Library Watch co-occurring disorders

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Caffeine intake in outpatients with schizophrenia.
Gurpegui M; Aguilar MC; Martinez-Ortega JM; Diaz FJ; de Leon J. *Schizophrenia Bulletin* 30(4): 935-945, 2004. (78 refs.)
Several studies suggest that caffeine intake is high in patients with schizophrenia and a few of them suggest that caffeine may contribute to schizophrenia symptomatology. None of these studies control for the effect of tobacco smoking, which is associated with induction of caffeine metabolism. Therefore, the high amount of caffeine intake among patients with schizophrenia may be due to their high prevalence of smoking. This is the first large study to explore whether caffeine intake in patients with schizophrenia is related to tobacco (or alcohol) use or to the severity of schizophrenia symptomatology. The sample included 250 consecutive consenting outpatients with a diagnosis of DSM-IV schizophrenia from Granada, Spain. Fifty-nine percent (147/250) of patients consumed caffeine. Current caffeine intake was associated with current smoking and alcohol use. As none of the females used alcohol, the association with alcohol was only present in males with schizophrenia. Among caffeine consumers, smoking was associated with the amount of caffeine intake. Cross-sectional schizophrenia symptomatology was not associated with caffeine intake. Public Domain.

Cannabis as a risk factor for psychosis: Systematic review. (review).
Semple DM; McIntosh AM; Lawrie SM. *Journal of Psychopharmacology* 19(2): 187-194, 2005. (44 refs.)
Various tines of evidence suggest an association between cannabis and psychosis. Five years ago, the only significant case-control study addressing this question was the Swedish Conscript Cohort. Within the last few years, other studies have emerged, allowing the evidence for cannabis as a risk factor to be more systematically reviewed and assessed. Using specific search criteria on Embase, PsychINFO and Medline, all studies examining cannabis as an independent risk factor for schizophrenia, psychosis or psychotic symptoms, published between January 1966 and January 2004, were examined. Additional studies were also reviewed from references found in retrieved articles, reviews, and a cited reference search (ISI-Web of Science). Studies selected for meta-analysis included: (i) case-control studies where exposure to cannabis preceded the onset of schizophrenia or schizophrenia-like psychosis and (ii) cohort studies of healthy individuals recruited before the median age of illness onset, with cannabis exposure determined prospectively and blind to eventual diagnosis. Studies of psychotic symptoms were also tabulated for further discussion. Eleven studies were identified examining the relationship between cannabis use and psychosis. Seven were included in the meta-analysis, with a derived odds ratio (fixed effects) of 2 (.) 9 (95% confidence interval = 2.4-3.6). No evidence of publication bias or heterogeneity was found. Early use of cannabis did appear to increase the risk of psychosis. For psychotic symptoms, a dose-related effect of cannabis use was seen, with vulnerable groups including individuals who used cannabis during adolescence, those who had previously experienced psychotic symptoms, and those at high genetic risk of developing schizophrenia. In conclusion, the available evidence supports the hypothesis that cannabis is an independent risk factor, both for psychosis and the development of psychotic symptoms. Addressing cannabis use, particularly in vulnerable populations, is likely to have beneficial effects on psychiatric morbidity. Copyright 2005, British Association for Psychopharmacology.

Co-occurring disorders in the adolescent mental health and substance abuse treatment systems.
Turner WC; Muck RD; Muck RJ; Stephens RL; Sukumar B. *Journal of Psychoactive Drugs* 36(4): 455-462, 2004. (44 refs.)
This article explores the rates of co-occurring disorders in two large federally-funded programs that target youth. In the mental health treatment system, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) supports the Comprehensive Community Mental Health Services for Children and Their Families Program. SAMHSA's Center for Substance Abuse Treatment (CSAT) supports a number of grant programs providing substance abuse treatment for adolescents. The data from these programs underscores the need for the use of systematic, validated, biopsychosocial assessment instruments for all youth entering either the substance abuse or mental health

treatment systems. The current evidence base for models of co-occurring treatment for youth is discussed and recommendations made for future activity related to adolescent co-occurring treatment. Copyright 2004, Haight-Ashbury Publications.

Co-morbidity of smoking in patients with psychiatric and substance use disorders. (review).
Kalman D; Morissette SB; George TP. *American Journal on Addictions* 14(2): 106-123, 2005. (164 refs.)
This article reviews cigarette smoking in patients with psychiatric disorders (PD) and substance use disorders (SUD). Rates of smoking are approximately 23% in the US population but approximately two- to four-fold higher in patients with PD and SUD. Many remaining smokers have had repeated smoking cessation failures, possibly due to the presence of co-morbid PD and SUDS. There is modest, evidence-based support for effective treatment interventions for nicotine addiction in PD and SUD. Further research is needed to increase our understanding of nicotine addiction in PD and SUD and develop more effective treatment interventions. Copyright 2005, American Academy of Psychiatrists in Alcoholism and Addictions.

Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system.
Folsom DP; Hawthorne W; Lindamer L; Gilmer T; Bailey A; Golshan S et al. *American Journal of Psychiatry* 162(2): 370-376, 2005. (42 refs.)
Objective: The authors examined the prevalence of and risk factors for homelessness among all patients treated for serious mental illnesses in a large public mental health system in a 1-year period. The use of public mental health services among homeless persons was also examined. Method: The study included 10,340 persons treated for schizophrenia, bipolar disorder, or major depression in the San Diego County Adult Mental Health Services over a 1-year period (1999 - 2000). Analytic methods that adjusted for potentially confounding variables were used. Multi-variate logistic regression analyses were used to calculate odds ratios for the factors associated with homelessness, including age, gender, ethnicity, substance use disorder, Medicaid insurance, psychiat-ric diagnosis, and level of functioning. Similarly, odds ratios were computed for utilization of mental health services by homeless versus not-homeless patients. Results: The prevalence of homelessness was 15%. Homelessness was associated with male gender, African American ethnicity, presence of a substance use disorder, lack of Medicaid, a diagnosis of schizo-phrenia or bipolar disorder, and poorer functioning. Latinos and Asian Americans were less likely to be homeless. Homeless patients used more inpatient and emergency-type services and fewer outpatient-type services. Conclusions: Homelessness is a serious problem among patients with severe mental illness. Interventions focusing on potentially modifiable factors such as substance use disorders and a lack of Medicaid need to be studied in this population. Copyright 2005, American Psychiatric Association.

Substance abuse in first-episode bipolar I disorder: Indications for early intervention.
Baethge C; Baldessarini RJ; Khalsa HMK; Hennen J; Salvatore P; Tohen M. *American Journal of Psychiatry* 162(5): 1008+, 2005. (6 refs.)
Objective: This study clarified the early characteristics of substance use disorders in patients with first-episode bipolar I disorder. Method: The authors evaluated substance use disorders, associated factors, and clinical course, prospectively, in the first 2 years of DSM-IV bipolar I disorder with standardized methods. Results: Baseline substance use disorder was found in 33% (37 of 112) of the patients at baseline and in 39% at 24 months. Anxiety disorders were more frequent in the patients with than without substance use disorder (30% and 13%, respectively). Associations of alcohol dependence with depressive symptoms and cannabis dependence with manic symptoms were suggested. Patients using two or more substances had worse outcomes. Conclusions: Since substance use disorders were frequent from the beginning of bipolar I disorder and were associated with anxiety disorders and poor outcome, early interventions for substance use disorder and anxiety might improve later outcome. Copyright 2005, American Psychiatric Association. Used with permission.

Influence of psychiatric comorbidity in alcohol-dependent subjects in a representative population survey on treatment utilization and natural recovery.
Bischof G; Rumpf HJ; Meyer C; Hapke U; John U. *Addiction* 100(3): 405-413, 2005. (60 refs.)
Background: It is well known that only a minority of alcohol-dependent subjects seek help and that the majority of alcohol-dependent individuals recover without utilization of formal help. Psychiatric comorbidity is highly prevalent among alcohol-dependent individuals. However, no data are available on the impact of psychiatric comorbidity on natural

recovery. Aims: To analyse the impact of non-psychotic psychiatric comorbid Axis I disorders on remission rate and utilization of formal help in alcohol-dependent individuals drawn from a representative general population sample in northern Germany (response rate: 70.2%, n = 4075). Psychiatric diagnoses and utilization of help were assessed in a personal interview using standardized instruments. One hundred and fifty-three life-time alcohol-dependent individuals were assessed, among whom 98 fulfilled the criteria for sustained long-term remission according to the Diagnostic and Statistical Manual version II (DSM-IV) criteria. Any coincidence of DSM-IV non-psychotic Axis I disorders with alcohol dependence was counted as comorbidity. Comorbidity rate in the whole sample was 36.1%. Results: The rate of individuals who remitted from alcohol dependence without formal help was 36.9% in the non-comorbid and 42.6% in the comorbid group. Utilization of formal help was unrelated to comorbidity. Dually diagnosed subjects without a history of help-seeking showed minor differences concerning reasons for not seeking help. Seeking help was not related to schooling, severity of dependence and gender. Conclusion: Data reveal that remission without formal help is equally prevalent among non-comorbid as among comorbid alcohol-dependent individuals. Axis I comorbidity is not related directly to utilization of alcohol-related help. Negative prognoses for untreated comorbid alcohol-dependent individuals are not justified from an epidemiological point of view. Copyright 2005, Society for the Study of Addiction to Alcohol and Other Drugs.

Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and system perspectives. (review).
Ziedonis DM. *CNS Spectrums* 9(12): 892-+, 2004. (86 refs.)
Individuals with mental illness and addiction comprise at least half of the patients in most mental health treatment systems. This combination results in increased risk for frequent psychiatric relapses, poor medication compliance, violence, suicide, legal problems, and high utilization of the emergency room or inpatient services. Traditional mental health and addiction treatments have not adequately addressed these co-occurring disorders due to clinical interventions, programs, and system flaws that have not addressed the individual's needs. Integrated treatment requires both an understanding of mental illness and addiction and the means to integrate and modify the traditional treatment approaches in both the mental health and addiction treatment fields. There is strong evidence to support the efficacy and effectiveness of integrated treatment in this population. All mental health clinicians should become experienced and skilled in the core psychotherapy approaches to treating substance use disorders, including motivational enhancement therapy, relapse prevention (cognitive-behavioral therapy), and 12-step facilitation. In addition, integrated treatment includes integrating medications for both addiction and mental illness with the behavioral therapies and other psychosocial interventions. This article reviews the clinical intervention, program, and system components of integrated treatment and specific clinical interventions for this population. Copyright 2004, MBL Communications, Inc.

Racial distribution of dual-diagnosis clients in public sector mental health and drug treatment settings.
Alvidrez J; Havassy BE. *Journal of Health Care for the Poor and Underserved* 16(1): 53-62, 2005. (21 refs.)
This study examined the racial distribution of dual-diagnosis clients in public sector residential mental health and drug treatment settings. In a sample of 179 dual-diagnosis clients, there was a significantly larger proportion of blacks in the drug treatment cohort than the mental health cohort. There were black-white differences in the types of substance use disorders found, but not in the types of mental health disorders. Diagnostic and drug use pattern differences did not account for the differential racial distribution in the two settings. However, the racial distribution was explained by the recent history of service use in the two treatment sectors. In the 2 years after study entry, blacks were less likely than whites to receive mental health treatment and whites were less likely than blacks to receive drug treatment. The implications of these findings regarding the appropriate treatment for dual-diagnosis blacks and whites in the public sector are discussed. Copyright 2005, Institute on Health Care for the Poor and Underserved, Meharry Medical College.

The prevalence and impact of alcohol problems in major depression: A systematic review. (review).
Sullivan LE; Fiellin DA; O'Connor PG. *American Journal of Medicine* 118(4): 330-341, 2005. (77 refs.)
Major depression and alcohol problems are common in primary care, yet little is known about the prevalence of alcohol problems in patients with depression or alcohol's effect on depression outcomes. We strove to answer the following questions: How common are alcohol problems in patients with depression? Does alcohol affect the course of depression, response to

antidepressant therapy, risk of suicide/death, social functioning and health care utilization? In which alcohol categories and treatment settings have patients with depression and alcohol problems been evaluated? English language studies from MEDLINE, Psych-INFO, and Cochrane Controlled Trial Registry were reviewed. Studies were selected using predefined criteria if they reported on the prevalence or effects of alcohol problems in depression. Thirty-five studies met criteria and revealed a median prevalence of current or lifetime alcohol problems in depression of 16% (range 5-67%) and 30% (range 10-60%), respectively. This compares with 7% for current and 16-24% for lifetime alcohol problems in the general population. There is evidence that antidepressants improve depression outcomes in persons with alcohol dependence. Alcohol problems are associated with worse outcomes with respect to depression course, suicide/death risk, social functioning, and health care utilization. The majority of the studies, 34 of 35 (97%), evaluated alcohol abuse and dependence, and 25 of 35 (71%) were conducted in psychiatric inpatients. We conclude that alcohol problems are more common in depression than in the general population, are associated with adverse clinical and health care utilization outcomes, and that antidepressants can be effective in the presence of alcohol dependence. In addition, the literature focuses almost exclusively on patients with alcohol abuse or dependence in psychiatric inpatient settings, and excludes patients with less severe alcohol problems and primary care outpatient settings. Copyright 2005, Excerpta Medica, Inc. Used with permission.

Training substance abuse treatment staff to care for co-occurring disorders.

Hunter SB; Watkins KE; Wenzel S; Gilmore, J.; Sheehe J; Griffin B. *Journal of Substance Abuse Treatment* 28(3): 239-245, 2005. (52 refs.)

Although co-occurring disorders have been associated with poorer substance abuse treatment outcomes and higher costs of care, few individuals with co-occurring disorders receive appropriate mental health care. This article describes the design and implementation of an intervention to improve the quality of mental health care provided in outpatient substance abuse treatment programs without requiring new treatment staff. The intervention focuses on individuals with affective and anxiety disorders and consists of three components: training and supervising staff, educating and activating clients, and linking with community resources. We evaluated three treatment programs (one intervention and two comparison) for the first component by having program staff complete both self-administered questionnaires and semistructured interviews. Staff knowledge and attitudes about co-occurring disorders, job satisfaction, and morale all indicated an improvement at the intervention relative to the comparison sites. The evaluation is still under way; results for implementation of the other two components and for outcomes will be reported later. Copyright 2005, Elsevier Science.

Influence of parental SUD and ADHD on ADHD in their offspring: Preliminary results from a pilot-controlled family study.

Wilens TE; Hahesy AL; Biederman J; Bredin E; Tanguay S; Kwon A et al. *American Journal on Addiction*s 14(2): 179-187, 2005. (42 refs.)

As part of a pilot-controlled family-based study of the children of parents with and without substance use disorders (SUD), the influence of parental SUD and ADHD on the risk for ADHD in offspring was evaluated. Using structured psychiatric interviews, 96 families, (183 youth; mean age 11.6 years) were assessed. To evaluate the effect of parental ADHD and SUD, the offspring were stratified into four groups based on parental status. children of parents with neither ADHD nor SUD, children of parents with SUD only, children of parents with ADHD only, and children of parents with both ADHD and SUD. Using generalized estimating equation models, parental SUD and ADHD were used to predict ADHD in the offspring. The rate of children with ADHD increased among children of parents with neither disorder (3%), children of parents with SUD (13%), children of parents with ADHD (25%), and children of parents with both ADHD and SUD (50%) ($p = .001$). Children of parents with ADHD or ADHD plus SUD were more likely to have ADHD in comparison to children of parents with neither diagnosis ($P < 0.05$). Children of parents with ADHD plus SUD were at greater risk of ADHD in comparison to children of parents with SUD only ($p = 0.01$). Despite the small sample size, the results of this study seem to suggest that the offspring of SUD or ADHD parents are at elevated risk for ADHD compared to controls. The offspring of parents with both ADHD and SUD appear to be at the highest risk for ADHD, highlighting the need for careful screening of this group of youth for ADHD. Replication studies clarifying the nature and strength of the association are necessary. Copyright 2005, Amer. Acad. of Psychiatrists in Alcoholism & Addictions.