

## Psychopharmacology Practice Guidelines For Individuals With Co-Occurring Substance Abuse (SA) And Serious Mental Illness (SMI)

### *Overview*

The results of the most recent national household survey found that there are:

- 17 1/2 million people with serious mental illness (SMI) in the United States, or
- 8.3% of the population (SAMHSA, 2002). Of these:
  - 5 million or, 28.9% of the SMI, had used an illicit drug in the previous year
  - SMI use illicit drugs at more than twice the rate of non-SMI
  - Four million, or 22.2% of all SMI, had a substance use disorder
  - 11.1 were heavy alcohol users (compared to 8.1% of non-SMI)
  - Adults with nicotine dependence were 1.5 times as likely to have SMI
- Of people in the general population with a substance use disorder, 20.4% were SMI.

In Hawaii, the Adult Mental Health Division has found that approximately 53% of the population it has screened has experienced problems as a result of substance use.

The comorbidity of schizophrenia and SA is of particular concern. While relatively infrequent prior to 1960, there is now a 70-80% lifetime incidence of a substance use disorder in people with schizophrenia.

In summary, there is a high rate of comorbidity between SMI and SA.

### *General principles of treatment in a drug abusing, seriously mentally ill population:*

#### Issues Related to Screening and Diagnosis

- Diagnostic assessment of individuals with co-occurring disorders is based ideally on obtaining an integrated, longitudinal, strength-based history, which incorporates a careful chronological description of the individual's functioning, including emphasis on onset, interactions, effects of treatment, and contributions to stability and relapse of both disorders at each point in time. Particular focus is on assessing either disorder during periods of time when the other type of disorder is relatively stable. Obtaining information from family members, previous providers, and collateral caregivers is important.
- Initial psychopharmacologic assessment in mental health settings does not require consumers to be abstinent. It should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medications during detoxification and early recovery.
- Substance abusers will often deny their substance abuse problems and blame their symptoms on the mental illness. Bipolar disorder in particular may be over diagnosed in a substance abusing population due to the fact that mental status can appear to cycle as a result of intermittent substance abuse. For example, stimulant (cocaine and methamphetamine) abuse can mimic manic episodes, and the "crash" that occurs when a stimulant effect ends can mimic depression.
- Families often blame psychotic symptoms on substance abuse when none is present. Families may not want to accept that their relative has a chronic psychosis. Furthermore,

patients can be delusional about their substance use, reporting using drugs, or being drugged, when this has not occurred.

- Abuse of more than one substance is common.
- Because of the high rate of comorbidity, the evaluator should maintain concern and vigilance when working with an individual with SMI. Urine drug analysis (UDA) may be useful. UDAs are not used as an intrusive or punitive tool, but rather to develop psychotherapeutic intervention/approaches. Examples are:
  - As a tool for ongoing monitoring and feedback and use of motivational techniques to increase readiness for change
  - To encourage and/or reinforce reduction in use or abstinence (i.e. rewarding clean UDAs)
  - Tailoring the treatment approach
  - Diagnostic purposes which would impact on course of illness/treatment

#### Issues Related to Treatment

- Psychopharmacology alone is inferior to combined psychopharmacologic and psychosocial therapies.
- Motivational enhancement approaches have been shown to be more effective than confrontational or punitive approaches, and are preferred when combining psychotherapy with psychopharmacology.
- Abusers may attempt to abuse any medication including anti-psychotic, anti-anxiety, and anti-depressant medications. Thus, medication adherence is a significant issue during times of substance abuse.
- For diagnosed psychiatric illness, the individual should receive the most clinically effective psychopharmacologic strategy available, regardless of the status of the comorbid substance disorder.
- Substance abusers are less likely to adhere to antipsychotic regimens. Depot neuroleptic medications are used more often in the SA/SMI population, likely due to adherence issues. For patients who do adhere to antipsychotic medications, there is evidence that substance abuse is lessened.
- Treatment of the severely mentally ill with dependency producing drugs is risky, especially in the long-term. Whenever possible, it is best to avoid the use of:
  - Opioids and muscle relaxants for chronic pain
  - Stimulants for attention deficit disorder
  - Benzodiazepines for bipolar disorder or anxiety
  - Barbiturates for chronic headaches
- If an outside physician persists in prescribing dependency-producing drugs to your consumer with mental illness, consultation with an addiction specialist may help in negotiating with the outside physician. (See below for consultation resources)
- Any consideration or consumer attempts to reduce substance use or achieve/maintain abstinence should be encouraged. Illicit drug use should not be condoned or minimized.

***Psychopharmacologic treatment principles:***

1. Acute **intoxication**: in general, it is best to let the effects of the intoxicating drugs wear off rather than manage these effects with another drug. If the patient is behaviorally out of control, it may be necessary to send the patients to an emergency room for treatment.
2. Treatment of dependence for **opioids, sedatives, alcohol, and stimulants** requires **detoxification**. Social detoxification is the treatment of choice for stimulants and may be satisfactory for the other classes of substances listed here. For significant levels of dependence however, detoxification can occur safely and comfortably using medication for sedative, alcohol, and opioid dependence if the proper structured environment is available. For high levels of sedative and alcohol dependence, withdrawal can be dangerous. A higher level of care other than outpatient (e.g. acute care, LCRS or partial hospital) may need to be considered. Consultation with an addiction specialist is recommended when evaluating for and performing medical detoxification.
3. A number of treatments are available to minimize and prevent substance abuse. Some treatment considerations are:
  - **Opioid Dependence**: The treatment of opioid dependence, either with detoxification or maintenance therapy, in the past has only been allowed by specially licensed treatment programs such as methadone maintenance clinics for outpatients. Now it is possible for any physician who holds a special narcotics license to use the new sublingual formulation of buprenorphine (Suboxone) to treat opioid dependence. Buprenorphine is a partial agonist with very high affinity for the mu opioid receptor. Because of its ceiling effect, it is relatively safe in overdose, and it can detoxify faster than methadone with milder withdrawal symptoms. The patient must be on the equivalent of 30 mg methadone or less, however, before taking it or it may cause withdrawal symptoms because it will replace the offending opioid on the mu receptor without stimulating it as much. The American Academy of Addiction Psychiatrists offers information about buprenorphine and an online course at: "<http://www.aaap.org/buprenorphine/buprenorphine.htm>" The American Psychiatric Association also offers this information at: [http://www.psych.org/edu/bup\\_training.cfm](http://www.psych.org/edu/bup_training.cfm)
  - **Alcohol**: The medication most used with the SMI population is disulfiram (Antabuse). A retrospective review showed that treatment with 250 mg daily appears to be effective and well tolerated and associated with reasonable compliance. Reports of disulfiram induced psychosis exist and but they appear to be rare in the United States and are associated with high doses. The theoretical exacerbation of psychosis does not appear to occur. Naltrexone (Revia) maintenance is the other treatment for which there is evidence of effectiveness in the SMI population. There appears to be no evidence that the use of disulfiram and naltrexone together improves efficacy. At present, there is no evidence that acamprosate (Campral) is effective in the SMI population. This is understandable, since this drug is much more difficult to take, requiring three times per day dosing. However, side effects and interaction risks with other medications are minimal.
  - **Cocaine and amphetamine** (including methamphetamine) dependent patients are particularly problematic since use of these drugs typically exacerbates psychosis. Psychopharmacologic treatment of the schizophrenia or schizoaffective disorder is indicated along with psychosocial treatments for stimulant dependence. SAMHSA has published a curriculum titled, "Matrix Intensive Outpatient Treatment for People with

Stimulant Use Disorders”, specifically for treatment of stimulant abusers. Information for obtaining this can be found below.

- **Marijuana** use is associated with more mental illness than occurs in non-users. A study of 14-16 year-olds who smoked marijuana found that they were more likely to ultimately develop a psychotic disorder than controls. While there is no good evidence for a “cannabis psychosis,” people diagnosed with schizophrenia are at higher risk for psychotic episodes. Cannabis is also more associated with positive rather than negative symptoms of schizophrenia. Bipolar patients may be at risk for lengthier affective episodes and rapid cycling. On the web, there are testimonials that marijuana helps bipolar disorder, but the scientific evidence is the opposite.

For non-psychotic individuals, there may be the perception that marijuana is a benign drug. However, emergency room visits associated with marijuana abuse have been rising and this is thought to be related to the increased potency of marijuana in recent years (SAMHSA). There is no specific pharmacologic treatment for marijuana dependence.

- **Nicotine:** Treatment of nicotine dependence should be attempted. Discussion of treatment options and health consequences when done in an empathic and a non-coercive way often helps the therapeutic relationship because the patient can see that the doctor is really interested in his or her health and not in blaming him or her for using drugs. The new drug, varenicline (Chantix), appears to be more helpful than nicotine replacement therapy. It is a partial agonist at the nicotine receptor. In theory, it may offer cognitive benefits in schizophrenia, although this has not been tested.

Addiction psychiatry consultation may be obtained from:

- Jon Streltzer, M.D. 586-7427
- Louise Lettich, M.D. 266-9937
- David Friar, M.D. 233-3775

*Selected references:*

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State of Hawaii, Dept. of Health, Adult Mental Health Division Adaptation Work Group:  
Eva Kishimoto, CSAC, DCSW, MISA Service Director, Project Lead  
Jon Stretzler M.D. University of Hawaii, John A. Burns, School of Medicine  
Louise Lettich, M.D. SAMHSA COSIG Grant  
AMHD Statewide Medical Executive Committee  
AMHD Clinical Operations Team

**Resources:**

Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders can be obtained at no cost from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. See links below for ordering or downloading:

Counselors Manual: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17441>

Family Handbook: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17442>

Client's Handbook: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17443>

Client's Treatment Companion:

<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17444>

Brief Counseling for Marijuana Dependence-A Manual for Treating Adults  
<http://www.kap.samhsa.gov/products/brochures/pdfs/bmdc.pdf>