Dual Treatment Best in Co-Occurring Disorders

Optimal approach is for addiction psychiatrists to focus on treatment, leave monitoring to primary care.

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MIAMI — In people with co-occurring substance use and mental health disorders, optimal treatment consists of brief screening and ongoing monitoring by primary care physicians, coupled with addiction psychiatry assessment and treatment, according to a presentation at the annual conference of the American Society of Addiction Medicine.

There are 14.9 million adults in the United States who meet criteria for a substance use disorder, and 19.4 million who meet criteria for serious psychological distress; 5.2 million meet criteria for both, according to the 2005 National Survey on Drug Use and Health.

"Of this 5.2 million, a remarkably small amount are coming into our treatment services," said Charlene E. Le Fauve, Ph.D., clinical psychologist and chief of the Co-Occurring and Homeless Activities Branch at the Substance Abuse and Mental Health Services Administration.

Almost half (48%) of this co-occurring disorder (COD) group gets no treatment at all. Approximately 5% get substance use treatment only, and about 6% get treatment for both substance use and a mental health disorder. Another 41% get treatment only for mental health problems, "but how many have positive, long-acting outcomes while treating one disorder and ignoring the other?" Dr. Le Fauve asked.

All individuals presenting for treatment for substance use should be screened for mental health problems and vice versa, Dr. Le Fauve said, because the presence of one type of disorder puts an individual at higher risk for developing the other type. For example, mood disorders, especially anxiety and depression, are very common in the addiction population.

Relationships between mental health and substance use disorders are often complex and challenging, Dr. Le Fauve said. Acute and chronic substance use can create psychiatric symptoms; substance withdrawal can cause psychiatric symptoms; and/or substance use can mask psychiatric symptoms. Consequences of substance use in patients with untreated psychosis include decreased compliance in all categories, increased psychotic symptoms, frequent use of health care services, increased tardive dyskinesia, violent behavior, and early mortality, Dr. Le Fauve said.

"We've talked to the primary care docs, and they don't have much time. The screening instruments have to be brief," Dr. Le Fauve said. Ongoing assessment of the person with CODs is another essential component. Always check on compliance and reasons for noncompliance, ask how their medications are affecting them, and acknowledge that they have a right not to take medications, she said.

Conduct a very extensive interview about all substances, including age at first use, patterns over time, periods of abstinence, and consequences of use, Dr. Le Fauve said. "We have people bring in everything. This gives you the opportunity to look at bottles, how much is left, and who prescribed it. You will be amazed at what you find out. Amazed."

Homeless people with CODs are a particular challenge to treat, and they are at higher risk for adverse outcomes, Dr. Le Fauve said. Once homeless, people with CODs require more services and are more likely to remain homeless than are other types of homeless people, she said. In addition, among homeless veterans, one-third to one-half have co-occurring mental illnesses and substance use disorders. "I say this right now in the context of our current war situation, but it's always an important issue."

Therefore, access to psychiatric care is necessary for clients presenting for treatment in substance use programs, Dr. Le Fauve said. Also, treatment will be more effective if clients have a sense of control and ownership over the treatment process. "This sounds preachy and canned, but it's true," she remarked. ■

Alter Environment to Stem Stimulant Misuse on Campus

MIAMI — Some general principles of substance abuse prevention are suitable for targeting college students who misuse stimulants to enhance performance, Dr. Theodore V. Parran Jr. said at the annual conference of the American Society of Addiction Medicine.

Changing environmental factors and providing consistent prevention messages are likely the most effective strategies. In contrast, increasing individual resiliency and delaying nonmedical stimulant use as long as possible are potentially less effective, said Dr. Parran, director of the addiction medicine fellowship program at Case Western Reserve University in Cleveland.

'Ease of access, price, and social norms ... are important in encouraging or discouraging performance-enhancing substance misuse.'

Misuse is defined as the use of prescription stimulants to enhance performance by an individual for whom they were not prescribed. Prevention efforts are intended to lessen the risk, pain and suffering, and number of deaths associated with the use of "performance-enhancing drugs" in a community, he said. Prevention efforts are particularly challenging in the college community because a lot of stimulant misuse is within peer-group norms.

Alteration of environmental factors could help with prevention. "Ease of access, price, and social norms and values are important in encouraging or discouraging performance-enhancing substance misuse," Dr. Parran said. Limitation of controlled, prescribed medications on a college campus is a very important strategy that is "often not paid attention to," he noted.

Prevention messages must be consistent. They must be longitudinal and multiple and involve several different venues, such as family, school, religious institutions, and academic leaders. "That tends to work regarding misuse," he said.

Identification of risk and resiliency factors, another general principle for substance abuse prevention, is somewhat applicable to stimulant misuse. "There are probably resiliency factors, factors in an individual that decrease the odds of misuse and abuse of prescription drugs," but their existence has not yet been proven, he said. If they do exist, "the job of the family and community is to build protective factors and limit risk factors."

A strategy to delay experimentation might not be applicable to stimulant misuse. Most beliefs and practices about substance use and misuse are established by the time an individual is in college.

A combination of primary, secondary, and tertiary prevention efforts can be effective in this population of college students. Primary prevention efforts, which target an entire community regardless of individual risk, might be more challenging for clinicians.

"Physicians tend to think about patients and not communities," Dr. Parran said. Secondary prevention targets high-risk subgroups of substance users and abusers. Tertiary prevention involves treatment of an individual, such as in a drug detoxification unit. ■

Combine Behavioral Therapies To Stop Marijuana Abuse

MIAMI — A triple combination of behavioral therapies yields the best abstinence rates among heavy users of marijuana, Dr. Ahmed M. Elkashef said at the annual conference of the American Society of Addiction Medicine.

This optimal combination of cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), and contingency management (CM) may not be realistic in clinical settings with limited resources, however, said Dr. Elkashef, chief of the clinical/medical branch of the division of pharmacotherapies and medical consequences of drug abuse, National Institute on Drug Abuse, Rockville, Md.

'In general, behavioral interventions do work, and if you combine two or three of them, you can get better results.' Family intervention can be added with teens.

A combination of CBT and MET or MET alone is a secondary option. Studies have demonstrated their efficacy, but success rates were lower. Other researchers have shown that CM alone with vouchers can also help heavy marijuana users.

"In general, behavioral interventions do work, and if you can combine two or three of them, you can get better results," Dr. Elkashef said. Family intervention and parent education can be added when working with adolescents.

Experts are still battling the perception that marijuana use is less serious than use of other substances. "Is it really that serious? Should we be concerned about [heavy marijuana use]? This perception in the field is dangerous," Dr. Elkashef said.

"The need is from the patient—they see problems with [their addiction] and a need to get off the drug." Surveys indicate that this population is receptive to treatment. A majority of heavy users of marijuana express interest in programs to help them stop smoking, Dr. Elkashef said.

In the study that found the triple combination optimal, researchers assigned 240 marijuana-dependent individuals to CM only, MET and CBT, or a combination of all three (Addict. Behav. 2007;32:1220-36[doi:10.1016/j.addbeh.2006.08.009]). All participants had nine weekly 1-hour sessions, except the CM-only group, which met for 15 minutes weekly. Although the CM-only group had the best abstinence rates post treatment, by 1 year abstinence rates were greatest in the CBT/MET/CM group.

The same triple combination is supported by another study in which researchers compared two brief interventions and a delayed-treatment control among 450 adults meeting DSM-IV criteria for cannabis dependence (J. Consult. Clin. Psychol. 2004;72:455-66). Marijuana use and associated consequences were best reduced by nine sessions of CBT, MET, and CM, compared with two sessions of MET, which in turn was more effective than delayed treatment. "The combination did much better over time in giving clean urines [than did] MET by itself," Dr. Elkashef said. ■