as short-term numbing agent

  --Marijuana mimics some symptoms

  --Cocaine may mask as well as cause

Dual Diagnosis Issues in Adolescents/Young Adults

- Depression is frequently overlooked in teenagers
  - Poor historians: often out of touch with feelings
  - In treatment under duress
  - Behavioral problems may be the primary manifestation

Dual Diagnosis: Alcohol

- Depression + Alcohol Abuse = extremely common presentation in mental health setting

Dual Diagnosis: Alcohol

- Alcohol is a CNS depressant that causes and worsens depression

- "Medicates" depression

Dual Diagnosis: Alcohol

- Depressed drinkers often can not maintain sobriety if depression is not treated

- Alcohol may "neutralize" medications for depression

- Alcohol abusing depressed individuals often have their alcohol use brought to attention before their depression

Dual Diagnosis: Alcohol

- BEST TREATMENT IS A COMBINATION OF THERAPY AND MEDICATION MANAGEMENT

Dual Diagnosis: Marijuana

- Cannabinoid Receptor
  - Pain control
  - Physical dependency + Psychological

- Binds to mu receptor (opiate receptor)

Dual Diagnosis: Marijuana

- Mimics some symptoms of depression
  - "amotivational syndrome"
- Impairs ability to learn
- Diminishes concentration

Dual Diagnosis: Marijuana

- Very common to medicate anxiety and depression with pot
- ‘Paranoid when I smoke’ = Anxiety Disorder
- Alleviates true psychotic symptoms while worsening outcomes

Dual Diagnosis: Marijuana

- K2/Spice: synthetic cannabinoids Binds to same receptor as marijuana. Activates the same receptors as THC, but are not THC. Have caused serious reactions

Dual Diagnosis: Cocaine& Stimulants

- Vasoconstrictors
- Increase BP, arrythmias, MI
- Lung complications: sxs of pneumonia
- Lowers seizure threshold
- Lowers appetite
- Delay need to empty bladder/bowel

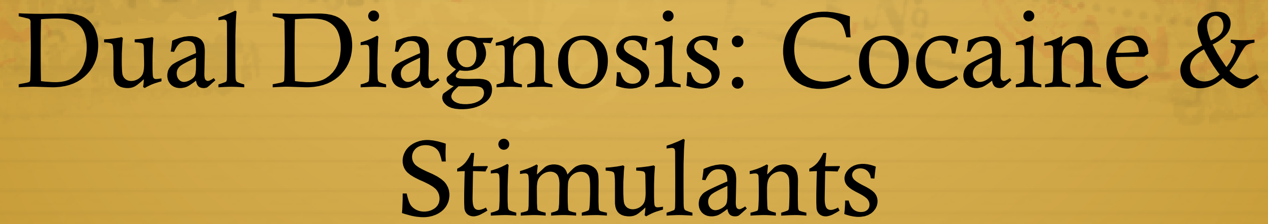
Dual Diagnosis: Cocaine & Stimulants

- Neurotransmitter Effects, long-term
  - Depletion of Serotonin, Norepinephrine
    - Low mood
    - Anxiety, panic
    - Insomnia
    - Impulsivity

Dual Diagnosis: Cocaine & Stimulants

- Can cause anxiety, depression, psychosis
  - Hallucinations (tactile)
  - Paranoia
  - Delusions
  - May resemble bipolar, manic phase
- Will have a paradoxical effect on ADHD
  - Therefore not a drug of choice for this population

Dual Diagnosis: Cocaine & Stimulants



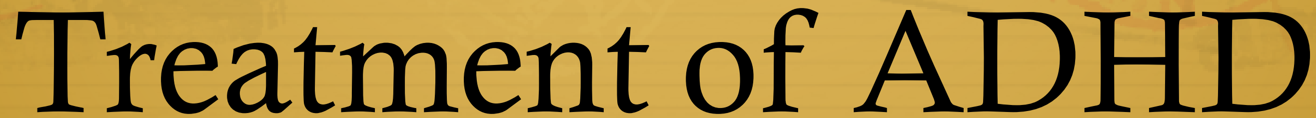
- May be used to self-medicate in depressed individuals

- Differential diagnosis for poor concentration:
  - Not enough sleep
  - Trying to do too much at once
  - Distraction of social media
  - Anxiety
  - Depression

ADHD

- Differential diagnosis (con't)
  - Not interested in the subject or task
  - Stress
  - Past trauma
  - Alcohol or other drug use
  - Other learning disorders that are not ADHD
  - Actually having ADHD, inattentive type

Treatment of ADHD



- Checklists are limited
- Take a good history (include family/teachers)
- Assess prior abuse of stimulants
- Comprehensive Psychological testing is gold standard

Dual Diagnosis: LSD, Other Hallucinogens

- Can precipitate psychosis in those predisposed (likely genetically vulnerable)

- Combination hallucinogen and stimulant
- Creates euphoria by causing brain to release stored serotonin
- Over time, can lead to serotonin depletion and depression in vulnerable individuals
- Do those who are already depressed tend not to like this drug?

Dual Diagnosis: Bath Salts (Neither a salt nor bath aid)

- Contain the stimulants methadrone or MDPV
- Most similar to methamphetamine
- May cause lasting psychotic symptoms
- Some users report becoming addicted quickly (after first use)

Dual Diagnosis: Opiates

- Too easy to acquire (e.g. online, medicine cabinet, MDs)
- Mistaken belief that they are safe
- Creates a challenge in medicating depression (e.g. methadone)

Dual Diagnosis: Opiates

- CNS depressant similar to effects of alcohol
- Greatest risk is of respiratory depression
- Opiate + Benzodiazepine = recipe for an overdose

Dual Diagnosis: Opiates

- All animals have opiate recepetors throughout their brains
  - Related to 'survival of the species'
- Opiates do not eliminate pain, but decrease the arousal that accompanies pain
- Cause an increase in norepinephrine

Opiates and Anxiety

- Extremely common presentation
- High degree of overlap between withdrawal and anxiety sxs
- While anxiety isn’t responsible for the opiate epidemic, it is a major barrier for individuals to stop using

Opiates and Anxiety

- Opiates are wonderful numbing agents and individuals with anxiety (and PTSD) want to be numbed

Opiate Withdrawal

Increased BP

Increased HR

Sweating/Chills/Hot flashes

Restlessness

Dilated Pupils

GI

Cramps/ Diarrhea

Nausea/Vomiting

Feeling of Dying

Tremor

Yawning

Gooseflesh

Runny nose/Watery eyes

Bone Pain

Muscle Aches

Anxiety

Increased BP

Increased HR

'Heart attack' feeling/Chest pain

Shortness of Breath/Smothering/Choking

'Room closing in'

Fear of going crazy/dying

Out of Body

Depersonalization/Numbness

Sweating/Chills/Hot flashes

Restlessness

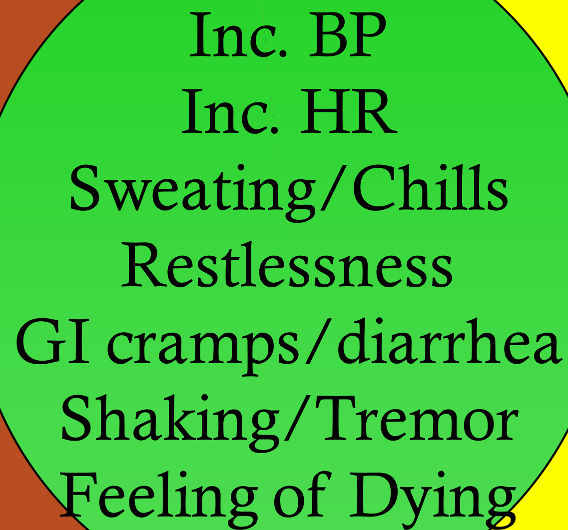
GI Cramps/Diarrhea

Shaking/Tremor

Can't Concen-trate

Dizzy/Ligh-headed/Tingling

Anxiety Vs. Opiate Withdrawal



Anxiety Vs. Opiate Withdrawal

- Take a good history
- Corroborate with family and friends
- Symptoms when abstinent
- Symptoms prior to use
- Look for physical evidence (e.g. gooseflesh, runny eyes/nose)

- Jack is a 26 year old computer programmer who presents for evaluation as a transfer from another buprenorphine provider. He has been prescribed 36 mg. per day for the past 10 months. He reports he isn't sure that the Suboxone® is working.

Case Study con't

- Jack reports that for the first several weeks of treatment, he had been given 16 mg. of Suboxone®. He used no other opiates during this time. However, 4-5 hours after taking his dose, he would experience shortness of breath, increased heart rate, sweating, edginess.

Case Study con't

His MD increased his buprenorphine to 20 mg for 2 days, then 24 mg. per day in a divided dose. He reported good effect, but after 1 week, all of his "withdrawal" symptoms returned, this time 4 hours after each dose. He had no use of other opiates but admitted thinking about it, only to relieve sxs.

Case Study con't

Suboxone® increased to 32 mg, then with continuing complaints of withdrawal up to 36 mg. (16mg in the morning, 20 mg in the evening.) After one month, he did try to decrease to 32 mg. but began to worry that his symptoms would come back so his MD increased and kept him at 36 mg.

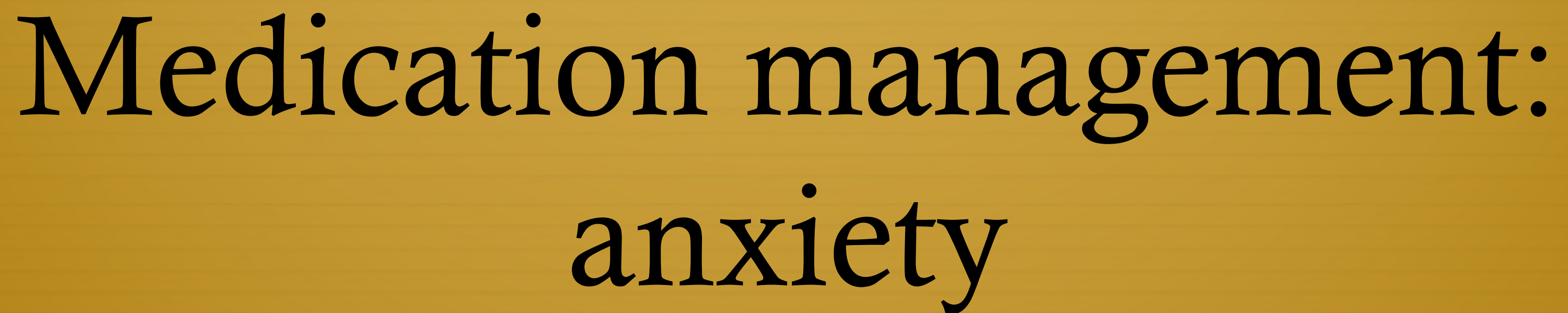
Case Study con't

- Diagnosed with Generalized Anxiety Disorder
- Started on citalopram and gabapentin
- Started individual CBT and group therapy. Over past year, Brainspotting.
- After 3 months of above, did decrease buprenorphine to 28 mg. Four years later, dose is 1mg. per day.

Opiates and Anxiety

- Extremely common presentation
- High degree of overlap between withdrawal and anxiety sxs
- While anxiety isn't responsible for the opiate epidemic, it is a major barrier for individuals to stop using
- Opiates are wonderful numbing agents and individuals with anxiety want to be numbed
- We as treaters need to be more mindful of our messages about anxiety

Medication management: anxiety



Use an alternative to benzodiazepines, please

ANTI-ANXIETY

- BENZODIAZEPINES
  - Immediate relief
  - Tolerance, mental dependence can result if used long-term in a susceptible individual
  - Binds in the same area of brain as alcohol
  - Numerous studies have stated contraindicated in PTSD as can be disinhibiting

ANTI-ANXIETY: non-addicting (prn vs sched)

- Gabapentin (prn vs scheduled)
- Clonidine
- Propranolol (situational)
- Quetiapine
- Tiagabine
- Trazodone
- Hydroxyzine
- Buspirone

How to Minimize Abuse of Medication in a Substance Abusing Population

- Avoid meds with potential for abuse whenever possible
- Education
- Limited Use of benzos if at all: e.g. small quantities (5 pills per month) for panic attacks

How to Minimize Abuse of Medication in a Substance Abusing Population

- PDMP (Pt Drug Monitoring Program for controlled substances)
  - Shorter time frames filled
  - Other opiates when on replacement
  - Surprises ('I forgot to tell you…')

Medication management: insomnia

******Use an alternative to benzodiazepines/zolpidem

Insomnia: non-addicting

- Trazodone
- Clonidine
- Quetiapine
- Hydroxyzine
- Diphenhydramine

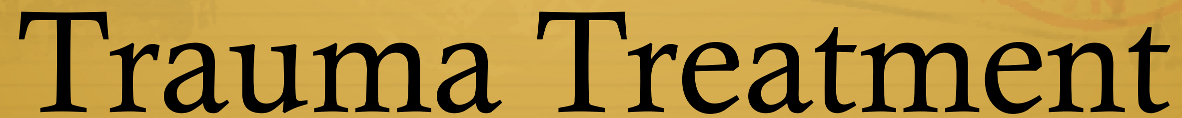
- Use Alcohol or drugs to cope
- Drink/use not to feel anything
  - 29-59% of women in AODA treatment have trauma. Likely much higher.
  - Women with PTSD have a 1.4-3.6x higher likelihood of substance abuse.
    - Najavits, et. al, American Journal of Addiction, 1997 6: 273-283.

The Connection between AODA and Trauma

- Never learned to manage feelings in a healthy way (bad modeling)
- Drugs are the 'perfect' solution to getting rid of memories and unpleasant feelings

Trauma and Substance Use

- Notice the connections between use and feelings
- Recognize that as use lowers, uncomfortable feelings will increase
- As coping increases, feelings will be more manageable (hang in there)
- Decrease use if unable to fully stop
- Work on both trauma and use together



Trauma Treatment

- DBT
- Seeking Safety
- EMDR
- Brainspotting
- “Trauma-informed care”

Almost always underlying the use….

- Anxiety
- Trauma
- Depression
- Insomnia

Dual Diagnosis: Issues in Addiction and Mental Health

- In summary….

Dual Diagnosis

- Avoid addictive medications
- Focus on treatment of sxs:
  sleep, anxiety, GI upset

Dual Diagnosis

- Relapse is a part of recovery
- Shame is a part of relapse
- We can not make anybody ready for treatment
- We can offer compassion along with good boundaries

Dual Diagnosis

- We can offer our best advice and expertise
- Each patient has to walk his/her path
- Their success or failure is not our responsibility

THANK YOU

Mental Health Problems Co-Occurring with Substance Use Disorders and How to Treat Them

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Implications for Practice

- Most difficult cases are undiagnosed when they present or diagnosed with co-occurring disorders while using and did not report their use
- Poor historians
- Shame, trauma, and trust issues are barriers for accurate reporting
- If diagnosed based only on individual reports many issues are missed
- Limited appointment times

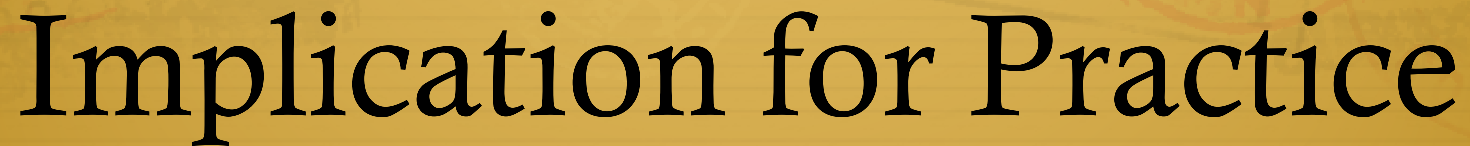
Implications for Practice

- COLLABORATION
  - Use us
  - We have longer appointment times
  - We can provide case management services
  - We can engage support systems
  - Refer and consult
- Involve support systems
  - Family
  - Teachers
  - Friends
  - Significant others

Implications for Practice

- ABR – Always Be Reassessing
  - Initial impressions can often be wrong
  - Increasing trust and rapport helps clients to open up
  - When stabilized, clients present differently
  - Look for the issues that get worse, not better in sobriety

Implication for Practice



- Opioid dependent clients on MAT
  - Co-occurring symptoms escalate while client titrates
    - 30 mg Methadone
    - 2 mg Suboxone

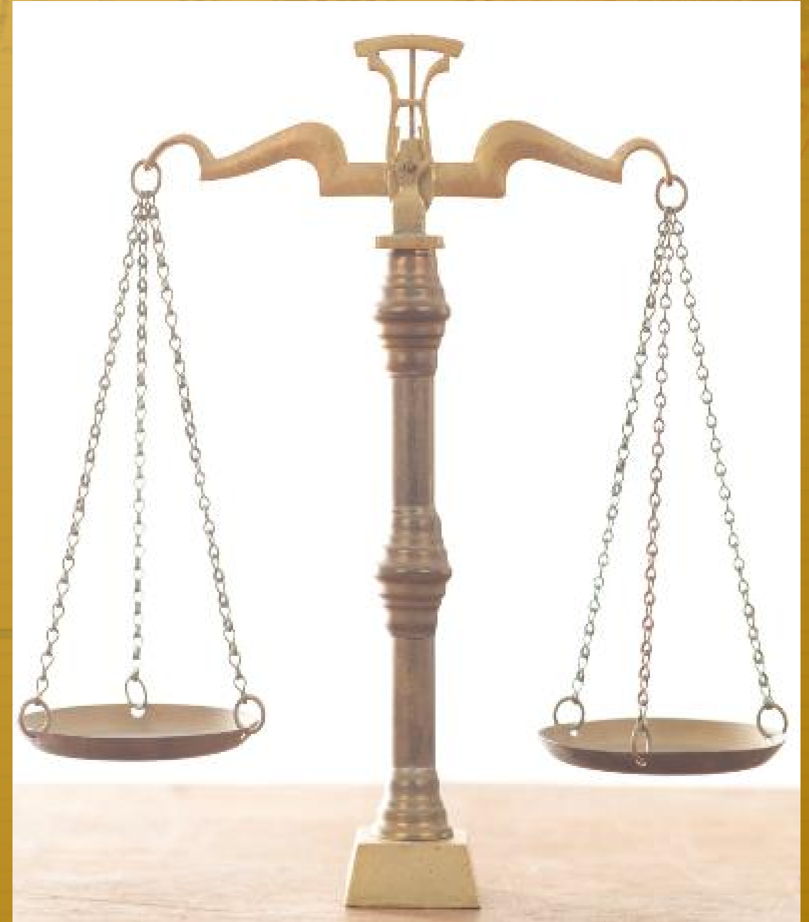
Guilt

- I made a mistake
- Useful
- Consequence that can change behavior

Shame

- I am a mistake
- Counterproductive
- Continues unwanted, self-destructive behavior

Balancing Compassion & Accountability



System Interventions

- Lifeskills - Identify and treat mental health disorders earlier (childhood)
- Parent Addiction Network - Support parents, teachers, and the community to understand and effectively support those that struggle
- Speaker Bureau – Decrease stigma through sharing voices of recovery
- Health Care Task Force – Amazing group of healthcare professionals that meet quarterly to research and implement evidence-based strategies for safe prescribing of opioids
- AnchorED – Recovery Coaches in ED to provide intervention and referral to treatment for those that experienced an overdose, follow until engaged in treatment

System Interventions

- Dane County Service Delivery Map – provides information to the public in a flowchart that shows what treatment options are available for individuals based on funding source, gender, and age
- CDC Academic Detailing – Four healthcare systems in Dane County have chosen goals to facilitate safe prescribing and have received training from NARCAD
- MedDrop – Permanent drop boxes, take back events, Transitional Care Coalition
- Recovery Friendly Directory – Local businesses and landlords have agreed to hire and rent to those in recovery regardless of their record

System Interventions

- Naloxone Expansion – police, EMS, prescribers, referral for those in corrections
- Don't Run, Call 911 – Good Samaritan 911 Community Education Campaign
- Overdose Prevention Community Trainings – Partnering with ARCW
- Collaboration with state – legislative, corrections, judicial
- Collaboration with MARI – amnesty for those that ask MPD for treatment instead of arrest
- Hub and Spoke Model – beginning stages, effective model in Vermont, offering crisis stabilization and referral to community services

What's Next

- So much has been done, there is so much left to do
- It will take all of us!
- Thank you for your support and collaboration!