Modern Management of Bipolar Disorder

Issue #3

Managing bipolar disorder with comorbid substance abuse

Professor David Castle

When illicit drugs are implicit in treatment: taking a harm reduction approach

A large proportion of patients with bipolar disorder will engage in substance abuse, drastically complicating the treatment picture due to drug–drug interactions and masking of symptoms. In this issue of MMBD, Professor David Castle, Chair of Psychiatry at the University of Melbourne, and a clinician based at St Vincent's Hospital, Melbourne, discusses the importance of being aware of the issues surrounding bipolar disorder and substance abuse and what psychiatrists can do to increase the chances of successful long-term management of bipolar disorder. He emphasises the need for taking a harm reduction approach, rather than attempting to enforce complete abstinence in all patients, as this has a better chance of success in patients who may not yet be ready to change. This approach will also assist in the maintenance of a helpful clinician–patient relationship to enhance engagement and thus influence.

Substance abuse is a highly prevalent comorbidity among people with bipolar disorder (Figure 1), and is associated with more severe symptoms, worse outcomes, more suicide attempts, longer episodes and a lower quality of life in general.[1–5] Despite these inherent risks, the impact of substance abuse on treatment outcomes is often overlooked in patients with bipolar disorder, and the two conditions are often treated and managed separately, despite increasing evidence that addressing both at once may be more effective.[3,5] Clinicians need to ensure that they have techniques in place for adequately dealing with these issues as they arise to ensure that patients are receiving the best care possible for their condition.

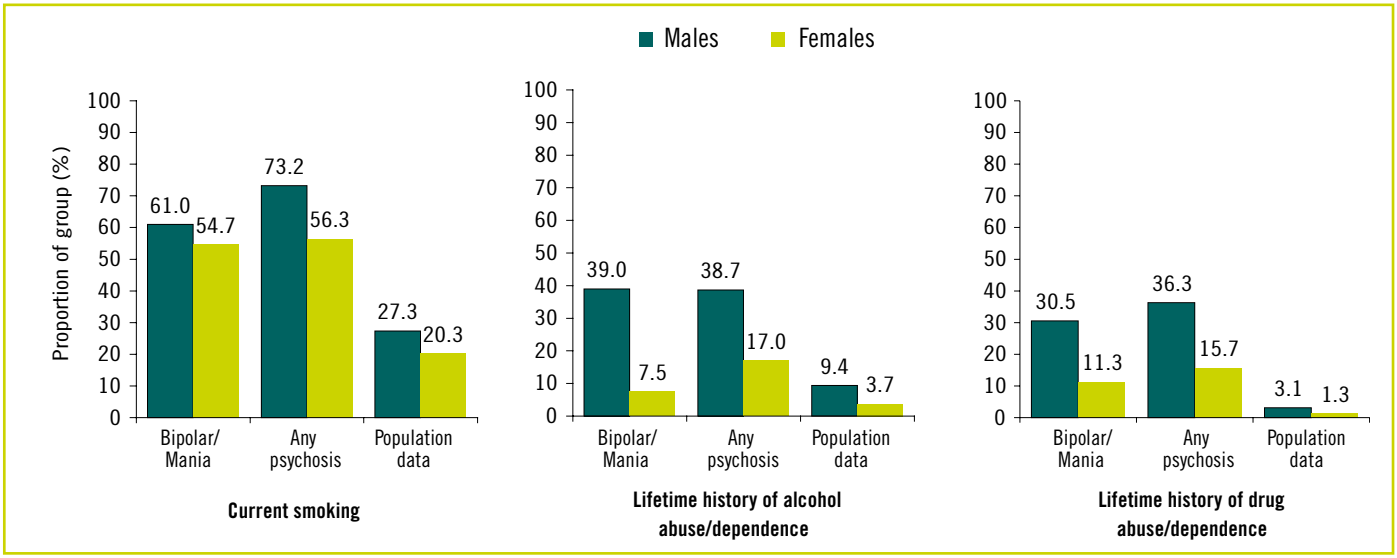

Figure 1. People, particularly males, with bipolar disorder and general psychoses experience much higher levels of smoking, alcohol and drug abuse or dependence than seen among the general population. Figures adapted from Morgan *et al.* (2005).[6]

Clinical data from around the world continually highlight the link between cannabis use and depression

The available data clearly establish a link between cannabis use and the subsequent development of mental health problems,[7,8] especially when use starts at an early age.[9,10] Clinicians should be particularly aware when treating patients with bipolar disorder and comorbid substance abuse of:

- possible interactions between illicit substances and prescription medications, particularly when they are metabolised via similar pathways[3,4]
- the need for targeted planning, particularly when patients are not yet ready to change[11]
- the need to be aware of useful techniques for addressing substance abuse in advance, so that patients can receive the best possible care from the outset.

Abstinence not for all: intervention should be tailored to stage of change

There are multiple stages on the path to changing any behaviour, including substance abuse (Table 1). Patients in different stages of change will need different therapeutic approaches and, while some patients may be ready to forego their use of illicit substances completely, others will be unready or unwilling to make such a drastic change. Harm minimisation is highly useful as an initial approach, and intervening according to the patient's stage of change can relieve much of the frustration experienced by both clinicians and patients.[11] Seeking complete abstinence in all patients could alienate some who could benefit from a more supportive, sustained clinical relationship.

Stage[11]	Description[11]	Possible intervention
Pre-contemplation	Patient is uninterested or unwilling to make a change	Educate the patient about substance misuse and allow them to examine problems associated with their current behaviour
Contemplation	Patient is considering change	Discuss the pros and cons of change
Preparation	Patient has decided to make a specific change and is preparing for this	Help the patient to determine the most appropriate strategies for change
Action	Patient exhibits genuine, determined action toward change	Assist the patient in instigating the strategies that have been decided upon
Maintenance	Patient is attempting to maintain new behaviour	Provide encouragement for the patient; develop and utilise relapse-prevention strategies
Relapse	Patient lapses into old behaviour	Support the patient and assist in renewing action toward change

Table 1. Patients with substance abuse will be in different stages of change, and the appropriate intervention should be chosen accordingly.

Techniques helping clinicians engage with patients can be effectively used in moderating substance abuse

Engaging with the patient is essential.[11] There are various techniques and tools that can be used to evaluate patients with substance abuse disorders and help clinicians engage with patients throughout the process of change. While psychotherapy alongside pharmacotherapy is likely to improve the chances of successful management,[5] different techniques will suit different patients and different stages of change.

The CAGE questionnaire

Two or more affirmative answers to the following questions indicate that alcohol or substance abuse is probably a problem for the patient, while any one affirmative answer warrants further investigation.[12]

- Have you ever felt you ought to **C**ut down on your drinking or use of [drug]?
- Have people **A**nnoyed you by criticising your drinking or use of [drug]?
- Have you ever felt **G**uilty about your drinking or use of [drug]?
- Have you ever had a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover? Or have you found that you have to take [drug] some days after waking up to feel okay?

Using motivational interviewing techniques

These techniques involve asking key questions with empathy and reflective listening. This can help clinicians be both directive and patient-centred, while maintaining a healthy therapeutic relationship.[11]

Goal planning using 'SMART' goals

'SMART' goals can help patients and clinicians focus on the actual change that needs to take place, making the process of change much more manageable. 'SMART' goals are Specific, Measurable, Attainable, Realistic, and have a Timeline.

Discussing barriers and concerns, listing the pro's and con's

This can help build a stronger and more useful therapeutic relationship, a critical factor in successful engagement, while also providing an opportunity to address the patient's concerns or develop strategies to overcome the problems or barriers that they envisage. A physical reminder of the potential benefits of change may also help motivate patients to work harder toward this goal.

Developing an action plan for change

Discussing useful strategies for change and writing these down with the patient can assist in working toward active, determined change. Specific strategies can break down a difficult task into smaller, more manageable steps.

Promoting self-efficacy and responsibility

Ultimately, the patient will be responsible for their own change. Clinicians need to help patients understand this and to encourage a certain level of autonomy in the treatment process.

References

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Risperdal® (risperidone) Minimum Product Information (for schizophrenia, bipolar and dementia). Description: RISPERDAL® tablets, oral solution; RISPERDAL® Quicklet® orally disintegrating tablets. **Indications:** Schizophrenia and related psychoses; acute mania in bipolar 1 disorder (short term); behavioural disturbances in dementia; conduct disorder (selected cases, see full PI) *(See Clinical Trials for maintenance data); behavioural disorders in autism (children, adolescents). **Dosage:** Schizophrenia – initially 1mg twice daily; 2mg twice daily on day 2; titrate as necessary (usual range 4–6mg daily given once daily or in 2 divided doses). Bipolar mania – initially 2mg once daily; increase by 1mg daily as necessary (usual range 2–6mg daily). Behavioural disturbances in dementia – initially 0.25mg twice daily; increase as necessary (usual range 0.5–1mg twice daily); once target dose reached, may be given as once daily dose. Conduct disorder, autism, elderly, renal, hepatic impairment - see full PI. **Interactions:** Centrally acting drugs; levodopa, dopamine agonists; antihypertensives; tricyclic antidepressants; frusemide (elderly), carbamazepine *(*A formal drug-drug interaction study to investigate the effect of risperidone on carbamazepine was not performed; however the effect of carbamazepine as adjunctive treatment to risperidone was investigated in a pharmacokinetic study. In this study, patients were stabilized on a risperidone dose of 3mg twice daily, and carbamazepine was administered from 3 weeks (Days 22 to 42) at a dose that was adjusted for the therapeutic concentration (5 to 12µg/mL, average dose 573 ± 168mg/day). Carbamazepine serum concentrations were determined at the beginning and at the end of the period of coadministration of the 2 compounds. The results showed that coadministration of risperidone with carbamazepine did not affect the serum concentrations of carbamazepine during the observation period of 3 weeks. The values were all within the therapeutic range of 5 to 12µg/mL).*; topiramate; hepatic enzyme-inducers; quinidine; phenothiazines; paroxetine, fluoxetine. **Contraindications:** Patients with known hypersensitivity to risperidone or excipients. **Precautions:** Overall mortality, cerebrovascular adverse events (in elderly patients with dementia); Orthostatic hypotension; cardiovascular disease; dehydration; hypokalaemia; epilepsy or a history of seizures; Lewy body dementia, Parkinson's disease; hyperglycaemia, existing diabetes mellitus; previous history of breast cancer or pituitary tumours; hepatic, renal impairment; elderly; pregnancy; lactation; children <15 years. Review of treatment is required in case of tardive dyskinesia, neuroleptic malignant syndrome. **Adverse Reactions:** Insomnia, agitation, extrapyramidal disorder, anxiety, headache, sedation (esp. children); weight gain; orthostatic hypotension; tachycardia; tardive dyskinesia, neuroleptic malignant syndrome; increased prolactin levels, cerebrovascular adverse events in dementia patients; very rarely: hyperglycaemia, benign pituitary adenomas, angioedema. *Very rare cases of QT prolongation have been reported in postmarketing experience. Others see full PI. **Presentation:** Tablets: 0.5mg, 1mg, 2mg, 3mg, 4mg. Oral solution (1mg/mL): 30mL, 100mL. Orally disintegrating tablets: 0.5mg, 1mg, 2mg, 3mg, 4mg Prepared November 2006. *Please note changes (italicised text). Please review full Approved RISPERDAL® Product Information before prescribing. Available from the company upon request. 1. Sachs G, et al. Am J Psychiatry 2002;159:1146-1154. 2. Yatham LN, et al. Br J Psych 2003;182: 141-147. 3. Vieta E, et al. J. Clin. Psychiatry 2001;62:818-825. 4. RISPERDAL® Approved Product Information. Janssen-Cilag Pty Ltd, ABN 47 000 129 975, 1-5 Khartoum Rd, North Ryde NSW 2113. RISPERDAL® is a registered trademark of Janssen-Cilag Pty Ltd for risperidone preparations. 03/07 JANSSEN-CILAG

GET MANIA UNDER CONTROL[1-3]

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LIMIT THE IMPACT OF BIPOLAR DISORDER[1-4]

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