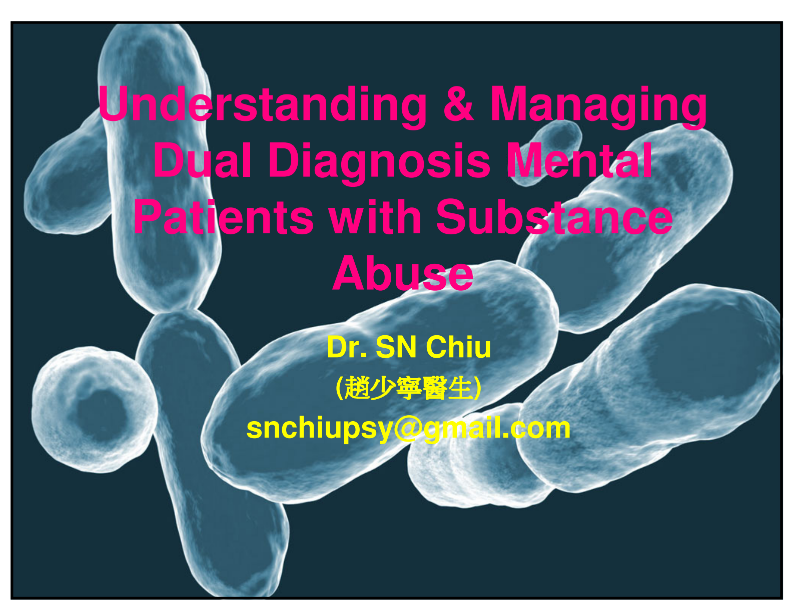

Understanding & Managing Dual Diagnosis Mental Patients with Substance Abuse

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Definition of Co-morbidity

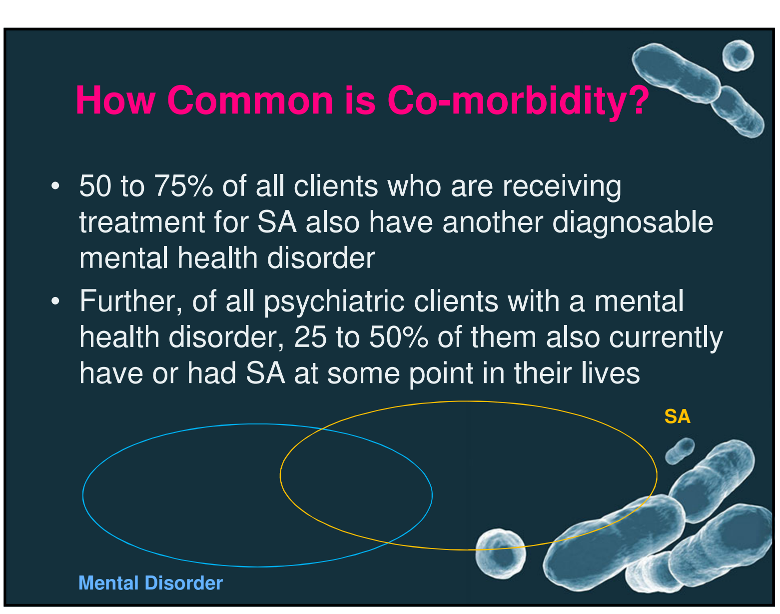
- The simultaneous existence of "one or more disorders relating to the substance Abuse as well as one or more mental disorders"

Co-morbidity =

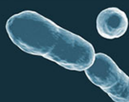
Substance Abuse + Mental Health Problem(s)

How Common is Co-morbidity?

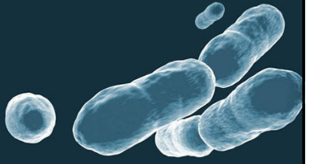
- 50 to 75% of all clients who are receiving treatment for SA also have another diagnosable mental health disorder
- Further, of all psychiatric clients with a mental health disorder, 25 to 50% of them also currently have or had SA at some point in their lives

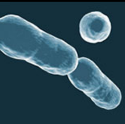


Common Examples of Co-morbidity

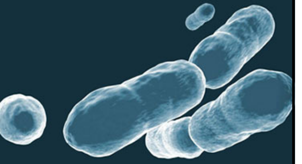


- Major Depressive Disorder and alcohol dependence
- Generalized Anxiety Disorder, benzodiazepine dependence and alcohol abuse
- Anti-social Personality Disorder and heroin/cocaine dependence

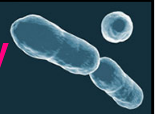




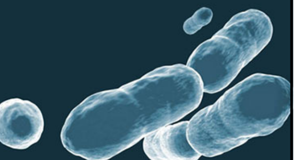
Co-morbidity in SA and Mental Disorder is a complicated situation; understanding the relationship between the two helps a lot in building up a management plan



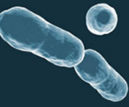
When Psychiatric Co-morbidity Exists…….



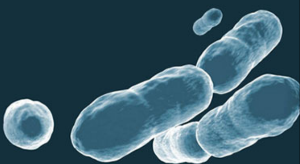
- We have to understand the inter-relationship:
  - A ==> B
  - B ==> A
  - C ==> A & B
  - A & B are totally unrelated



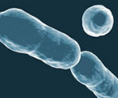
When Psychiatric Co-morbidity Exists…….



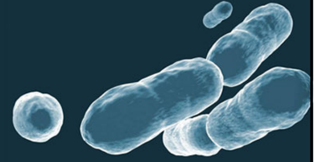
- Applying this to relationship between SA (A) and Mental Disorder (B):
  - A ==> B
- There are two conditions:
  - Direct effect
  - Indirect effect



A ==> B Direct Effect

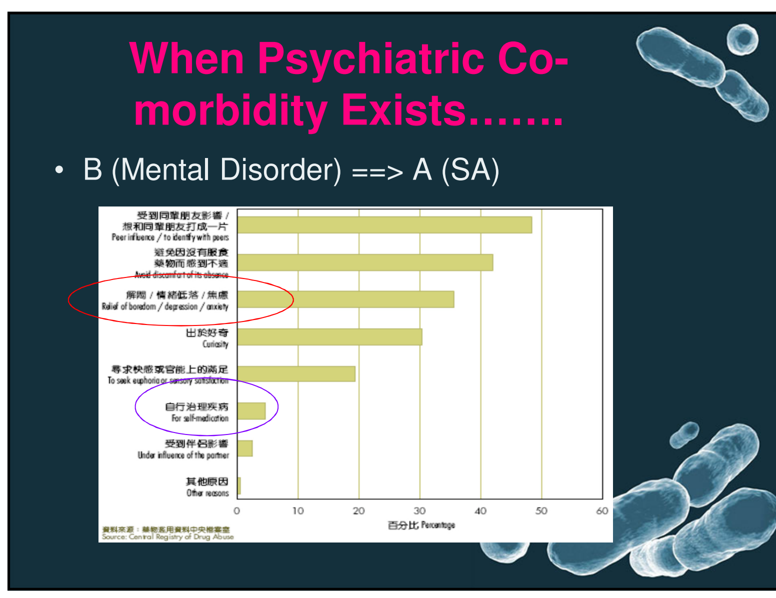


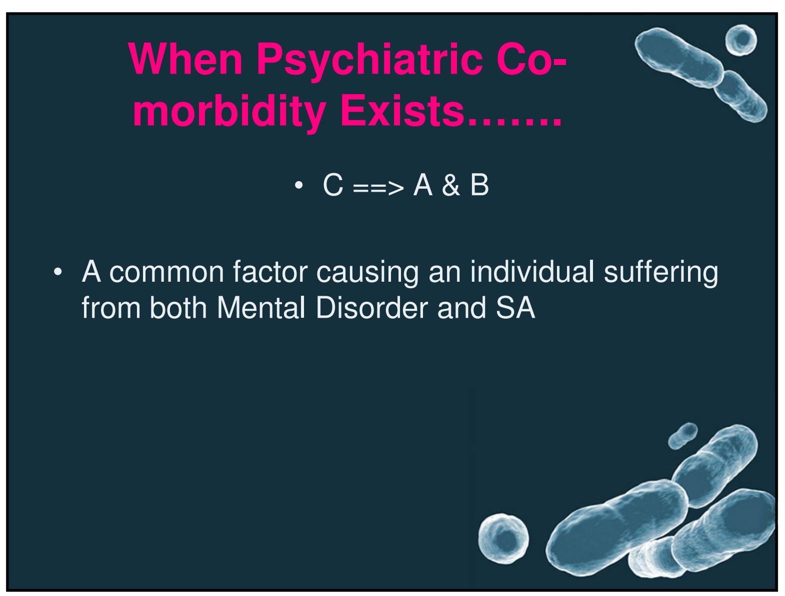
- Mainly caused by Psychostimulants and Hallucinogens:
  - Cocaine
  - Amphetamine-containing drugs
  - Ketamine etc.

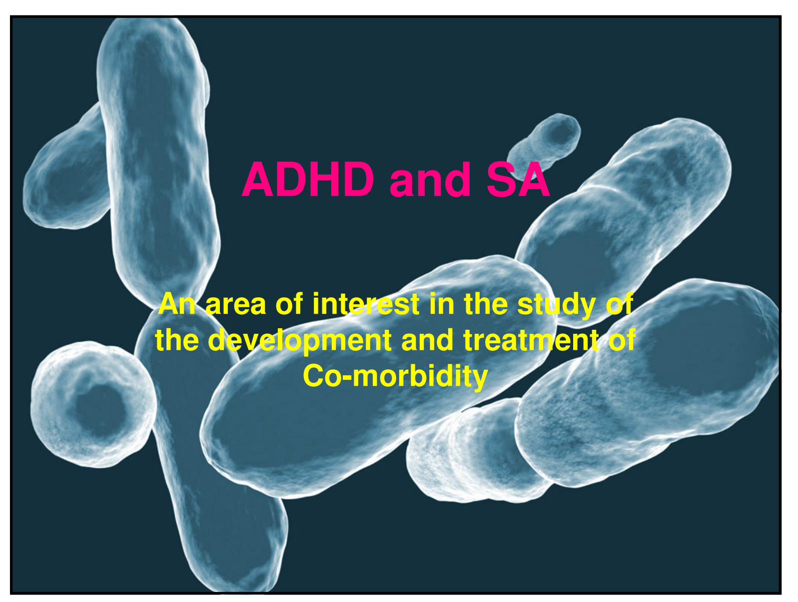


A ==> B Indirect Effect

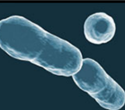
- Cannabis may trigger off Schizophrenia or Delusional Disorder, Paranoid type
- Even psychostimulants and hallucinogens can do the same



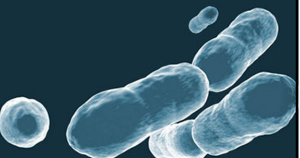




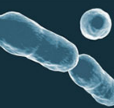
ADHD & SA



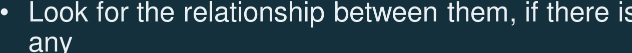
- Can be linked up by 2 common factors:
- ***1. Poor Response Inhibition***
  - Impulsiveness and hyperactivity are core features of ADHD
  - Drug-taking is a form of impulsive risk-taking behaviour



ADHD & SA

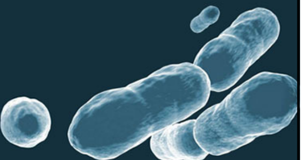


- Can be linked up by 2 common factors:
- **2. Dopamine System Deficit:**
  - In ADHD:
    - Genes of interest:
      - DRD4, DRD5, SLC6A3, DBH, SNA25, SLC6A4, HTR1B
      - Almost certain that it involves genes responsible for Dopamine regulation in the brain
    - In SA:
      - Involves the reward system in the brain in which Dopamine is the main neurotransmitter



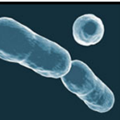
- **? The same apply to the co-morbidity between SA and Personality Disorder**

  (esp. Cluster B PD)



When SA and Mental Disorder Co-morbidity Exists…….

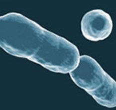
- Look for the relationship between them, if there is any
- Is there a synergistic effect between the two? (vicious cycle)
- What other helping resources (professionals or family) to be involved?
- Multi-axial diagnosis approach in complicated cases
- Systematic assessment: stage of change, stage of treatment
- Choose appropriate treatment model, including model of care, drug v.s. non-drug treatment
- Regular monitoring



Psychiatric Co-morbidity

Consider Multi-axial Diagnosis (DSM):

•Axis I: Psychiatric Illness
•Axis II: Personality Disorder
Intellectual Disability
•Axis III: Medical Illness
•Axis IV: Psychosocial Stressors
•Axis V: Global Assessment of Functioning (GAF)

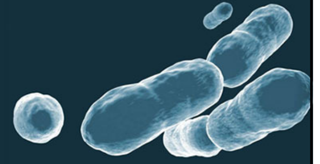


Strategies of Management

- The 3 primary psychosocial treatments are:
  1. **Motivational Enhancement Therapy (MET)**
  2. **Cognitive-behavioral Therapy (CBT)**
  3. **12-step Facilitation (TSF)**
- The Dartmouth Psychiatric Research Center at Dartmouth Medical School integrated 3 evidenced-based therapies into a stage-wise treatment model called the Co-Occurring Disorders Program (CDP), published by Hazelden
- In CDP, a specific curriculum called Integrating Combined Therapies (ICT) integrates MET, CBT and TSF

Strategies of Management

- To summarize the conceptual purpose of ICT:
  - **Motivational Enhancement Therapy:**
    - Initiate motivation to change
  - **Cognitive-behavioral Therapy:**
    - Make change
  - **12-step Facilitation:**
    - Maintain change



Thank You !!