

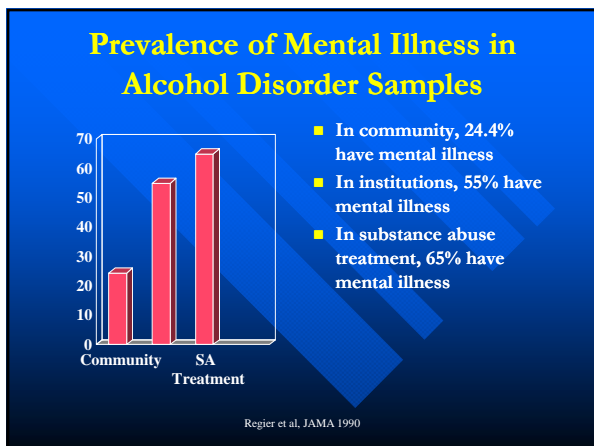
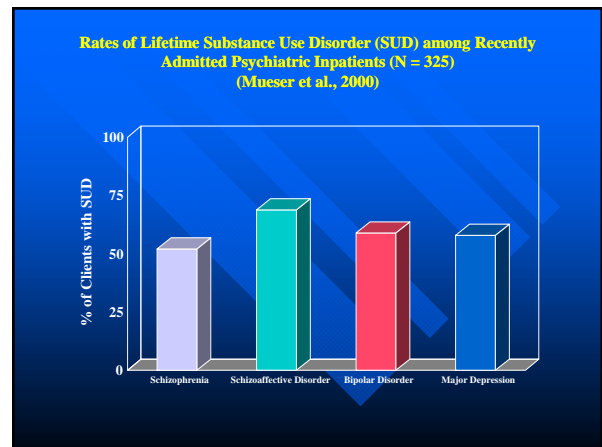
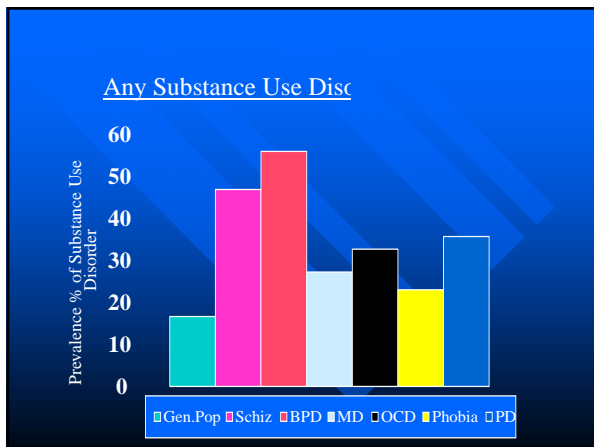
Research on the Treatment of Co-Occurring Disorders

Kim T. Mueser, Ph.D.
 Professor of Psychiatry
 Dartmouth Medical School
Kim.T.mueser@dartmouth.edu

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Overview

- Comorbidity of substance use & severe psychiatric disorders
- Distinguishing features of psychotic disorders with comorbid addiction
- Understanding comorbidity: models of etiology & treatment implications
- Special treatment needs of psychotic & other severe psychiatric disorders with comorbid addiction
- Research reviews of integrated treatment for co-occurring disorders
- New research on treatment of co-occurring disorders
- Resources



Severe Mental Illnesses (SMI)

- Psychiatric disorder that has profound effect on:
 - Work or school
 - Parenting
 - Self-care
 - Social relationships
- People often on disability due to mental illness (e.g., SSI, SSDI)
- Common SMIs:
 - Schizophrenia & schizoaffective disorder
 - Bipolar disorder
 - Major depression
 - PTSD
 - Borderline personality disorder
- Often present for treatment in psychiatric settings, but also common in addiction treatment settings

Psychotic Disorders

- Psychosis = “Lack of contact with reality”
- Common psychotic symptoms:
 - Hallucinations
 - Delusions
 - Grandiosity
 - Suspiciousness
 - Bizarre behavior
 - Formal thought disorder (disordered or disorganized speech)
 - Conceptual disorganization
- Psychotic symptoms common in schizophrenia, schizoaffective & bipolar
- Psychotic symptoms relatively common in major depression & PTSD
- Presence of psychotic symptoms associated with more severe mental illness & greater co-occurring addiction

Understanding Comorbidity: Why are the Rates of SMI/Psychotic Disorder so High?

- Self-medication
- Other common motives for using
- Super-sensitivity
- Common factors for mental illness & substance misuse

Self-Medication

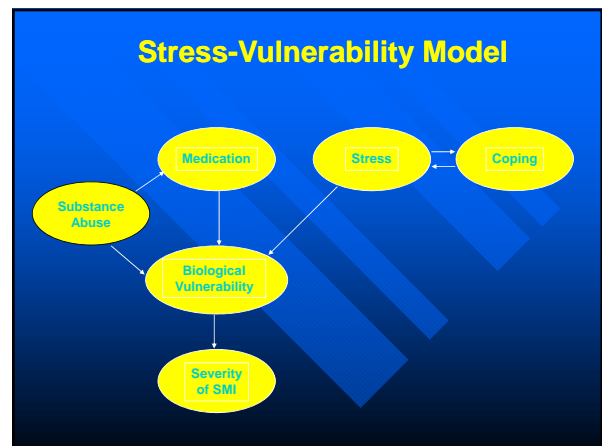
- Many clients report using substance for at least some reasons related to symptoms, BUT:
- More symptomatic clients don't use more than less symptomatic ones
- No relationship between symptoms & types of substances used
- No relationship between psychiatric diagnosis and types of substances used
- Many clients report using DESPITE awareness it worsens symptoms or triggers relapses
- Strongest case for self-medication: alcohol use disorder in PTSD frequently related to sleep problems
- Self-medication/use for coping purposes is one of host of motivations related to SMI for using substances, but doesn't explain all comorbidity

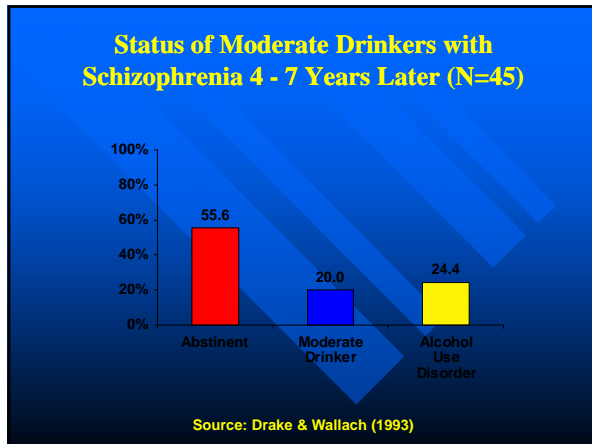
Other Common Motives for Using

- Socialization
- Leisure & recreation
- Dealing with stress
- Escaping the stigma of mental illness
- Lack of structured time
- Lack of engagement in personally meaningful roles (e.g., worker, student, parent)

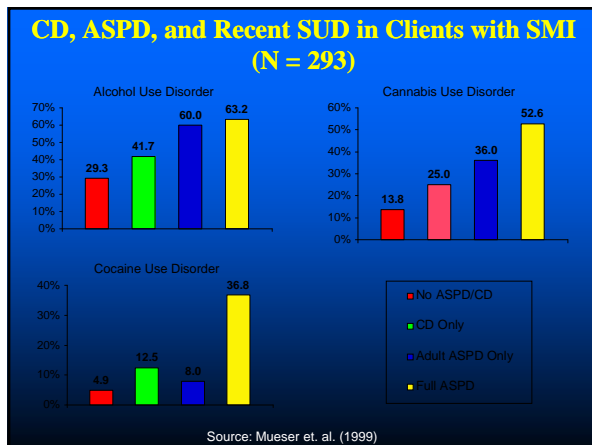
Supersensitivity to Alcohol & Drugs

- Biological sensitivity increases vulnerability to effects of substances
- Smaller amounts of substances result in problems
- “Normal” substance use is problematic for clients with SMI but not in general population
- Sensitivity to substances, rather than high amounts of use, makes many clients with mental illness different from general population





- ### Common Factors for SMI & Addiction: Conduct Disorder (CD) & Antisocial Personality Disorder (ASPD)
- ASPD has highest addiction comorbidity of all psychiatric disorders (60-70% in most estimates)
 - CD is powerful predictor of later onset of SUD
 - ASPD associated with earlier onset of addiction
 - CD & ASPD more common in SMI than general population
 - CD/ASPD increase risk of addiction in SMI
 - CD/ASPD related to more severe addiction in co-occurring disorders
 - Estimated prevalence in co-occurring population: 20-25%



- ### Other Potential Common Factors Leading to Increased Comorbidity
- Poverty/deprivation
 - Neurocognitive impairment
 - Trauma

- ### Special Treatment Needs of Co-Occurring SMI/Psychotic Disorder
- Integration of mental illness & substance use disorder treatment
 - Concurrent treatment
 - Same treatment providers
 - Integrated treatment of both disorders
 - Minimization of treatment-related stress
 - Outreach & engagement
 - Close monitoring, especially for co-occurring disorder clients with ASPD

- ### Special Treatment Needs: Motivational Enhancement
- Stages of change
 - Stages of treatment
 - Engagement
 - Persuasion
 - Active treatment
 - Relapse prevention
 - Adapted motivational interviewing
 - Articulation of personal goals
 - Active work towards goals
 - Supportive self-efficacy for goal attainment & substance reduction/abstinence

Motivational Enhancement (Con'd)

- Concept of recovery from mental illness
 - Recovery defined by client, not in traditional medical terms
 - Recovery possible despite continued symptoms
 - Instills hope
 - Common themes: social relationships, role functioning, community membership, respect for self & from other

Special Treatment Needs: Management of Cognitive Impairment

- Smaller “chunks” of information
- Asking questions so client actively processes information
- Frequent review of material
- Shaping approach to reinforcing successive steps towards desired goals
- Patience & abundant reinforcement in light of small changes
- Programming generalization of skills to natural environment by
 - Home practice assignments
 - Involvement of significant others in practicing skills
 - Involvement of paraprofessionals in helping clients practice skills

Special Treatment Needs: Training in Illness Self-Management

- Information about mental illness & its treatment
- Stress-vulnerability model
- Involvement of family or significant other persons
- Driven by personal goals
- Principles of relapse prevention:
 - Medication adherence
 - Minimization of alcohol & drug use
 - Stress reduction
 - Meaningful but not over-demanding daily structure
 - Coping & competence skills
 - Social support
 - Relapse prevention plan

Special Treatment Needs: Psychiatric Rehabilitation

- Address motives underlying substance use
- Skills training to address social motives, independent living skills
- Coping skills training/CBT for persistent symptoms
- Targeted CBT to address primary or comorbid depression, anxiety, PTSD symptoms
- Supported employment/education for competitive work or return to school
- Family psychoeducation to reduce family stress & burden, & facilitate management of co-occurring disorders
- Cognitive remediation for cognitive impairment
- Supported housing for housing instability

Special Treatment Needs: Psychiatric Medications

- Primary medications for schizophrenia-spectrum disorders & bipolar disorder effective despite active substance use
- When in doubt, assume both disorders are primary & pharmacologically treat psychiatric disorder
- Medication non-adherence high
 - Fear of interactions with substances despite rarity (main exception: MAOIs)
 - Denial/minimization of psychiatric disorder
 - Forgetting to take medication: behavioral tailoring to integrate into daily routine
 - Simplify medication regimen complexity
- Promote dialogue between client & prescriber

Special Treatment Needs: Medications for Alcoholism

- Naltrexone established efficacy for alcoholism in SMI
- Disulfiram effective in SMI, but psychiatrists reluctant to prescribe it

Research Reviews of Treatment of Co-Occurring Disorders

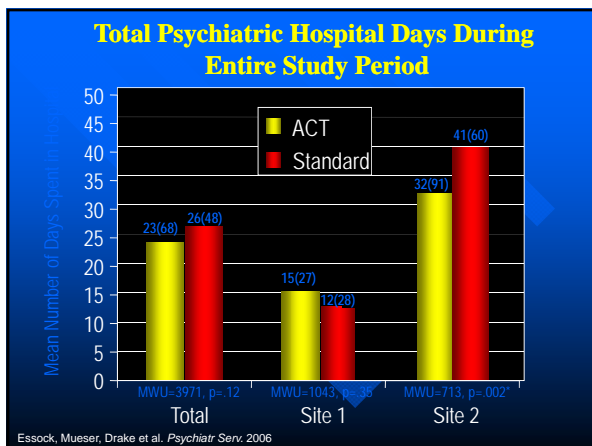
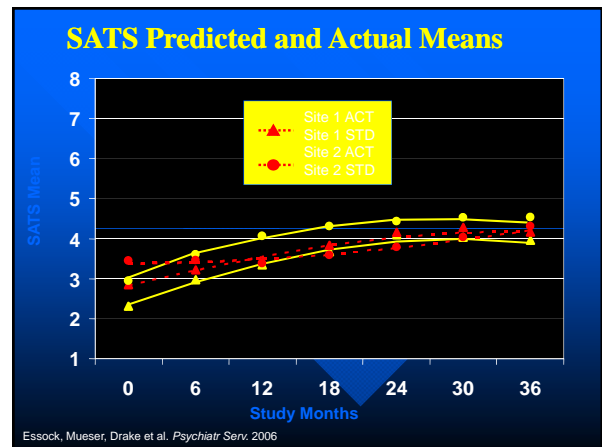
- Drake et al. (1998): 36 studies, including pre-post, quasi-experimental, and RCTs
- Brunette et al. (2004): 10 quasi-exp or RCTs of residential programs for DD
- Drake et al. (2004): 26 recent studies, quasi-exp or RCTs (1994-2004)
- Donald et al. (2005): 10 RCTs
- Mueser et al. (2005): 30 studies of specific interventions, including pre-post, quasi-exp, & RCTs
- Kavanagh & Mueser (2007): 17 RCTs
- Cleary et al. (2008): 25 RCTs
- Drake et al. (2008): 22 RCTs, 23 quasi-exp

Summary of Research on Treating Co-Occurring Disorders in SMI

- Limited impact of brief interventions
 - Primary purpose is to engage in treatment
 - Useful for enhancing follow through for mental illness & substance misuse treatment
- Limited gain from providing more intensive case management, such as Assertive Community Treatment
- But, effects of intensity of service may interact with client characteristics, such as ASPD

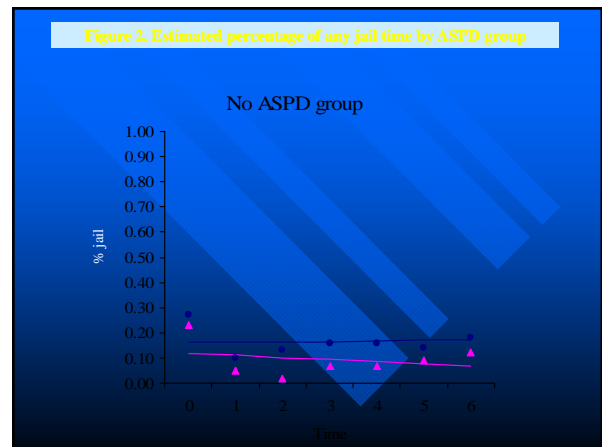
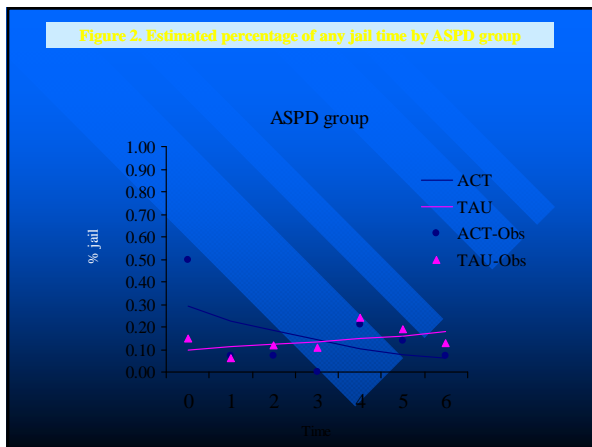
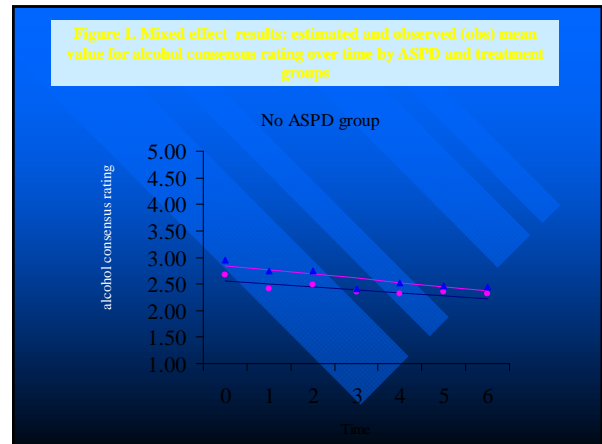
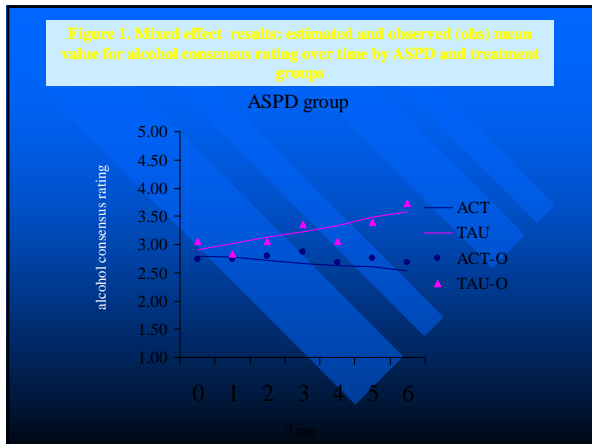
Study Design (Essock et al., 2006)

- 198 clients with SMI
- 2 sites in Connecticut: Hartford & Bridgeport
- 3 year follow-up period with assessments every 6 months
- Randomized to ACT (N = 99) or SCM (N = 99)
- Everyone received integrated treatment for co-occurring disorders



Did Clients with ASPD Benefit from ACT Treatment More?

- Secondary data analysis (Frisman et al., 2009)
- Focused on most extreme subgroups: Full ASPD (N = 36) or No CD/ASPD (N = 88)
- Outcomes = AUS, DUS, days alcohol use, days drug use, SATS, BPRS, hospital days, homeless days, jail days
- Statistical analyses: mixed effects linear modeling with time, treatment group, and ASPD group, with test of primary interest being the 3-way interaction
- Significant interactions 2 variables: AUS and days in jail

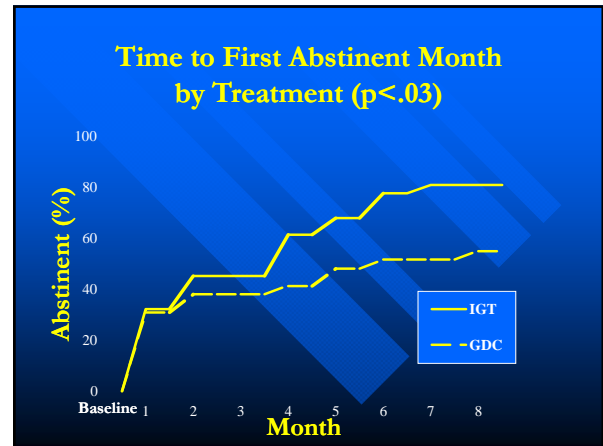
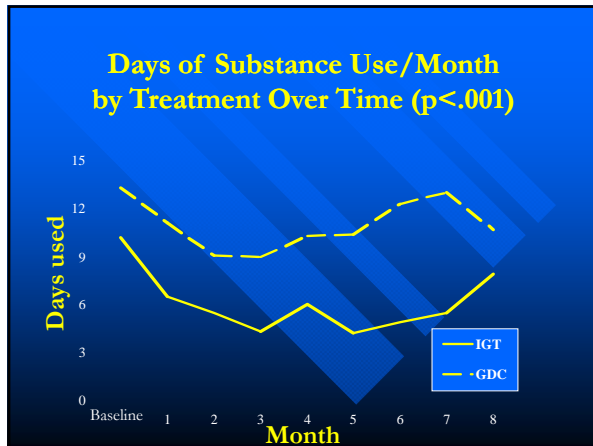


Summary of Research on Treating Co-Occurring Disorders in SMI

- Co-occurring treatment associated with better substance abuse & psychiatric outcomes
- Strongest effects for group counseling, contingency management, & residential treatment
- Group counseling most studied treatment modality

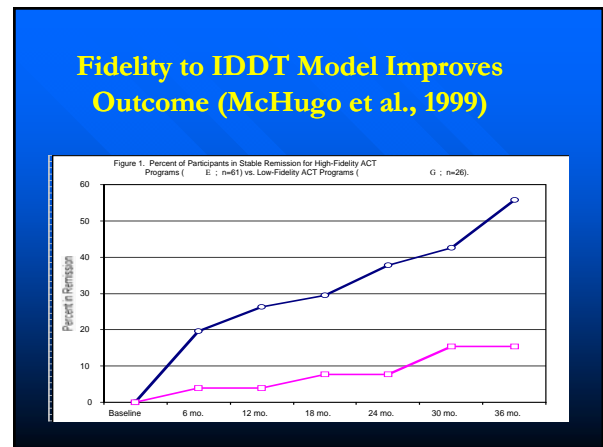
Integrated Group Therapy (IGT) for BPD & SUD (Weiss et al., 2007)

- Supported by NIDA Behavioral Therapies Development Program
- Goal: to develop & test an integrated group therapy for clients with bipolar disorder & substance misuse
- 20 sessions that have 12 repeating topics, “rolling admissions”
- Identifies thoughts & behavior patterns common to recovery from & relapse/recurrence to substance use and psychiatric symptoms
- Evaluated in RCT comparing IGT with Group Drug Counseling (GDC)



Summary of Research on Integrated Treatment for SMI

- Cognitive-behavioral therapy (CBT) approaches appear promising than supportive, educational, or 12-step approaches
- Program fidelity to principles of integrated treatment contributes to better outcomes



Efforts to Provide Integrated Treatment of Anxiety Disorders & Substance Abuse

- RCTs of integrated treatment for panic disorder & social phobia indicate improvement in anxiety & substance misuse for both integrated & substance treatment groups
- No trials of integrated treatment for GAD or OCD
- Limited success thus far with integrated PTSD treatment, but new developments under way

Integrated Treatments for PTSD & Addiction

- Substance Dependence PTSD Therapy (Triffleman, 1999)
 - Exposure-based, 40 sessions, no RCTs
- Concurrent Treatment of PTSD & Cocaine Dependence (Brady et al, 2001)
 - Exposure-based, high dropout rate (62%), no RCTs
- Transcend (Donovan et al, 2001)
 - Broad-based, residential, 60 session, no RCTs
- Seeking Safety (Najavits, 2003; Hien et al, 2004)
 - Eclectic, moderate dropout rate (35-40%), RCTs don't support treatment over standard substance abuse treatment

