Title: Treating Co-Occurring Substance Use and Psychological Disorders
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Now let me introduce Dr. Roger D. Weiss professor of psychiatry at Harvard Medical School and chief of the division of alcohol drugs, and addition at McLean Hospital in Belmont, Massachusetts. I'd also like to introduce Dr. R Kathryn McHugh, director of the Stress, Anxiety, and Substance Use Laboratory at McLean Hospital and an assistant professor at Harvard Medical School. Welcome, Dr. Weiss and Dr. McHugh.

Dr. R Kathryn McHugh: Thank you so much and good afternoon everybody. I really appreciate you all taking the time out of your days to engage a little bit on this important topic. We've already gotten a number of great questions in advance of this webinar. We're looking forward to digging in. I'm actually going to start us off. I'm going to start by talking about co-occurring anxiety and substance use disorders. Then I'm going to hand it over to Dr. Weiss who will talk more about substance use and mood disorders.

Just to set the stage for this anxiety and substance use disorders co-occur at a tremendously high rate. Depending on which direction you look at this, many people with an anxiety disorder also have a substance use disorder, it's about 15%. If we look at it from the other direction among people with a substance use disorder around 17% to 18% will also have an anxiety disorder. This gets quite a bit higher. If we are looking at folks in treatment where you're seeing close to a third upwards of 40%. I would also note that this does not include PTSD. These numbers get even higher if we're actually looking at PTSD as well.

One important note and this is one place where anxiety and substance use disorders differ from mood and substance use disorders, is that substance-induced anxiety disorders are actually quite rare. Anxiety symptoms commonly co-occur with substance use disorders. Oftentimes these will remit after a period of abstinence, usually in the ballpark of two to four weeks. However, if you see the full syndrome of an anxiety disorder, it is unlikely to be substance-induced. That's about less than one to 2% of anxiety disorders. Again, if you see the whole syndrome, it is probably not substance-induced.

If we think about the impact of this co-occurrence, it has tremendously widespread effects and, and this could be 20 slides long of the impact of anxiety on substance use disorders. It's among the most common reasons or motives for use it's a trigger for relapse. It can actually exacerbate withdrawal and there's certainly associated with worst functioning and quality of life. Really across the board, you see a tremendous impact of anxiety on substance use disorders.

If we look at how does this co-occurrence happen, why do we see such tremendously high rates of co-occurrence, there really been three primary pathways that have been proposed. The first one is what you could think of as a self-medication model, which is that anxiety increases the risk for substance use disorder. Very simply, that when someone has anxiety, they may use substances to try to relieve that anxiety. In the short term that actually works. Many substances can actually provide tremendous acute proximal relief of anxiety. The problem is in the long term, chronic substance use can certainly increase stress and anxiety, thus fueling this cycle. That's one pathway.

Another pathway has been that substance use increases risk for anxiety. This can happen in a couple of different ways. First of all, substance use, particularly when chronic, increases life stress in a number of different ways, which can lead to anxiety. Also, pretty much any substance of abuse also heightens the brain's response to stress. It turns up the degree to which our brains are actually responding to stress, which can then create anxiety. Then the third pathway suggests that they're common risk factors, that there are risk factors that may put someone at risk for both of these disorders and that this is why we see these disorders co-occur.

In terms of which of these three is actually the most accurate representation of this co-occurrence, there's data to support all three models. I would give the caveat that this is actually a tremendously difficult question to answer. In part because we typically will just have to rely on developmental studies that look at, which came first. Did anxiety onset first in substance use onset first?

One of the challenges in relying on those data is that the developmental risk periods for these disorders differ. You can certainly see social anxiety, early signs of social anxiety in relatively young children. You're typically not going to see substance use at that age. At this point, probably the most educated guests that we can make based on the data is that actually any one of these three pathways could actually be the way that people get to this comorbidity. Then in fact, we might actually have quite a bit of heterogeneity in how people end up with both of these disorders.

One slight aside here, but this seemed important to note given the amount of attention on opioid use right now, is much of the conversation about preventing opioid misuse and opioid use disorder is focused understandably on pain. However, it's really important to note that anxiety is also a tremendous risk factor for opioid misuse. For those of us who are really thinking about prevention and monitoring of opioid misuse, anxiety is a target we should be thinking about.

Just a couple of pieces of data here. People with anxiety disorders are more likely to be prescribed opioids. Also, people with anxiety disorders have a heightened risk for the future development of opioid use disorder. About 60% of people with an opioid

use disorder have had an anxiety disorder in their lifetime. Again, this does not include PTSD. This is higher than any other substance use disorder with the exception of understandably sedative use disorder, primarily benzodiazepine use disorders.

We also know that anxiety symptoms often proceed opioid use and are a common reason for opioid use. I think this is an important piece of context, and this is something that I don't think we're considering quite enough from a prevention perspective, but anxiety certainly is playing a role there.

Shifting gears to treatment we actually have tremendous knowledge gaps in the optimal ways of treating anxiety and substance use disorders. This is for a couple of different reasons. If you look at the anxiety disorders literature, the vast majority of anxiety disorders trials will exclude substance use disorders. These are on occasion, you'll see studies that will allow nicotine use disorder in there, but as a general rule, these disorders are actually excluded from anxiety trials. Oftentimes we can't look there for an answer.

If we look at substance use disorder research, those trials don't typically exclude anxiety disorders, but they also don't typically assess them. Even if when they are assessed, they oftentimes don't report anxiety outcomes. The excellent literature in this area is a little bit hard to interpret. Although there have been some advancements in recent years that can give us a little bit of guidance.

Dr. Weiss will talk about this as well, but you can think about two main ways of treating co-occurring disorders and the first way would be treating a single disorder or sequential treatment. In other words, this would be you just treat one disorder and hope the other one gets better, or you treat one disorder and then treat the other. Typically in practice settings, and having worked both in primary substance use disorder treatment settings and primary mental health treatment settings, typically that is go to the substance use disorder folks, get that under control, and then we'll treat your anxiety.

Basically what we know from the literature here is this is probably not the best model. What can we say about this? Interestingly enough, if someone has an anxiety disorder and a substance use disorder, and they get substance use disorder treatment, they're not necessarily going to do any worse. In other words, you can't effectively treat a substance use disorder in someone with an anxiety disorder. I have to admit, this was surprising to me when I saw this, but if you look across the totality of literature, this is actually a pretty consistent finding.

However, the substance use disorder treatment will not necessarily help the anxiety disorder. What you end up with is you can successfully treat the substance use disorder, but the person is still suffering. They're functioning less well because they still have an anxiety disorder on board. This story looks basically the same if you treat the anxiety disorder. You can treat an anxiety disorder in someone who has a substance use disorder, but if you're not specifically targeting both, you leave people with a fair bit of suffering. I would argue, put them at risk for longer-term poor outcomes.

The alternative model here would be either concurrent or integrated treatment, which either means we're treating both disorders at the same time. Perhaps this is with two different providers or you're integrating treatment. Again, Dr. Weiss will talk a bunch about this thinking of these two disorders almost as one entity within a particular person that we're actually trying to target common factors that might underlie both disorders.

This is like a growing literature. It's a small one at this point. There's actually much more in the PTSD literature than there is in the anxiety literature, but thus far, there is some promising early evidence for medication treatment. Much of this has been combining medication for substance use disorder with behavior therapy, for the anxiety disorder. For example, there've been a number of trials of combining naltrexone, which is a medication for alcohol use disorder with prolonged exposure for PTSD. There's some promising findings there.

There are also a number of behavior therapy trials that have looked at a behavior therapy that targets both the substance use disorder and the anxiety disorder at the same time. Matt Cushner has done some really wonderful work with alcohol use disorder that these expanding to other substance use disorders. The COPE program is another really wonderful one. Sudi Beck and Kathleen Brady down at Medical University of South Carolina, as well as Kathy Carol have worked on this, where basically you're combining prolonged exposure with CBT for the treatment of substance use disorders.

One really important note here, and I have a couple of asterisks here and I'll say it twice because I think it's exceptionally important in the literature to date. There is absolutely no evidence for an increased relapse risk if you're doing exposure-based treatment, this has been a real concern. Can you do exposure-based therapies for anxiety disorders in folks with substance use disorders?

There is of all of the studies that have been published. Again, this is a small, but growing literature, there is absolutely no evidence that it is you're going to increase risk for relapse and I can preview, we're actually writing it up now, we haven't published it yet, but we have some data from a small pilot trial looking at folks with severe opioid use disorder. Even in that population, do any at doing an exposure-based treatment did not increase risk for relapse. I think that this is a really important point. I think people have been encouraged by these data so far. I think with more data hopefully we can start to move more folks towards doing exposure-based treatments in this population.

To get a little bit more into the weeds about how we think about treating this co-occurrence as we think about integrated treatments, really the target here is what are common maintaining processes that might underlie both disorders. These are a number of processes that can underlie co-occurring anxiety and substance use disorders. Certainly heightened negative effect is something that we would think about for both of these disorders.

Anhedonia and low positive affectivity I think is an absolutely essential target for us to be thinking about, in addition to the fact that you may see that this because of a co-occurring depressive disorder in this population. for folks who are early in their

recovery, especially folks who have a more severe substance use disorder that repeated substance use is just hammering away at the reward system of the brain. People will tend to look quite anhedonic in early stages of recovery. I have to say with this population, I use a ton of behavioral activation too really go after this low positive of activity anhedonia presentation.

physiological arousal, another common target. A couple of different ways that we can target this, either through relaxation-based strategies, looking to take a little bit of the edge off of that physiological arousal, progressive muscle relaxation is one that we use a fair bit from the exposure perspective, interceptive exposure is also another treatment so that we can use, which can also have some value. We talk about this in the Q and a, if folks have questions about it for medication discontinuation and for substance withdrawal, interceptive exposure could play a really nice role there.

Really if we think about what is probably the most fundamental overlapping feature of these two disorders is a pattern of maladaptive coping. When anxiety, we can see this escape and avoidance presentation in substance use disorders, substance use for the escape or avoidance motive. Basically, what's happening in this situation is people are continuing to escape or avoid situations either through substances or behaviorally even at the cost of other things in their life. That there've been negative consequences related to their substance use or their avoidance that continue. The target we really think about for this is the construct of distress and tolerance.

Let me just walk you through it. Think of really two big components of this. One component is a sensitivity to distress. I hate this. I don't like it. I can't handle this. This is it's bad, which tends to amplify distress. This is for people to do a lot of panic disorder work. This is really the heart of panic disorder is a fear of fear, a fear of distress. This element can really amplify people's distress. Then oftentimes we'll come hand in hand this lack of persistence. If I can't handle this, if this is bad or scary, I also need to get rid of it. When do I need to get rid of it? I need to get rid of it as quickly as possible.

This is one of the places where I think we run into one of our most fundamental challenges with anxiety and substance use is there's very little that we have behaviorally that can compete with substances in terms of providing very quick relief for relatively low effort. Oftentimes building alternative coping mechanisms, alternative coping strategies also requires helping people to be able to tolerate that distress long enough.

In other words, someone knows that if they drink alcohol or use opioids, they can get a pretty quick response in the short term. To be able to use an alternative, healthier coping strategy to exercise or seek social support, the effect takes a little bit longer. Really working with people to enhance their ability to handle distress when it comes up as a really core component of behavioral treatment for this particular population.

In the couple minutes I have left, I want to end on a couple of quick notes about benzodiazepines and this is a very large topic. This is one that we could spend a whole lot of time on, but I just want to highlight a couple of pieces here. Benzodiazepines are among the most commonly prescribed psychiatric medications more than 1 in 20 people in the US have a prescription each year.

Actually, similarly to opioids. If we go back about a decade, benzodiazepine prescriptions are increasing and we're seeing them increased both in terms of numbers. Number of prescriptions filled number of benzodiazepine visits, but also in terms of quantity. That the potency of what is being prescribed is going up. There are some numbers there that you can see on the screen in terms of what the magnitude of those changes are.

I would note that we're going to talk a little about COVID in the Q&A but I would, if I were to make a prediction, I would assume you're actually going to see these numbers continue to escalate both for the treatment of anxiety and for the treatment of sleep disruption given some of the mental health consequences of COVID. Why do we need to think about this? Benzodiazepines are an efficacious treatment for anxiety disorders. There's quite a bit of data on that. They do come with some pros and cons, but one of the potential downsides of benzodiazepines is that they can be misused. This doesn't mean that everyone misuses them by any stretch of the imagination, but they are commonly misused.

What I'm showing you here, these are some data from the national survey on drug use and health, which is an annual survey that's administered by Samsung. What you're seeing here is of the people who misused drugs, this is not including alcoholic tobacco, but misuse of a drug in the past year, misuse of benzodiazepines and related sedative drugs. These are mostly the Z drugs, is third behind marijuana and opioid analgesics. It's more common than misuse of cocaine. It's more common than misuse of prescription stimulants.

This tends to be a less severe presentation. This doesn't necessarily mean that these are folks who have a severe substance use disorder, sedative use disorder, but the misuse of these medications is quite common. If we look at what is the population that is at risk for misusing these medications, it's folks with substance use disorders.

These are some disorders. This is from data that we published. These are also based on national survey on drug use and health data. What you're looking at here is the percentage of people who have misused a benzodiazepine in either their lifetime or the past year. From left to right, you're looking at alcohol use disorder, opioid use disorder, or their combination. What you see here, this has been known for a while, particularly opioid use disorder is that a majority of people with a history of opioid use disorder have misused benzodiazepines, and a not insubstantial proportion of people who struggle from alcohol use disorder have misused these medications.

Again, this doesn't necessarily mean that we should never be using benzodiazepines in this prescription, in this population or that it doesn't have a role. This is something that we need to be keeping in mind that this is a risk and something that needs to be monitored and considered because this is a population that's actually going to be at heightened risk for that consequence. That is the end of my slides. I'm actually going to hand it over to Dr. Weiss who will talk about mood disorders.

Dr. Roger D. Weiss: Thanks very much to Dr. McHugh for her. A wonderful talk as always. I'm going to shift a little bit and talk about the treatment of patients with co-occurring mood and substance use disorders.

The NESARC study showed the odds ratios of having a substance use disorder if you have bipolar disorder. An odds ratio is the increased risk that you, that a particular thing will happen if you know that something else is happening. It shows that if you have bipolar disorder, you are 5.7 times more likely to have alcohol dependence and 14 times more likely to have drug dependents. If you have major depressive disorder, you're about four times more likely to have alcohol dependence, nine times more likely to have drug dependence. Clearly mood disorders and substance use disorders co-occur frequently.

One of the questions that would come up is why is that? Why do people with mood disorders have so many more substance use disorders? I think there are a number of different potential reasons for this. One is enhanced reinforcement. For some people, in addition to the innately reinforcing properties of the various drugs that people use, some of these drugs in people with mood disorders may reduce unwanted symptoms, such as depression, anxiety, et cetera, let's call that mood improvement.

The second issue is something that mood change, which doesn't necessarily mean the same thing as mood improvement. For many people, particularly those with severe depression, what they'll say is that what they're really trying to do is just to escape from the way that they feel. To try to numb themselves out, to obliterate their mood and not feel anything. Why would they do that? Even if they know that it's, can't actually improve their mood, it's because they feel hopeless about improving their mood.

I think that these patients very often have what I call three layers of hopelessness, where the first layer of hopelessness is I feel hopeless that I can stop my alcohol or drug use. The second one, which I think is the most important one is I feel hopeless that even if I do stop drinking or using drugs, that my life will get any better because I've dug such a deep hole for myself, I'm never going to get out of it. That I think is the single biggest obstacle to recovery in this population. Finally, patients, particularly those with bipolar disorder can experience, poor judgment, risk-taking, and the inability to appreciate the negative consequences of their substance use.

How does depression influence the course of a substance use disorder? A current diagnosis of major depressive disorder is typically associated with poor outcomes for a variety of substance use disorders. On the other hand, depressive symptoms upon entering treatment do not have prognostic impact. As I'm going to talk about in a minute, depressive symptoms often lead to treatment seeking. They are the rule, not the exception among people entering treatment. It stresses the importance of a careful diagnostic assessment to distinguish between temporary depressive symptoms and a diagnosis of major depressive disorder.

What's the significance of having a substance use disorder. If you have bipolar disorder? Comorbidity causes a more severe course of bipolar disorder, specifically in an earlier onset, more frequent and severe mood episodes, more hospitalizations, more medication nonadherence, aggressive, impulsive behavior and legal problems, more homelessness, poor treatment outcome, and importantly higher rate of suicide.

For people with substance use disorders, how do you diagnose psychiatric disorders in general and mood disorders specifically? One of the questions that often comes up, one that I'm frequently asked is how long should you wait until a patient has been off all drugs and alcohol before you can diagnose any psychiatric disorder? While that's a common question it's a misleading question because there are a couple of assumptions behind this question that are not true. One is that coming off of all drugs or alcohol looks the same.

The other is that all psychiatric disorders look the same and finally that they all look the same. If you find it difficult to distinguish between someone coming off of alcohol and a particular disorder, then you wouldn't find the same level of confusion with someone just coming off of cocaine or methamphetamine, and that same disorder, because alcohol withdrawal and cocaine withdrawal don't look anything like each other.

By the same token, if you found some substance-related syndrome that was that you found confused with panic disorder, you wouldn't find that same disorder that you would be confused with bulemia, because bulemia and panic disorder don't look the same. A better question is how long should you wait until the patient has been off of drug X before you can diagnose disorder Y? In which case the answer could be anywhere between no time at all versus weeks or months, depending on the disorder and the drug or drugs that the person has been taking.

This leads to the question of how much does it matter if there's a primary versus a secondary depression. As it turns out while many of us, including myself, spent many years thinking this was a very important distinction, as long as you meet the criteria, say for major depressive disorder, it may not matter that much if you've been using alcohol or drugs in terms of the treatment approach.

What about treatment? Co-occurring disorder pharmacotherapy typically focuses on the treatment of the psychiatric disorder, though more recent studies have focused on substance use disorder as well. For example, most studies of people with co-occuring depression and alcohol use disorder have looked at antidepressants. More recently, some of them have looked at medications such as naltrexone.

Importantly, there have never been any comparative effectiveness studies. All the medications have always been tested against placebo. You can't say that this antidepressant is particularly well suited to this patient because the patient has a co-occurring alcohol use disorder. Rather the choice of medication is typically based on the usual considerations, such as side effect profile, family history of medication response, and the likelihood of medication adherence.

What are the key reasons for medication nonadherence in patients with co-occurring mood disorders and substance use disorders? Nonacceptance of illness, especially in bipolar disorder. A wish to not mix medications and drugs. Someone will say I was drinking heavily. I didn't want to mix that with my medication. I didn't take my medication, always a bad idea. My medication nonadherence doesn't always mean taking too little, not taking it at all. It sometimes means taking too much medication. Sometimes it's to get high for with medications, such as benzodiazepines, but sometimes it's because people are impatient waiting for the medication to work.

Those are not necessarily medications that have a high misuse potential. It may be antidepressants where someone will take, who is prescribed 50 milligrams of desipramine might take 200 milligrams because they were really depressed. These are the same folks who will sometimes take four to six Tylenol when they have a headache. For some people more is better. It's something that's always worth looking at.

Dr. McHugh talked about the different models of treatment and advocated integrated treatment. There are different models of integrated treatment. Integrated treatment means different things to different people. If you ask people in

50 different treatment programs, do you use an integrated model? Probably most of them would say yes, but they would give you very different answers. The different models of integrated treatment depend on the disorders and their relationship and the context.

Oftentimes, integrated treatment is talked about on a program basis. What Dr. McHugh was referring to and what I'm going to be talking about is on the integrated treatment on a patient basis. Behavioral therapy of substance use disorder and depression, there's been very little good research on this topic. There's preliminary evidence for CBT and for behavioral activation but not many large trials. AA attendance may be associated with reduced suicide risk in people with co-occurring disorders.

I'm going to talk for a little while about integrated group therapy, which is something that I developed with my team at McLean Hospital for co-occurring bipolar disorder and substance use disorders. The core principles of this treatment, it's a cognitive-behavioral model that focuses on parallels between the disorders and the recovery and relapse thoughts and behaviors. The thoughts and behaviors that will help you in recovery from one disorder will help you in recovery from the other disorder, and the same kinds of thoughts and behaviors that will get you into trouble with one disorder will get you into trouble with the other. Think of that as the parallels in the recovery process.

We also focus on the interaction between the disorders. Drinking is bad for your mood. Playing around with your medication is bad for your drinking. We use something called the single disorder paradigm. Rather than having patients think of themselves as having two discrete disorders, each of which has its own treatment, we tell them, "Think of yourself as having a single disorder that we call bipolar substance use disorder." The treatment for that is, stay away from drugs and alcohol, take your medications as prescribed, get a good night's sleep, monitor your drug urges, monitor your moods, et cetera.

Then we have something called the central recovery rule. The central recovery rule says no matter what, don't drink, don't use drugs, take your medications as prescribed, no matter what. The structure of integrated group therapy, we start with a check-in. The check-in asks about substance use, mood, and medication adherence. We review the previous week's group. We review the skill practice from the previous week, which might be something like, "Write down two things you might say if someone asked you if you wanted to drink."

We have a didactic and a handout on an integrated topic that's relevant to both disorders, such as dealing with depression without using alcohol and drugs, and then there's a discussion. We've conducted three studies that were funded by the National Institute on Drug Abuse. We initially compared integrated group therapy to either treatment as usual or a standard manualized group drug counseling. All three studies showed a significantly greater likelihood of abstinence in ITT patients.

In the last study, we had a outcome that we call good clinical outcome, meaning that in the last month of treatment, patients were abstinent from alcohol and drugs, and had no mood episodes in the past month. We found that 45% of ITT patients versus 20% of group drug counseling patients met the criteria for good clinical outcome. How does this play out in the group? Just one quick example of how we deal with the parallels in the recovery and relapse process, so we compare the abstinence violation effect, which is, what happens if somebody has been abstinent for a few months, and then takes a drink, and then says, "I may as well drink the whole bottle"?

I've wondered whether this occurred in people with bipolar disorder, and it does, in that people can say, "I've been taking my medication as prescribed, religiously, and I still got depressed. I may as well stop my medication." What these two thought processes have in common is they both begin with the word, "I may as well do this. I may as well do that." We talked about something called 'may as well thinking', which means you're about to make a bad decision.

It's because you think it doesn't matter what you do, how you can take two things that are so different, keep drinking, stop drinking, keep on your medication, stop your medication. It's because of that hopelessness that I talked about at the beginning, that even if I stopped using drugs and alcohol, it won't make a difference. May as well thinking is something we call relapse thinking. The opposite of that, recovery thinking is, it matters what you do. That's the sort of cognitive-behavioral intervention that we use in the program.

We make concrete suggestions for taking one step at a time toward recovery, basically saying that you're always on the road to either getting better or getting worse. It always matters what you do. ITT can be adapted to other settings. Other items can be added to the check-in such as, "Did you get any exercise? Were you honest? Did you attend meetings such as AA?" Sometimes we can add a preparation group for people who don't believe they have two problems. We've broadened the population at McLean Hospital now. This is for all mood disorders. We use it on all of our treatment programs.

You can also use ITT principles in individual therapy. It's actually what I did with individual therapy that I adapted to a group. The current status of ITT, it's been adapted for people with psychotic disorders. It's in use in both at McLean Hospital and in multiple clinical research and correctional settings in the United States, and several other countries, Canada, France, Switzerland, actually even Nepal. A book was published in 2011, the manual for using ITT. That's the end of my talk. Now we can take questions and answers.

Kathryn: Great. Roger, I can give you a break and take the first one here. Thanks so much, everybody, for the great questions that have been coming through. Please do keep sending them in. We have a bunch that we received ahead of time. A lot of these actually fell into similar categories. We're going to try to cover some of the big ones that we got. I can start us off. We got a lot of questions about cultural considerations in diagnosis and treatment from a lot of different perspectives. We got questions about race, ethnicity, biological sex, some groups like veterans, so to try to give a couple of big picture thoughts on that.

One effort that's been going on in the last several years, and this is not necessarily targeted to co-occurring disorders, although I think this is certainly relevant to co-occurring disorders, is the development of treatments that are targeted to a specific subgroup. A couple of examples of that, so Shelly Greenfield, who's a colleague of ours at McLean has built up the women's recovery group, which is targeted to women with substance use disorders.

Ayana Jordan just gave a wonderful talk for Recovery Month earlier this week. She's down at Yale. She's done some really great work with implementing CBT for substance use disorders in Black churches in the New Haven area. Basically, these types of treatments have two basic principles in terms of cultural adaptations. One is that the composition of people with whom you're seeking treatment is similar to you in some way, so for example, women receiving treatment with other women, which is one component of that.

One thing that I certainly see this in women, particularly women with a trauma history and a sexual trauma history in particular, oftentimes will prefer to be in an all women's treatment setting. Composition is one component and then also the content. These treatments also tend to have content that is targeted to the population. That might be addressing issues that disproportionately affect a certain population or that might be really relevant to a population. This could even mean how are things framed, what types of metaphors are used, what types of parallels are used.

We got a bunch of questions about veterans. Certainly, in the veteran population, in the emergency responder population, which we do a little bit of work on, using even terminology around things like resilience, or referring to things as a class, as opposed to a treatment, even those little tweaks can actually make a pretty big difference. There's some pretty good data for those types of treatments. I think this is a growing area where we'll see a lot of work. The other piece to this, and this will dovetail with one of the questions that Dr. Weiss is going to answer, is as we're talking about working with any individual educating ourselves on their different roles, the different cultures to which they belong is essentially important in part because there are a few groups, whether they be small or large, that don't have strong opinions about substances. As we even think about working with someone around trying to reduce substance use or trying to recover and seek social support, knowing what is the perspective of the family environment or their broader culture on substances?

We actually had a couple of questions come through about cannabis, where we can see just tremendous variability in how cannabis is considered, how is alcohol

considered, is it demonized? Is it considered to be something that is in and of itself culturally relevant? Again, this is a topic we could take a whole webinar on, but those are two ways of thinking about that. Both culture will very directly impact how we treat these disorders, behaviourally how we will treat these disorders and some of those targeted treatments might be things to think about for certain subgroups. I know Roger, you had some thoughts about that issue also with respect to abstinence versus harm avoidance, so on, and I hand it over for you to you for that next one.

Roger: Questions came up about abstinence versus harm reduction. If folks could tell in the integrated group therapy model, it is an abstinence-based model because I think one of the things that's with people with severe mental illness and with bipolar disorder, generally people experience destabilization in their life with much lower amounts of substance use than we see in people who enter treatment for their substance use disorder who don't have a major mental illness.

When we look at patients who show up in our treatment program or studies or people that show up in my studies for alcohol use disorder, cocaine use disorder, opioid use disorder, whatever, where we're not specifically treating co-occurring mental illness. These are folks who will be drinking every day using cocaine 20 days a month using opioids every day and using and if they were drinking averaging 13, 14 drinks a day.

When you look at the people who entered the bipolar substance use disorders study, these are folks who were using drugs and alcohol maybe eight days a month, 10 days a month, but it's still causing them terrible problems. The amounts that they're using may not be high. It's not clear that there is a safe amount of alcohol and drug use in that population. Now that said, so the central recovery rule, which is a cornerstone of the treatment, patients who entered the group at first, don't really like it. They say it's too simple, you don't understand, I'm self-medicating. A lot of the focus of the treatment is on that.

As this treatment has been used in other settings, it's been very interesting to see how it gets adapted. I had the opportunity to observe an IGT group that was running in Washington DC in a mental health center that dealt with mostly homeless, psychotic patients who were a lot of them were using cocaine. They loved the clarity of the central recovery rule and at the end of each group, they held hands and spoke it aloud. That's one end.

On the other hand, I've talked with colleagues in France and Switzerland who have used it, where in Switzerland people left after the first group, because they found the prescriptiveness of the central recovery rule offensive. Something similar happened in France and so they changed it and made it suggestions. The context in which all of this is delivered is very important. You have to know who your audience is, what is your patient population, what are what's their belief system and adapt it accordingly.

There was a question that came up. I just want to quickly address, someone said I said there were three layers of hopelessness, but I only mentioned two. The third layer of hopelessness is the cognitive hopelessness that people with depression have. Sorry, I forgot that one at the time. Kate, do you wan to [crosstalk]

Kathryn: Yes. Another question that we got from a bunch of different folks was related to suicide risk. A couple of things to think about on this domain. When you're talking about co-occurring substance use and psychiatric disorders, you're actually talking about basically double risk factors. Not necessarily double in terms of magnitude, but substance use disorders are an independent risk for suicide as are psychiatric disorders.

When we look at the substance use disorders, generally, the greatest risk is actually folks with opioid use disorder. If you actually look across substances, there is increased risk for suicide very clearly for any substance. The only exception is actually the cannabis association is peculiar. It varies across the literature. It points in all directions that, that at the moment is, in my opinion, a very unanswered question. Generally, you actually see for any of the central nervous system depressants so things like opioids, alcohol, sedatives, a very heightened risk for suicide.

One thing clinically and our colleague Dr. Hilary Connery at McLean and Dr. Weiss, and I have done a little bit of work in this area, is there appears to be overlap between what we consider the accidental overdose epidemic and suicide epidemic, where we tend to dichotomize overdoses as they were either intentional and suicidal, or they were completely accidental and not at all intentional. It is rare to have any kind of process in psychology that is truly binary like that. This appears to be one of those that is certainly not binary.

We've been collecting some data on this to show that even in overdoses that would be categorized as accidental people who have a nonfatal overdose, there was some level of suicidal thinking in the mix for many of these. What appears to be the case is that there's really a spectrum of desire to die and intention to die that if we're using some standard suicide assessments, we might not actually pick up. Things Dr. Weiss was talking about, hopelessness or even examples of risk-taking, or this idea of almost I might live, I might die. It's not necessarily gonna flag if we're asking someone if they're trying to harm or kill themselves, but as resulting in risky behaviors that can be fatal.

As we're thinking about this comorbidity, making sure that when we are assessing for suicide, it's not just "Frank, do you intend to die? Do you have a plan to kill yourself", but also looking at risky or reckless behaviors, more ambitious thinking around, I may live, I may die, I know this is risky. Expanding that assessment to capture some of that gray area is exceptionally important and something that we're we're discovering is more and more important as we see both overdoses and suicides escalating in the US. Roger, I don't know if you have anything to add on that, on the bipolar comorbidity end.

Roger: One thing that's actually fairly interesting on the bipolar comorbidity is the increased rate of suicide among people who smoke cigarettes. Cigarette smoking and bipolar disorder appears to be a particularly problematic comorbidity. In our group therapy study, or the first one we did, we found that by a huge margin, the best predictor of dropout was, did people smoke cigarettes? When we were choosing factors that we wanted or variables that we wanted to look at as predictors, we weren't even thinking of that.

One of the members of our research team said, "What about smoking?" We shrugged our shoulders and said, "Well, okay. We don't think that'll be it." It was far and away, the best predictor. The suicide risk among people who smoke, who have bipolar disorder is substantially increased. It's not clear why that's such a powerful comorbidity, but it is.

Kathryn: Do you want to take the COVID question as well?

Roger: Yes. The impact of COVID on all of this, we know a couple of things, one, opioid overdoses have gone up during COVID, drinking has gone up. Locally we know, particularly among older people in our geriatric population, the alcohol problems have increased. I was just on our inpatient unit today and heard about a woman that was admitted, who did not have an alcohol use disorder until COVID and her drinking just escalated pretty quickly. We also know there've been an increase in depression during COVID. Mental health problems, substance use problems have increased, the other--

Then on the treatment end, you've got the transformation of the treatment system, both professional and mutual help to remote. The mutual help, AA, NA et cetera, what they always say is don't isolate, don't isolate, that that's the kiss of death and of course, people have been isolated. That's problematic. Then the transformation to Telehealth actually has gone fairly well in terms of professional treatment. There's, there's been pretty good satisfaction individually less so with groups. I think it's harder running groups than doing individual work on Zoom. Access is obviously easier but I think that the group models do miss something. Do you have any other thoughts, Kate, or is that about it on that one?

Kathryn: Yes. The one thing, and I'm sure everybody's, who's been doing clinical work over this stretch knows this story well, it's, if you had asked me before this happened, what is the worst possible thing I could do for my mental health and substance use? I would say, do what we're doing now, isolate. Don't be around other people and stay in your home and reduce activity. I think it's required a lot of creativity.

I agree that the expansion of Telehealth has been really tremendously important, but you have to- trying to engage people in treatment and behavioral activation and exposure-based treatment when many of the things that are available to people are not available. Then certainly that's getting a little bit better as things open up, but it's been a real, tremendous challenge in many directions for folks. The need to be more creative in how we're supporting people around behavioral interventions, I think has been a real challenge.

This gets us to a question I have been a little bit tempted to avoid, but I think maybe we should address anyways, which is we got a lot of questions about how do you find a referral and how do you find a treatment provider? Part of the reason why I was avoiding this question is because it's exceptionally hard. Even as someone who works in this area it is always hard to find good referrals. It's always hard to vet what's a good provider, what's a good treatment facility. I did want to throw out a couple of things I realized actually. One of these as an APA resource.

There are a number of treatment locator resources out there which can be a starting point. The problem is many of these are actually national, which means that they aren't updated particularly quickly. Even the professional organization materials sometimes tend to not be updated frequently enough. That can be a starting point. SAMHSA has some resources. If you have a state or local resource, those tend to be stronger and that varies depending on the location but looking for local resources tends to be more accurate, more up to date.

One thing that I did want to highlight, this is a resource it's actually expanding a little bit, the addiction policy forum has a new resource center that's been compiling resources which will give information about whether or not medications are available at certain settings, whether they're accredited. Those are two good things to look for in a treatment facility. Is, do they provide medications for substance use disorders? Are they accredited? I think those are a couple of things to look at.

A couple of things just to be cautious about because there can be some problematic facilities out there is if it looks too good to be true on paper, it probably is. If someone is promising tremendously high treatment response rate, you should probably be skeptical for a reason. Those are just a couple of ideas about that. Roger, I don't know if you have any ideas to add to that. A lot of people had asked a question like this.

Roger: Yes. It is a very hard one. Particularly when you're looking-- There's asking around but then that has its limits particularly when you have to look at a distance. For psychiatry, there are state psychiatric associations. For example, in Massachusetts, you can call the Massachusetts Psychiatric Society and you'd say, "Well, I want somebody that knows about addiction."

The problem is when you fill out something, at least in Massachusetts, when I fill out interests, I'll put in addiction, but I could put in anything, including things I don't know very much about, and they're not vetting me and saying, "Well, do you really know anything about PTSD or about autism or whatever it is that I say that I know about, which I may or may not." It's not ideal. I think Kate's thought process with that is something I would agree with as well as the fact that it is very difficult once the people that you know, and the people that they know, once you run past that, it's not easy.

Kathryn: Thanks, everybody. We're out of time so we're gonna hand it back to APA to wrap up.

Moderator: Thank you both so much for joining us, Dr. Weiss and Dr. Mchugh. and thank you to all of our listeners today for your participation and thank you to the McLean Hospital for making this webinar possible. A recording of the presentation will be emailed to everyone in about two weeks time, and that recording will include the slides in case you've had any trouble downloading them today from the handouts section.

As soon as this webinar has ended, a short survey will appear on your screen. If you could please take that survey and give us your feedback again, we thank you for your attention and hope you have a great rest of your day.

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