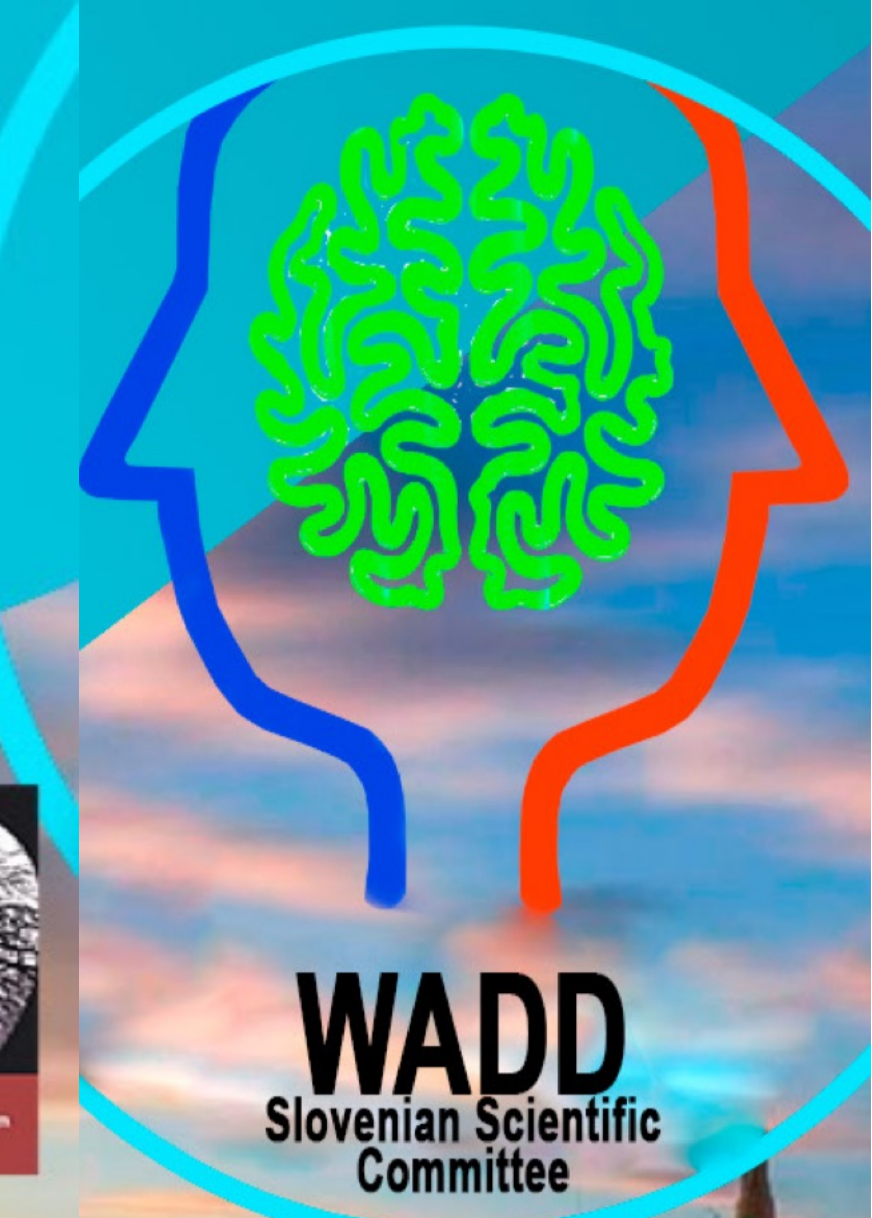


2023

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Association between Suicidal Behavior and Non-Suicidal Self- Injury in BPD Tobacco Smokers: A Retrospective Study

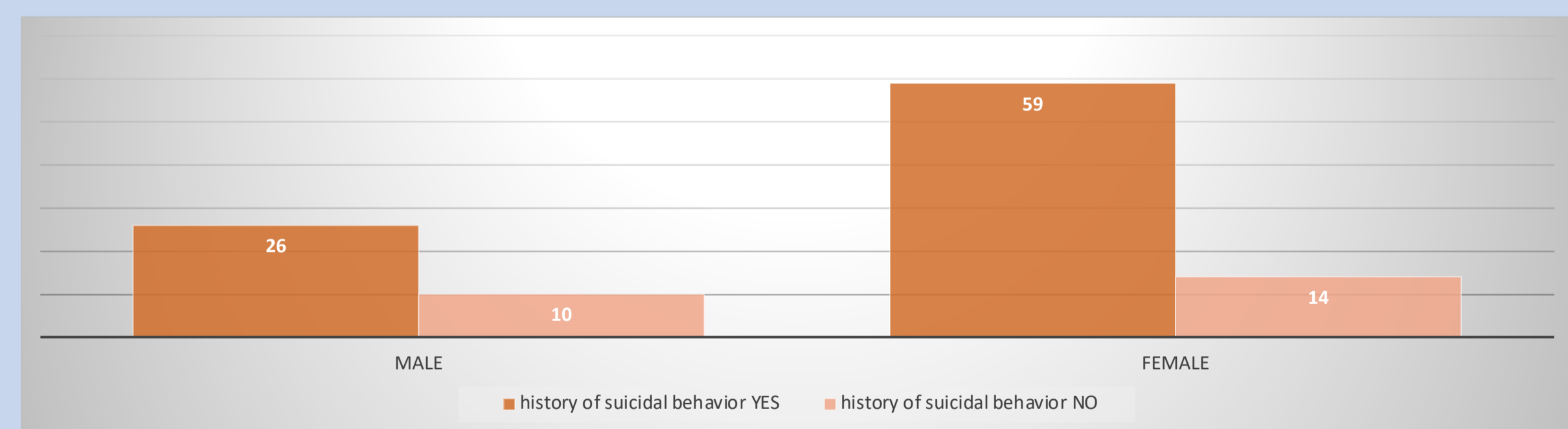
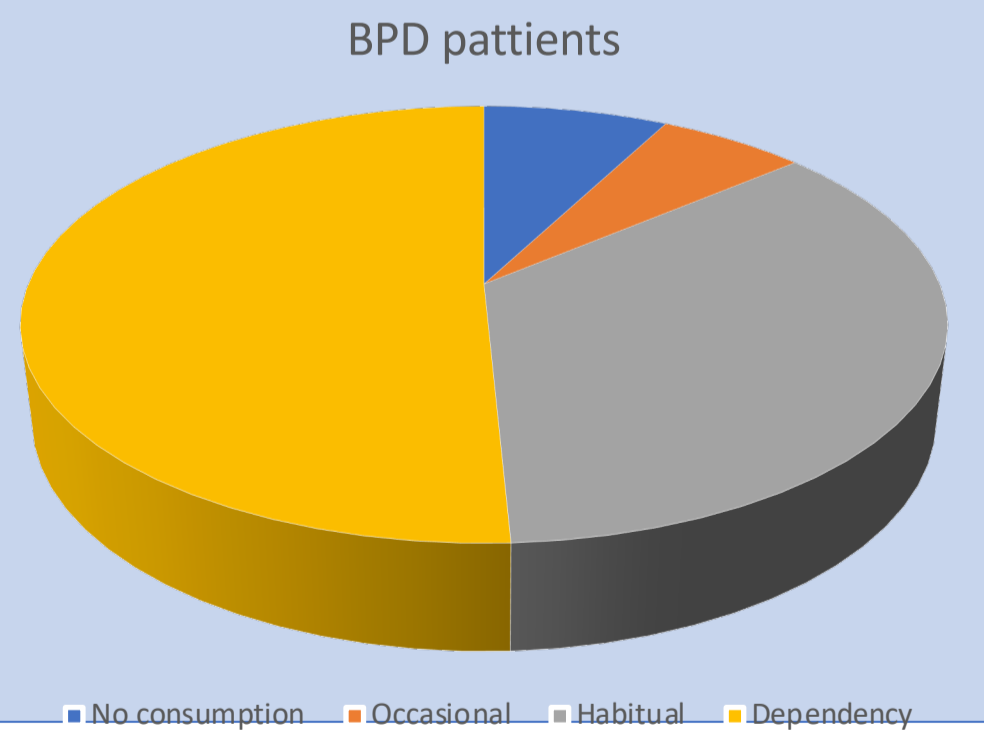
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Introduction. Suicidal behavior (SB) spectrum is nuclear in the clinic and management of Borderline Personality Disorder (BPD). This association is closer in substance-using BPD, being its dichotomization very complex. Few works talk about the reason for the co- occurrence between both entities in the psychiatric population in general and in BPD in particular. The aim of the report is to analyze the link between SB and NSSI in in tobacco-using BPD.

Methodology. A cross-sectional, observational and retrospective study of a sample of 130 patients between 18 and 56 years old, with a diagnosis of BPD according to DSM-5 criteria, tobacco users, was carried out. The association between variables was analyzed through a multivariate and negative binomial logistic regression model.

Results Of the sample, 50.77% showed a pattern of dependence, 35.39% habitual use, 6.15% occasional use and 7.69% did not use tobacco. A total of 77.6% reported a history of at least one SI, while 22.4% reported none. The mean number of SI is 2.69. For ASFS, 64.2 % had them, while 35.8 % did not. A statistically significant association was found between the two. ASFS is also significantly related to a higher number of SI according to multivariate analysis.



Discussion The present study finds a strong statistical association in multivariate analysis between ASFSFS and CS in patients diagnosed with BPD, stronger findings when we discriminated by tobacco use. Suicide risk is associated with ASFS, in particular with repeated self-harm. A statistically significant association is found in the multi-variate analysis performed by negative binomial regression between ASFS and the number of SI, especially in BPD smokers with a dependence pattern.

There are few longitudinal studies that allow us to establish the direction of the nexus between ASFS and CS. But, in any case, the statistical relationship between a history of ASFS and the risk of future CS can be affirmed. 19 ASFS behaviors are found to be a greater predictor of SI than vice versa, i.e., SI with respect to NSSI, as pointed out by recent work. The two are found to be closely related and may form a continuum in the expression of a basic distress common to them. Therefore, the identification of ASFS could be of interest for the prevention of more disruptive and severe behaviors such as SI, based on these results.

Conclusions. The results suggest that these behaviors are nuclear and frequent in BPD, especially in those with a pattern of tobacco dependence. Both appear significantly related to each other.

Alberdi-Páramo I, Díaz-Marsá M, Sáiz González MD, Carrasco Perera JL. Association between non-suicidal self-injury and suicidal behavior in Borderline Personality Disorder: a retrospective study. Actas Esp Psiquiatr. 2021 Sep;49(5):199-204. Epub 2021 Sep 1. PMID: 34533202; PMCID: PMC9330283. Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. Borderline personality disorder. Lancet. 2011;377:74-84.

CONFLICT OF INTERESTS: None.

Abstract and Introduction

Mental health disorders and substance abuse disorders share many epidemiological factors. Therefore, comorbidity among these groups of pathologies is quite common. Cooperation between different specialists (if the fields of interest are targeted individually) is thus key to proper assessment and treatment and to improve prognostic endpoints.

We're carrying out a longitudinal study in the context of a joint clinical management unit, which was born in 2020 from the cooperation between the Psychiatry and Toxicologic Unity in the Careggi Hospital, Florence. The following data, presented hereby, constitute the preliminary information from this study.

Objectives

The main aim of the present work is to provide an evaluation of performance and pitfalls of a joint approach in treating substance abuse disorder's patients in a public healthcare setting. The rationale of this method of intervention relies on the evidence that such an approach harbors significant improvement in the outcome of these disorders (1).

Methodology

All patients accessing our joint assessment unit were considered eligible; therefore, inclusion criteria almost entirely overlap with the indications to access the service. The patients are sent to the unit by either Psychiatrists, Toxicologists or General Practitioners when the clinical presentation suggests the co-existence of psychiatric and substance abuse disorders.

The patients are evaluated by a multi-disciplinary equipe and administered questionnaires to aid a standardized evaluation of their clinical status:

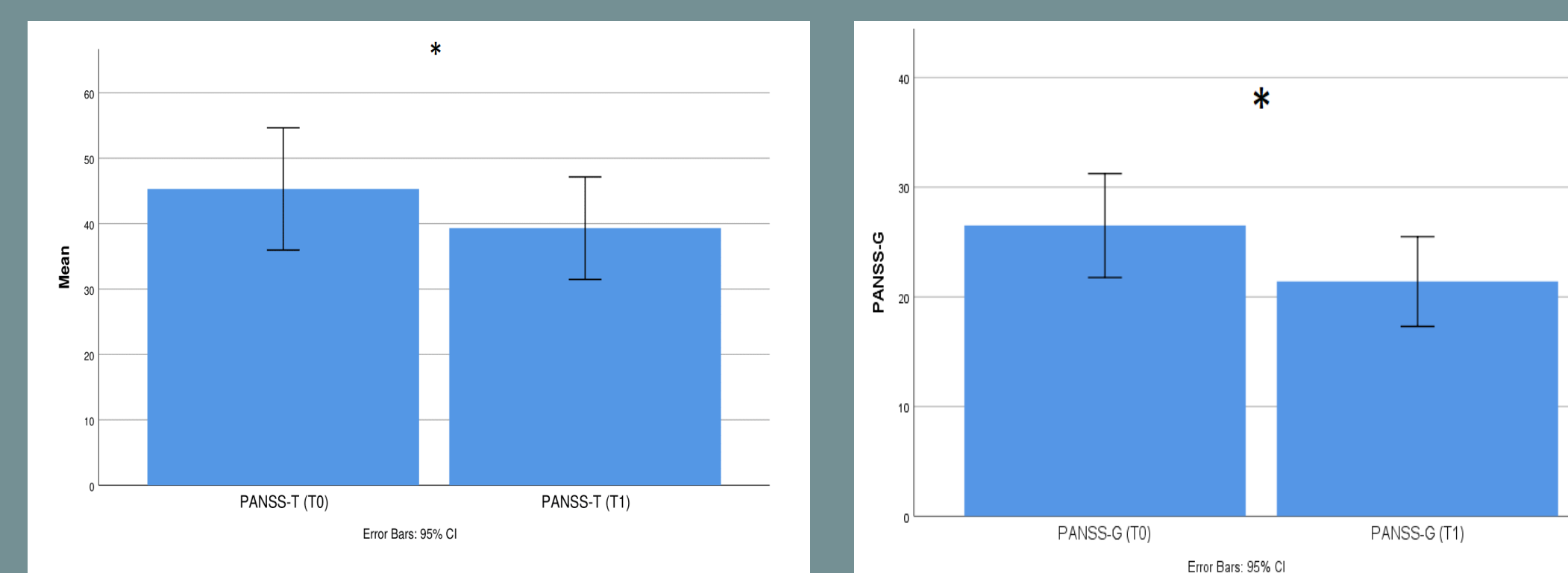
- Montgomery-Asberg Depression Rating Scale (MADRS);
- Hamilton Anxiety Scale (HAM-A);
- Positive and Negative Syndrome Scale (PANSS);
- Aberrant Saliency Inventory (ASI), Italian version (2);
- Craving Type Questionnaire (CTQ);
- WHO Quality of Life Questionnaire (WHO-QOL);
- Aggressivity Questionnaire.

Supplementary questionnaires are administered in case of adherence to the rTMS (repetitive magnetic transcranial stimulation) protocol, a parallel project intended to employ rTMS to treat cocaine use disorder (3). Before being administered rTMS, a psychiatric evaluation has to be carried out to exclude dual diagnosis (which, in some cases, might be the reason underlying the substance use disorder).

All these considerations are contained in a protocol which was submitted to the hospital's ethical committee; however, the psychometric data collection was initiated only in a second time, and only recently all of this material has been made available to utilize also for research purposes. Further indicators of the efficiency of the joint assessment unit are constituted by performance and suitability indicators, which are supported by a cost-benefit analysis.

Results

From our preliminary observations, what emerged is an improvement in the PANSS score (in particular, general symptoms); the improvement reached statistical significance even if the sample was small (n = 12).



However, given the limited amount of data, it was impossible to draw conclusions on some other domains which, in our opinion, harbored great significance in terms of clinical improvement and sustainability of the project, namely the questionnaires exploring working alliance, and the ones more closely related to substance abuse disorder and its outcome.

The dual diagnosis unit's accesses flow increased over time; since we first started collecting these data (i.e., June 2022) until the end of the same year, 36 patients have accessed this service and 154 visits have been carried out. Despite this being an outpatient service, 6 of these patients were hospitalized for a brief period (usually for rapid detoxification purposes) over this time span.

More than 80% of the patients affected by concurrent disorders were evaluated in this setting, the rest being followed separately by specialized units.

The rate of urine and hair tests attendance was higher at the first endpoint (at T1, at 2 months) if compared to baseline (72.2% vs 77.7%), presumably suggesting an higher degree of commitment.

Conclusion

The data presented in this study are limited, but considering the preliminary results (especially in terms of general symptoms) and the trajectory of the patients followed by the unit born out of our common effort, we can conclude that this approach seems to be promising in terms of primary outcomes, treatment adherence and sustainability. With time and expertise, it will be possible to translate the empirical findings into valuable scientific evidence, to serve as an encouragement to replicate our approach.

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A Feasibility Study of Patients with Major Depression and Substance Use Disorders: Vortioxetine as Maintenance Treatment.

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Background

Limited studies have evaluated the effectiveness of vortioxetine in real-world settings, and none of them has involved patients with dual depression (major depressive disorder [MDD] and substance use disorder [SUD]). The objective of the study was to describe the effectiveness of vortioxetine in clinical practice and determine its effect on affective symptoms, cognitive function, quality of life, and substance use in patients with MDD and SUD.

Therefore, the objective of the present study was to describe the effectiveness of vortioxetine in routine clinical practice and determine its effect on affective symptoms, cognitive function, quality of life, and substance use in patients with MDD and SUDs.

Methods

Post-authorization, retrospective, multicenter, descriptive, and observational study in 80 patients with MDD and SUD receiving a maintenance treatment with vortioxetine for six months between January 2017 and April 2021.

Results

Compared with baseline, scores significantly decreased after 3 and 6 months of treatment in the Montgomery-Åsberg Depression Rating Scale total (from 28.9 to 17.7 and 12.0), and global functional impairment of the Sheehan Disability Inventory (from 26.3 to 19.1 and 16.7). The number of correct answers in the symbol digit modalities test significantly improved during vortioxetine treatment (from 40.4 to 43.8 and 48.4). Regarding the clinical global impression scale, the score for disease severity significantly decreased from 3.8 to 3.0 and 2.4. Compared with baseline, there was a significant reduction in consumption of practically all substances, especially of alcohol, cannabis, and cocaine.

Discussion

We found that vortioxetine is effective in clinical practice for alleviating depressive symptoms and functional impairment, while improving cognitive and executive functions and disease severity for the management of MDD and SUD. The treatment approach for MDD is changing to cope the heterogeneity of clinical phenotypes and endophenotypes of depression, especially when SUDs is also present. An adequate treatment for patients with both disorders aims at improving the depression-related symptoms (including affective, somatic, and cognitive dimensions), reducing the behaviors associated with seeking behaviors and consumption of substances. Additionally, these therapies are also directed to enhance the quality of life and life-satisfaction of patients and achieve a higher well-being for the family and society. Vortioxetine, a novel antidepressant drug with a multimodal mechanism of action, has demonstrated its efficacy in the treatment of MDD. However, limited number of studies have explored the effectiveness of vortioxetine in real-world settings. The main limitation of the study was its retrospective nature, providing only the available information on medical charts. Additionally, it was a naturalistic study, so no comparisons were made towards a control group. On the other hand, main strengths of the study included that it was performed in real-world settings and evaluated depression and SUD simultaneously. Real-world studies on vortioxetine are limited, thus the present study provides additional and positive evidence about its use, especially for MDD and SUD.

Table 1

Sociodemographic and Clinical Characteristics of Patients

Abbreviations: SD, standard deviation; BMI, body mass index.

	Patients (N=80)
Gender, n (%)	
Female	29 (36.3)
Male	51 (63.8)
Age, mean years (SD)	45.1 (13.8)
Marital status, n (%)	
Never been married	29 (36.3)
Educational level, n (%)	
Primary education	32 (40.0)
Employment status, n (%)	
Unemployed (by other reasons)	27 (33.8)
Comorbidities, n (%)	
Arterial hypertension	13 (16.3)
Obesity (BMI >30 Kg/m ²)	8 (10.0)
Human immunodeficiency virus	7 (8.8)
Diagnosis of major depressive disorder, n (%)	
One episode	15 (18.7)
Mild	2 (13.3)
Moderate	6 (40.0)
Severe	4 (26.7)
With psychotic features	3 (20.0)
Recurrent episodes	65 (81.3)
Mild	10 (15.4)
Moderate	38 (58.5)
Severe	15 (23.1)
With psychotic features	1 (1.5)
Partial remission	1 (1.5)
Substance use history, n (%)	
Tobacco	32 (40.0)
Alcohol	53 (66.3)
Cannabis	21 (26.3)

Table 2

Features of Treatments During Vortioxetine Treatment

Abbreviation: SD, standard deviation.

	Baseline (N=80)	3-Month (N=80)	6-Month (N=80)
Vortioxetine treatment			
Mean dose mg/day (SD)	13.8 (5.5)	14.4 (5.2)	15.1 (5.2)
Doses, n (%)			
5 mg/day	10 (4.2)	6 (2.5)	4 (1.7)
10 mg/day	31 (13.0)	31 (13.0)	29 (12.2)
15 mg/day	7 (2.9)	10 (4.2)	6 (2.5)
20 mg/day	32 (13.5)	33 (13.9)	39 (16.4)
Psychopharmacological-associated treatment, n (%)	73 (91.3)	72 (90.0)	71 (88.8)
Antidepressant drugs	25 (31.3)	24 (30.0)	25 (31.3)
Benzodiazepines	29 (36.3)	28 (35.0)	26 (32.5)
Antipsychotics	30 (37.5)	32 (40.0)	31 (38.8)
Antiepileptics	29 (36.3)	25 (31.3)	24 (30.0)
Alcohol Interdictors	11 (13.8)	14 (17.5)	16 (20.0)
Psychotherapy, n (%)			
Individual	36 (58.1)	37 (58.7)	37 (58.7)
Group	4 (6.5)	3 (4.8)	3 (4.8)
Both	22 (35.5)	23 (36.5)	23 (36.5)

Effect of the Vortioxetine Treatment

Compared with baseline, consumption of practically all substances decreased over the 3- and 6-month treatment, especially alcohol (from 35.0 to 23.8% and 17.5%, respectively), cannabis (from 18.8% to 13.8% and 6.3%), and cocaine (from 17.5% to 12.5% and 6.3%; [Figure 2](#)). Tobacco use remained stable at baseline and after 3 months (28.8% of patients), while it decreased after 6 months of treatment (25.0%). The severity of the alcohol addiction significantly decreased from baseline (mean: 9.1; 95% CI: 8.0-10.3) to the third month (mean: 6.6; 95% CI: 5.6-7.6; p<0.001), and the sixth month (mean: 4.7; 95% CI: 3.6-5.8; p<0.001; [Table 3](#)). Similarly, severity of cannabis addiction reduced significantly from baseline (mean: 9.7; 95% CI: 8.3-11.2) to the 3-month (mean: 7.6; 95% CI: 6.2-8.9; p=0.014), and 6-month treatment (mean: 4.1; 95% CI: 2.6-5.6; p<0.001). Decreases in severity were also significant for cocaine (mean: 5.3; 95% CI: 3.7-6.8, versus baseline, mean: 7.4; 95% CI: 5.4-9.3; p=0.022) and sedative-hypnotics (mean: 4.8; 95% CI: 1.4-8.3, versus baseline, mean: 9.2; 95% CI: 4.4-13.9; p=0.080) after 6 months, while a reduction of heroin was observed after 3 months (mean: 6.3; 95% CI: 0.1-12.6, versus baseline, mean: 12.4; 95% CI: 9.7-15.1; p=0.019).

Table 3

Severity of the Addiction to Substances During Vortioxetine Treatment

Note: *Difference with baseline. Abbreviation: 95% CI, 95% confidence interval

Severity of Addiction, Mean (95% CI)	Baseline	3-Month	p*	6-Month	p*
Tobacco	8.4 (7.1-9.8)	8.4 (7.6-9.3)	0.920	7.2 (6.2-8.2)	0.157
Alcohol	9.1 (8.0-10.3)	6.6 (5.6-7.6)	<0.001	4.7 (3.6-5.8)	<0.001
Cannabis	9.7 (8.3-11.2)	7.6 (6.2-8.9)	0.014	4.1 (2.6-5.6)	<0.001
Cocaine	7.4 (5.4-9.3)	6.3 (4.9-7.7)	0.262	5.3 (3.7-6.8)	0.022
Sedative-hypnotics	9.2 (4.4-13.9)	7.3 (3.7-11.0)	0.436	4.8 (1.4-8.3)	0.080
Gambling disorder	8.1 (3.8-12.5)	6.1 (3.9-8.4)	0.345	5.3 (2.6-8.0)	0.283
Heroin	12.4 (9.7-15.1)	6.3 (0.1-12.6)	0.019	4.3 (-1.0-9.5)	0.250
Other opioids	8.0 (0.8-15.2)	5.7 (1.9-9.5)	0.346	5.3 (0.2-10.5)	0.392

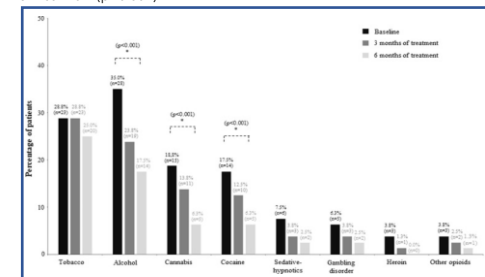
Changes in SUDs During Vortioxetine Treatment

Compared with baseline, consumption of practically all substances decreased over the 3- and 6-month treatment, especially alcohol (from 35.0 to 23.8% and 17.5%, respectively), cannabis (from 18.8% to 13.8% and 6.3%), and cocaine (from 17.5% to 12.5% and 6.3%; [Figure 2](#)). Tobacco use remained stable at baseline and after 3 months (28.8% of patients), while it decreased after 6 months of treatment (25.0%). The severity of the alcohol addiction significantly decreased from baseline (mean: 9.1; 95% CI: 8.0-10.3) to the third month (mean: 6.6; 95% CI: 5.6-7.6; p<0.001), and the sixth month (mean: 4.7; 95% CI: 3.6-5.8; p<0.001; [Table 3](#)). Similarly, severity of cannabis addiction reduced significantly from baseline (mean: 9.7; 95% CI: 8.3-11.2) to the 3-month (mean: 7.6; 95% CI: 6.2-8.9; p=0.014), and 6-month treatment (mean: 4.1; 95% CI: 2.6-5.6; p<0.001). Decreases in severity were also significant for cocaine (mean: 5.3; 95% CI: 3.7-6.8, versus baseline, mean: 7.4; 95% CI: 5.4-9.3; p=0.022) and sedative-hypnotics (mean: 4.8; 95% CI: 1.4-8.3, versus baseline, mean: 9.2; 95% CI: 4.4-13.9; p=0.080) after 6 months, while a reduction of heroin was observed after 3 months (mean: 6.3; 95% CI: 0.1-12.6, versus baseline, mean: 12.4; 95% CI: 9.7-15.1; p=0.019).

Figure 2

Substance uses during vortioxetine treatment.

Asterisks (*) represent statistical significance between baseline and six months of treatment (p<0.001).



Conclusions

Vortioxetine was effective in clinical practice for reducing depression symptoms and functional impairment and improving cognitive and executive functions and disease severity in patients with MDD and SUD. Moreover, the treatment with vortioxetine favored a reduction in substance use and the severity of the SUDs. Further prospective, long-term studies, including larger cohort of patients, are required to corroborate these results.

Keywords: vortioxetine, major depressive disorder, substance use disorder, dual disorder, major dual depressive disorder, real-world evidence.



TREATMENT OF OPIATE ADDICTED VETERANS WITH PTSD AND A CHRONIC HEPATITIS C CO-MORBIDITY, MORE THAN 25 YEARS AFTER THE WAR



Igna Brajević-Gizdić, Magda Pletikosa Pavić

Background

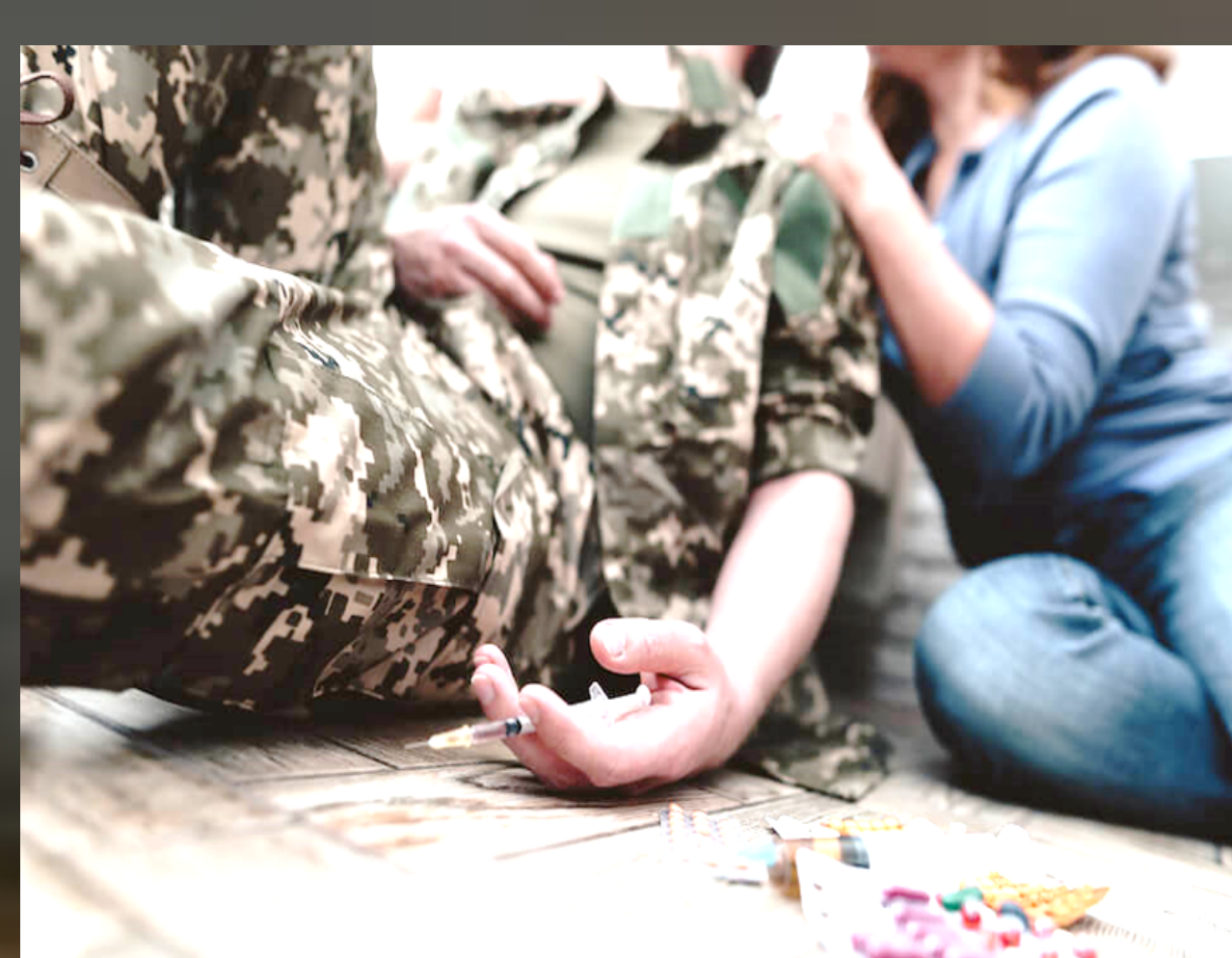
There is an increased rate of various substance use disorders (SUD) among patients with post-traumatic stress disorder (PTSD). It is a great challenge to treat veterans with a dual diagnosis of PTSD and opioid drug addiction, especially in comorbidity with Hepatitis C (HCV). The goal of the study is to highlight and present the current therapeutic response and treatment options among the patient population of addicted veterans with dual diagnoses of PTSD and HCV as comorbidity from the aspect of achieving and maintaining opioid abstinence, after more than 25 years of war. We hypothesized that veterans having both PTSD and opioid addiction, as well as HCV, would have a lower therapeutic response in addiction treatment and have difficulty establishing and maintaining abstinence.

Purpose

This research aimed to evaluate and present the current therapeutic response and treatment options among the patients' population of addicted veterans with dual diagnoses of PTSD and HCV as comorbidity from the aspect of achieving and maintaining opioid abstinence, after more than 25 years of war.

Methods

Participants were outpatients (N=51; male) in the treatment of opioid addiction with dual diagnosis of opioid addiction and PTSD with HCV comorbidity. Data was collected from patient's medical record.

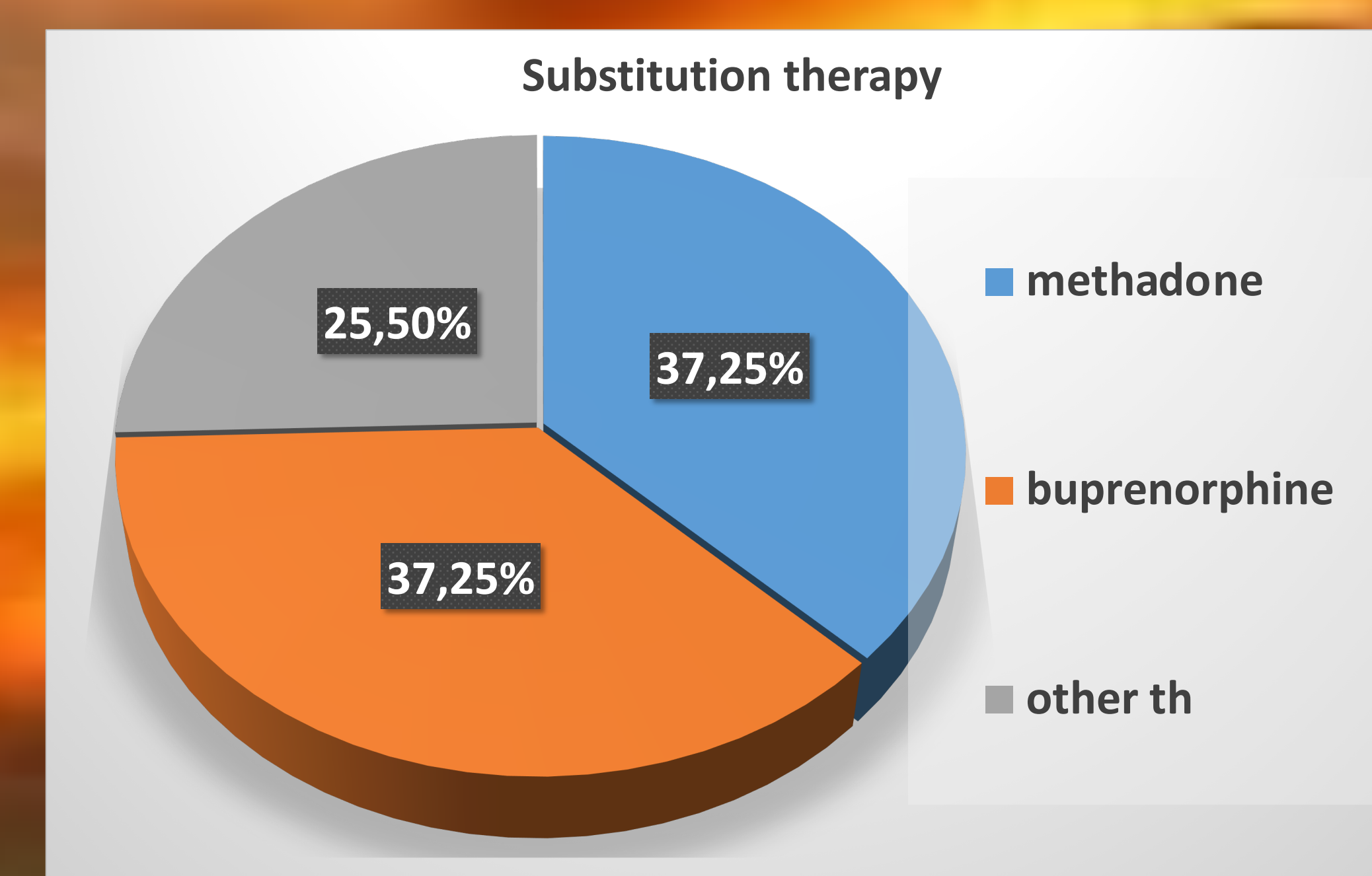
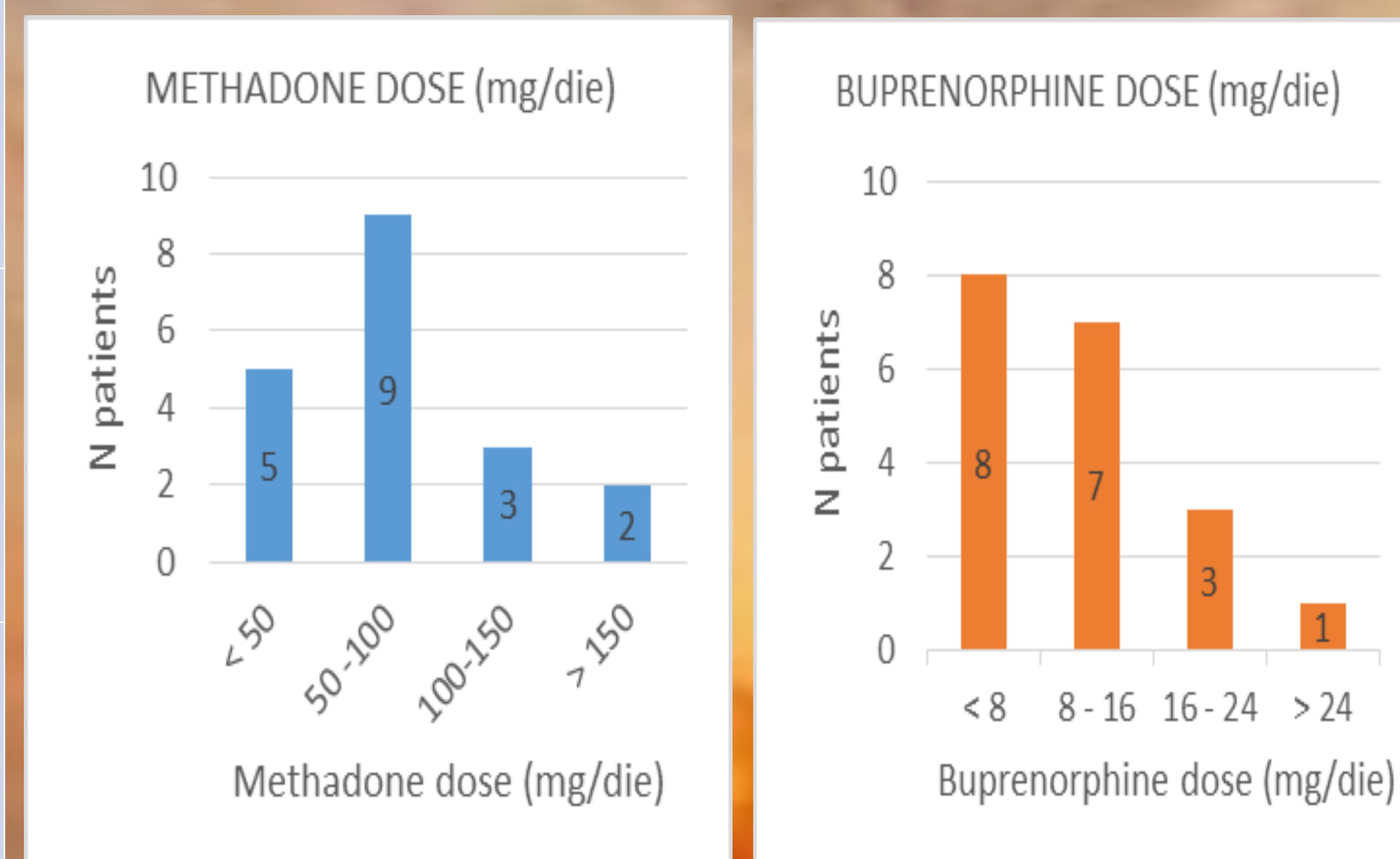


Results

- Majority of participants were above 45 years old (51 – 55 years old; 68%), 57% are retired from military, 25% are unemployed, 61% are single or divorced, 57% have children.
- The majority of patient are on opioid substitution therapy (OST) with maintained dose. Equal number of them are taking methadone or buprenorphine-maintained dose. 26% taking other psychopharmacotherapy. 61% are in illicit opioid abstinence.
- There are less of 30% unknown state of abstinence, according to the last medical record.
- Less than 10 % patient are not stable in abstinence maintenance.
- Antiviral treatments were undertaken for HCV recovery.
- 82% were referred in antiviral treatment in Infectious Disease clinic that offers comprehensive management of HCV with 21.57% of participants need to be referred more than ones to get the full hepatitis recovery condition.

Demographics (N=51)	%
AGE GROUP /years old	
45 - 50	16
51 - 55	69
56 - 60	12
> 60	4
CURRENT STATUS	
employed	6
not employed	26
retired	8
military retired	57
occasionally working	4
MARITAL STATUS	
married	31
single	35
divorced	26
widowed	2
cohabitation	6
PARENTHOOD	
yes	57
no	43

Treatment status (N=51)	%
SUBSTITUTION THERAPY(OST)	
Methadone	37
Buprenorphine	37
Other therapy	26
ILLICIT OPIOID ABSTINENCE	
Yes	59
No	12
Unknown	30
HCV TREATMEN	
Yes, once	61
Yes, several times	22
No	18



Discussion

Croatian war veterans are a group with a high risk of chronic hepatitis C infection.¹ Generally, military veterans may have more of the traditional risk factors for the condition, such as using injected drugs, along with having had transfusions or tattoos.² For opioid-addicted patients, opioid substitution therapy can increase linkage to HCV care, including uptake of HCV testing and treatment.³ Multiple interventions are available that can address the barriers to HCV care for people who inject drugs at the patient-, provider-, and systems-level. The design of models of care to improve HCV testing and treatment among people who inject drugs must consider the unique barriers to care that this population faces.⁴ As in other findings, these results strongly speak to the need for better systems of care to treat and cure HCV among persons who are receiving office-based treatment for their opioid use disorders.⁵ A multidisciplinary approach to the management of HCV-infected patients is needed.⁶ The findings of this study confirmed previous findings.

Conclusion

- Contrary to our expectation, the results show that opioid addicts with PTSD and Hepatitis C diagnosis mostly had a good therapeutic response to achieve and maintain abstinence, even more, they were strongly motivated to treat HCV
- It is important to include as many PTSD veterans as possible in opioid treatment with the mandatory screening test for detecting HCV as a complete therapeutic approach. Retention in a treatment and good compliance seems to have a main role in patients' recovery
- To fully detect dual diagnosis, including both PTSD and opioid addiction with additional HCV treatment, it is necessary to reach out and collaborate with veterans' associations, NGOs, and specialized centers and other institutions involving this sensitive population
- Although it has passed over 25 years of the war, PTSD patients who are heroin addicts with HCV are still motivated and active to improve their Quality of Life. Therefore, healthcare professionals and society need to be involved in appropriate approach and multidisciplinary comprehensive team to support their effort in treatment.

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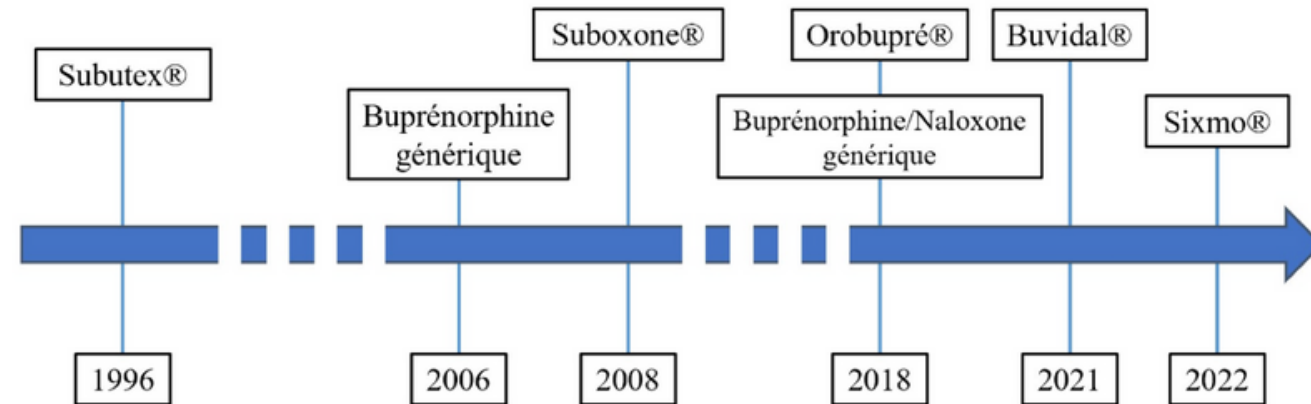
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Clinical and Social Feedback from Patients Who Initiated Long-Acting Buprenorphine in a French Addiction Center

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INTRODUCTION

Several treatments are available for Opioid use disorder. The molecules prescribed in France are Methadone, and Buprenorphine (+/- Naloxone). The next figure shows the availability of galenic forms of buprenorphine in France:



The one-weekly and once-monthly subcutaneous lipid-based injection formulation, called CAM2038 is commercialized as Buvidal®, and need to be prescribed and administered in hospitals and addictions specialized center.

METHODS

A qualitative, retrospective, monosite study, was conducted with 18 years old outpatients who received at least one injection of Buvidal®, in a French addiction center. From April to May 2022, sociodemographic characteristics and treatment datas were collected, as well as datas from three questionnaires created by the staff. The first one considered the clinical situation before treatment beginning. The second was a follow-up questionnaire used for each injection. The third was a semi-directive one, proposed three months after the first injection or after quitting treatment.

RESULTS

34 patients were included in the OPALE study. One had never received buprenorphine. The others already had it, on average 18.5 mg/day (SD 8.6).

Ten of the 34 patients discontinued treatment, including one lost to follow-up. The principal reasons given were : side effects (3), treatment not corresponding to their lifestyle (3), misuse other drugs (2), personal choice (1).

20 patients have participated to the semi-directive questionnaire after 3 months treatment or stopping (17 men and 3 women, from 28 to 66 y.o.) (see table opposite). At the time of the interview, 15 patients are "stabilized" -wich means that they declared no craving and no withdrawal syndrome- and 5 are not, including 4 who stopped the treatment.

CONCLUSION

Many participants reported positive feedback about long acting buprenorphine, especially regarding improvements of their quality of life, modifications in their interpersonal relationships, stigma reduction and distancing their opioid dependance.

Results of the questionnaire after 3 month Buvidal® treatment or stopping

Theme	Population n = 20	
Overall Buvidal® personal experience	Only Positive 70 % Positive & Negative 25% Only Negative 5%	Positive feedback described an overall increased quality of life and effectiveness. The negative ones were related to side effects (pain), three concerned withdrawal symptoms and short-term effects; two talked about difficulty changing.
Corresponding to the expectancies	Yes 85% No 5% Yes & no 10%	Patients who said yes, thank for the treatment effectiveness and tolerance and the freedom they acquire.
Feeling « empty »	Yes 30% No 70%	The responses only concerned opioid withdrawal symptoms. Few patients felt some of them: end of dose asthenia, diarrhea or sweating, and one patient experienced craving for the oral form.
Feeling freer for not having to think about the treatment	More freedom 90% Not more 5% No answer 5%	The majority felt freer with Buvidal®, with less mental workload for not forgetting to take their daily pills, thus reporting an improved quality of life.
Modification of how opioid addiction is perceived	Positive 60% Negative 5% No answer 35%	Twelve patients described they felt more distanced from their addiction; one said he now felt "normal" and another, he had "forgotten his addiction".
Professional changes	Only positive 35% Only negative 10% Positive & negative 5% No answer 50%	Participants reported improved social interactions with colleagues, less stress, felt more energy and could better organize themselves at work.
Changes with healthcare structures	Positive 30% Negative 15% No answer 50%	Concerning the links to healthcare structures, one patient appreciated the fact that he did not have to go to the pharmacy anymore which made him feel less stigmatized. Patients who felt familial and personal relationships improved, reported more stability in interpersonal relationships, more time to invest them, and less mental workload (about hiding their previously oral treatments).
Familial and personal relationships changes	Positive 45% Negative 5% No answer 50%	Seven patients perceived changes in their leisure: more time and energy to do activities as sports, and the possibility to travel long distance without caring about the pills.
Leisure changes	Positive 35% No answer 65%	

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Gender and substance use and other mental disorders comorbidity. Sociodemographic, clinical and treatment differences

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Introduction

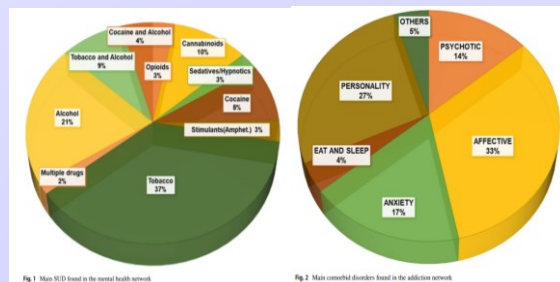
To learn more about the prevalence and the pharmacological treatments provided for the co-occurrence of substance use disorders (SUD) with other mental disorders (OMD) in Spain, with a gender perspective, the specific aim of this study was to determine the differences between males and females regarded to sociodemographic, clinical, dual diagnostics and pharmacological treatments received for both disorders in samples of mental health and specific addiction networks in Spain. All subjects in the sample identified as either male or female (73.6% as men/male).

Method

An observational, cross-sectional, multicentre study, with a randomized sample of patients undergoing treatment for addictive disorders or other mental disorders throughout Spain (N = 1,783) was carried out. A questionnaire, specifically designed by the study authors, on patients' diagnoses and treatments in specific addiction and mental health treatment networks was completed by health professionals working in those settings. The study population were patients receiving treatment in mental health or addiction care networks in Spain, who were aged over 18 years, and had a diagnosis of substance use or other mental disorder at the time of the survey. A convenience, consecutive, random sampling was used. The variables studied were: sociodemographic, somatic pathologies, substance use disorders, other mental disorders, and medications prescribed both for the SUD and for the OMD, and anxiolytics. Differences between male/female were searched. The design tries to ensure that the sample's composition reaches the highest representativeness of the universe from which it is drawn.

Results

A high prevalence of OMD was found in those patients treated for their SUD (71%), and also of diagnoses of SUD (59%) in people treated for OMD. Significant relationships between addiction to certain substances and specific mental disorders were found, but with no main differences between women and men. The treatments for OMD were very common in the addiction treatment networks, but that for SUDs in those patients treated in the mental health networks were less than expected. A high prescription of benzodiazepines was found. Women lived in a higher percentage with their own family and less with a family of origin than men, and that they were pensioners (retired) in a lower percentage. Hepatitis B and C and HIV were more frequent in men than in women. Women were less frequently diagnosed with cannabis, opioid and specially cocaine use disorders. And they had fewer psychotic disorders and more affective, anxiety, sleep and eating disorders, with the rest being the same, including personality disorders. Proportionally, women had fewer treatments with agonists and more with antagonists. And they had more prescriptions of anxiolytics and antidepressants.



Sociodemographic, substance use disorders and other mental disorders characteristics

N= 1780	Male (1310)	Female (470)	Value χ^2 ; p
Sociodemographic variables			
Living with own family	383 (29.2%)	202 (43%)	23.11; <.000
Living with a family of origin	482 (36.8%)	110 (23.4%)	26.12; <.000
Working	394 (30.1%)	128 (27.2%)	0.083
Unemployed	466 (35.6%)	154 (32.8%)	0.097
Pensioner	359 (27.4%)	102 (21.7%)	1.81; 0.029
Substance use disorders, F10-19			
Alcohol	326 (24.9%)	89 (19%)	12.81; 0.008
Tobacco	486 (37.1%)	155 (33%)	0.110
Opioids	156 (11.9%)	34 (7.2%)	9.03; 0.005
Cannabis	329 (25.1%)	85 (18.1%)	10.73; 0.002
Cocaine	417 (31.8%)	104 (22.1%)	17.5; <.000
Anxiolytics/hypnotics(not prescribed)	90 (6.9%)	26 (5.5%)	0.313
Others	72 (5.5%)	14 (3%)	0.068
Other mental disorders, not F10-19			
F0-9. Dementias	12 (0.9%)	6 (1.3%)	13.11; <.001
F20-29. Psychotic disorders	248 (18.9%)	58 (12.3%)	9.82; 0.002
F30-39. Affective disorders	357 (27.3%)	215 (45.7%)	14.51; <.001
F40-49. Anxiety disorders	199 (15.2%)	111 (23.6%)	12.44; <.001
F 50-59. Eating and sleep disorders	44 (3.4%)	37 (7.9%)	21.92 <.000
F 60-69. Personality disorders	343 (26.2%)	122 (26%)	0.703
F 70-99. Other disorders	42 (3.3%)	12 (2.6%)	3.82; 0.03

The statistically significant values are in bold
Degrees of freedom between 1 and 6; χ^2 values between 0.24 and 110.46

*: rest not specified or not answered

Substance use disorder and other mental disorder relationships (p values)

Grades of freedom=1; χ^2 Pearson values between 0.03 and 20.66

N=1783	ALCOHOL	OPIOIDS	CANNABIS	SEDATIVES	COCAINE	OTH.STM.	OTH.DRGS.	TOBACCO
ORGANIC	0.468	0.716	0.435	0.803	0.090	0.020	0.821	0.216
PSYCHOTIC	0.012	0.188	0.000	0.594	0.739	0.000	0.866	0.000
AFFECTIVE	0.001	0.112	0.276	0.079	0.000	0.079	0.562	0.161
ANXIETY	0.633	0.093	0.006	0.013	0.693	0.736	0.880	0.424
EAT & SLEEP	0.638	0.609	0.170	0.541	0.046	0.164	0.100	0.044
PERSONALITY	0.033	0.000	0.000	0.000	0.000	0.031	0.757	0.000
OTHER	0.597	0.079	0.036	0.690	0.019	0.129	0.831	0.009

Prescribed pharmacological treatments

N=1783	TOTAL n= 1783	MENTAL H n= 322	ADDICTIONS n= 1461	Values χ^2 ; p
For SUD (any)	954 (53.5%)	96 (17.4%)	858 (65.4%)	26.16; <.00001
Disulfiram/cyanamide	183 (10.3%)	42 (13%)	141 (9.7%)	3.08; 0.069
Opioid agonists	423 (28.1%)	12 (3.7%)	411 (31.3%)	31.12; <.000001
Opioid antagonists	57 (3.7%)	4 (1.9%)	53(3.9%)	1.05; 0.121
For OMD (any)	1329 (74.5%)	284 (88.2%)	1045 (71.5%)	9.11; <.0001
Antipsychotics	599 (33.6%)	171 (52.1%)	428 (29.3%)	13.23; <.0001
Mood stabilizers	294 (22%)	69 (23.2%)	225 (21.7%)	0.07; 0.574
Antidepressants	714 (53.5%)	129 (43.4%)	585 (56.4%)	10.54; <.0001
Anxiolytics	779 (43.7%)	108 (36.4%)	671 (45.9%)	11.96; <.0001

N=1780*	Male (n=1310)	Female (n=470)	Values χ^2 ; p
Opioid agonists	367 (28.1%)	54 (11.5%)	13.95; <.001
Opioid antagonists	35 (2.7%)	22 (4.7%)	1.88; 0.034
Disulfiram/cyanamide	130 (9.9%)	53 (11.3%)	0.04; 0.407
Anxiolytics/Hypnotics	540 (41.2%)	239 (50.9%)	13.28; <.001
Mood stabilizers	228(18.9%)	66 (14.9%)	0.98; 0.093
Antidepressants	457 (38.3%)	257 (54.7%)	21.16; <.0001
Antipsychotics	452 (36.5%)	147 (31.3%)	0.059

*: in 3 subjects some data were not available SUD: substance use disorder OMD: other mental disorder

Conclusions

This study provides preliminary information on the coexistence in routine clinical practice of addictive disorders and other mental disorders in Spain, and on the treatment provided. And shows differences in prevalence and clinical characteristics, and especially in treatment approaches, between women and men. Thus, should be useful to adapt the treatment response with greater precision, and with a gender perspective.

Co-occurrence of substance use disorders and other mental disorders in people undergoing specific treatment for any of them in Spain

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Background

The co-occurrence of substance use disorders (SUD) and other mental disorders (OMD) is assumed to be high but is, in fact, unknown in Spain; and it is approached from different healthcare networks. The objective of the present study was to know the prevalence of this co-occurrence, both in specific addiction treatment networks and in mental health networks, in Spain.

Method

An observational, multicenter cross-study, with a randomized sample, of patients under treatment for SUD or OMD in different Autonomous Communities (regions) of Spain was carried out (N=1,783). A specific ad hoc online questionnaire collecting sociodemographic variables, substance use and diagnoses of SUD and OMD was completed. The Socidrogalcohol website hosted the ad hoc survey where professionals could enter each patient's data, always guaranteeing the highest levels of confidentiality and anonymity. The patients were anonymized from the start.

Results

The data obtained in the survey show a significant concurrence of SUD and OMD diagnoses (in more than 60% of the patients). A high prevalence of OMD was found in those patients receiving treatment for their SUD (71%), and also of diagnoses of any SUD (68.9%) and active substance use (50%, except tobacco) in people receiving treatment for diagnoses of OMD. Also were found significant relationships between addiction to certain substances and specific mental disorders: personality disorders with all SUDs; psychotic disorders with cannabis use disorder, but not cocaine use disorder; affective disorders with cocaine use disorder, and anxiety disorders with cannabis use disorder.

Sociodemographic and clinical (somatic) characteristics

	TOTAL N=1783	MENTAL H. N=322	ADDICTIONS N=1461	Values of $F; \chi^2, p$
Sex (male)	1310 (73.6%)	216 (67.3%)	1094 (75%)	7.67; 0.005
Age*	47.54 ± 1.38	48.30 ± 12.17	43.11 ± 11.21	1.79; 0.04
Living arrangements (own family+alone)	1049 (33+25.9%)	34.5+27.3%	25.5+32.6%	1.08; 0.75
Work situation (active+OD)	591 (29.3%)	89 (20.8%)	462 (31.2%)	5.38; <.0001
Marital status (single)	908 (50.9%)	168 (52.2%)	740 (50.7%)	1.51; 0.624
HVC	292 (16.4%)	27 (8.4%)	265 (18.1%)	4.97; <.0001
HVB	65 (3.6%)	7 (2.2%)	58 (4%)	1.05; 0.120
HIV	89 (5%)	5 (1.6%)	84 (5.7%)	8.12; 0.002
Neurological disease	71 (4%)	15 (4.7%)	56 (3.8%)	0.07; 0.493

*: Mean, standard deviation. OD: Occupational disability.

Prevalence of substances used

	TOTAL N=1783	MENTAL H. N=322	ADDICTIONS N=1461	Values of χ^2, p
Any previously	1287 (72.2%)	251 (78%)	1036 (70.9%) *	3.85; 0.011
Any previously except tobacco	1258 (70.6%)	237 (73.6%)	1021 (69.9%)	1.06; 0.185
Any current	1482 (83.1%)	250 (77.6%)	1232 (84.3%)	7.67; 0.004
Any current except tobacco	1044 (58.6%)	161 (50%)	883 (60.4%)	9.03; 0.001
Substances consumed last month				
Tobacco	1195 (89.1%)	215 (80.2%)	980 (91.3%)	10.03; <.0001
Alcohol	693 (50.3%)	129 (48.7%)	564 (50.6%)	0.08; 0.568
Cannabis	413 (45.3%)	49 (31.6%)	364 (48.1%)	16.78; <.0001
Cocaine	331 (33.6%)	27 (20%)	304 (35.8%)	12.11; <.0001
Stimulants (amphetamines)	31 (1.7%)	12 (3.7%)	19 (1.3%)	7.97; 0.003
Heroin	117 (8.5%)	4 (1.5%)	113 (10.1%)	25.64; <.0001
Prescription opioids	191 (9.3%)	5 (1.4%)	186 (18.3%)	10.06; 0.002
Substances consumed, but not in the last month (quit)				
Tobacco	146 (10.9%)	53 (19.8%)	9 (8.7%)	11.93; <.0001
Alcohol	686 (49.7%)	136 (51.3%)	550 (49.4%)	1.16; 0.158
Cannabis	498 (54.7%)	106 (68.4%)	392 (51.9%)	13.76; <.0001
Cocaine	654 (66.4%)	108 (80%)	546 (64.2%)	9.89; <.0001
Stimulants (amphetamines)	260 (14.6%)	73 (22.7%)	187 (12.8%)	19.31; <.0001
Heroin	253 (18.3%)	24 (9.1%)	229 (20.6%)	20.08; <.0001
Prescription opioids	44 (18.7%)	6 (54.5%)	38 (17%)	22.13; <.0001

*: Rest not specified or not answered.

Diagnosis of substance use disorders

	TOTAL N=1783	MENTAL H. N=322	ADDICTIONS N=1461	Values χ^2, p
Any previously	1431 (80.3%)	215 (66.8%)	1216 (83.2%) *	16.07; <.0001
Any current	1036 (58.1%)	222 (68.9%)	814 (55.7%)	14.21; <.0001
Any previously (except tobacco UD)	875 (49.1%)	190 (59%)	685 (46.9%)	11.96; <.0001
Any current (except tobacco UD)	643 (36.1%)	142 (44.1%)	501 (34.3%)	8.68; 0.002
Substance use disorder in the past 12 months				
Alcohol	744 (41.7%)	80 (24.8%)	664 (45.4%)	18.32; <.0001
Opioids	370 (20.8%)	12 (3.7%)	358 (24.5%)	28.93; <.0001
Cannabinoids	416 (23.3%)	41 (12.7%)	375 (25.7%)	13.11; <.0001
Sedatives/ Hypnotics	116 (6.5%)	10 (3.1%)	106 (7.3%)	15.07; <.0001
Cocaine	521 (29.2%)	33 (10.2%)	488 (33.4%)	18.81; <.0001
Stimulants (amph.)	45 (2.5%)	12 (3.7%)	33 (2.3%)	1.02; 0.128
Hallucinogens F16	5 (0.3%)	0	5 (0.3%)	0.96; 0.293
Tobacco F17	643 (36.1%)	142 (44.1%)	501 (34.3%)	8.98; 0.001
Multiple F19 drugs	36 (2%)	6 (1.9%)	30 (2.1%)	1.91; 0.826
Substance use disorder prior to last 12 months (currently abstinent)				
Alcohol	498 (27.9%)	93 (28.9%)	405 (27.7%)	1.52; 0.674
Opioids	305 (17.1%)	22 (6.8%)	283 (19.4%)	18.75; <.0001
Cannabinoids	355 (19.9%)	71 (22%)	284 (19.4%)	0.66; 0.288
Sedatives/ Hypnotics	109 (6.1%)	6 (1.9%)	103 (7%)	22.91; <.0001
Cocaine	505 (28.3%)	66 (20.5%)	439 (30%)	6.99; 0.001
Stimulants (Amp.)	81 (4.5%)	26 (8.1%)	55 (3.8%)	10.87; 0.001
Hallucinogens	23 (1.3%)	1 (0.3%)	22 (1.5%)	3.48; 0.085
Tobacco	347 (19.5%)	98 (30.4%)	249 (17%)	10.16; <.0001
Multiple drugs	45 (2.5%)	16 (5%)	29 (2%)	8.49; 0.002

*: Rest not specified or not answered.

Diagnosis of other mental disorders

	TOTAL N=1783	MENTAL H. N=322	ADDICTIONS N=1461	Values of χ^2, p
ANY	1334 (74.8%)	297 (92.2%) *	1037 (71.0%)	10.06; <.0001
PSYCHOTICS (F 20-29)	315 (17.7%)	113 (35.1%)	202 (13.8%)	14.02; <.0001
AFFECTIVE (F 30-39)	580 (32.5%)	108 (33.5%)	472 (32.3%)	0.06; 0.669
ANXIETY (F 40-49)	296 (16.6%)	43 (13.4%)	253 (17.3%)	1.21; 0.084
EAT and SLEEP (F 50-59)	70 (3.9%)	10 (3.1%)	60 (4.1%)	0.09; 0.402
PERSONALITY (F60-69)	459 (25.7%)	71 (22%)	388 (26.6%)	1.16; 0.094
OTHERS (F 00-09, 70-99)	75 (4.2%)	7 (2.1%)	68 (4.7%)	3.08; 0.042

*: Rest not specified or not answered.

Substance use disorders and other mental disorders relationships

N=1783	F-10 ALCOHOL	F-11 OPIOIDS	F-12 CANNABIS	F-13 SEDTIVES	F-14 COCAINE	F-15 OTH ESTIM.	F-16,18,19 OTH DRGS.	F17 TOBACCO
F0-9. ORGANIC Ds	0.468	0.716	0.435	0.803	0.090	0.020	0.821	0.216
F20-29. PSYCHOTIC Ds	0.012	0.188	0.000	0.594	0.739	0.000	0.866	0.000
F30-39. AFFECTIVE Ds	0.001	0.112	0.276	0.079	0.000	0.079	0.562	0.161
F 40-49. ANXIETY Ds	0.633	0.093	0.006	0.013	0.693	0.736	0.880	0.424
F 50-59. EAT & SLEEP Ds	0.638	0.609	0.170	0.541	0.046	0.164	0.100	0.044
F 60-69. PERSONALITY Ds	0.033	0.000	0.000	0.000	0.000	0.031	0.757	0.000
F 70-99. OTHER MDs	0.597	0.079	0.036	0.690	0.019	0.129	0.831	0.009

(G.L.=1; values of χ^2 Pearson between 0.03 and 20.66).

Conclusions

Given the characteristics of its design, which tried to avoid various biases, and despite its limitations, this research provides indicative and valuable preliminary information on the high prevalence of co-occurrence of SUD and OMD diagnoses both in mental health and especially in addiction networks throughout Spain. And, moreover, on the relationships between SUDs and OMDs.

More research is needed to deepen our knowledge and thus enable healthcare responses to better adapt to reality, and with greater efficiency.

Characterization of women with and without dual diagnosis attended in an outpatient addiction center in Barcelona during the period between 2017-2022

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Background

While substance use disorder (SUD) is more prevalent in men, dual diagnosis (DD) is more likely to occur in women. In addition, when SUD appears in women, they tend to present greater physical and psychological impairment, and have less social support than men do. Despite the importance of addressing SUD and DD in women at an early stage, gender inequalities hinder their access to treatment.

Aim and methods

To describe and compare the sociodemographic and clinical data between women with and without dual diagnosis attended in an outpatient addiction center in Barcelona (CAS Santa Coloma) from 2017 to 2022. Data obtained from patients' medical records.

Results

Of the total 972 patients treated between 2017 and 2022, 191 (20%) were women, of whom 99 (51%) had DD. The global mean age was 46 years (21-81). Women with DD were more often unemployed than those without DD (64% vs 48% respectively, $p=0.017$) (table 1). The most frequent main SUD were alcohol use disorders (48%) and stimulants use disorder (20%). Women with DD required follow-up by another mental health center more frequently than those without DD (30% VS 4.3%, $p=0.001$). At the end of 2022, there were 96 women under follow-up at the center, of which 42 (42,4%) were women with DD and 54 (60%) were women without DD ($p=0.018$) (table 2). Of these, 62% of women with DD had a good outcome, compared to 41% of those without DD ($P=0.032$) (graphic 1). The most frequent comorbid diagnoses were cluster B personality disorders (26%), depressive disorders (15%), stress-related disorders (14%) and anxiety disorders (11%) (graphic 2). The most common reason for discharge in women with and without DD was abandonment of follow-up, (55% and 44% respectively) (table 2).

Conclusions

Women seeking treatment represent only 20% of the patients treated for an addiction problem, and half of them have a psychiatric comorbidity. When DD occurs, these women often require more complex treatments, so close coordination between the centers that care for them is essential. Although patients without DD are more likely to continue follow-up care, when women with DD do, they have good outcomes. Efforts should be focused on ensuring that women with addictions with and without comorbid psychiatric disorders enter and stay in treatment.

Table 1.- Sociodemographic characteristics of women with and without DD attended at CAS Santa Coloma between 2017-2022.

		No DD % n=92 (48%)	DD % n=99 (51%)	Total % N=191	P
Nationality	Spanish	86	89	87	ns
Mean age (SD)		44,8 (12,09)	46,22 (10,7)	46	ns
Marital status	Single	48	48	48	ns
	Married	12	23	18	
	Separated/Divorced	12/20	8,1/19	10/19,5	
	Widowed	3,7	0,5	4,2	
Employment situation	Working	48,4	64,6	57	0,017
	Not working	51,6	35,4	43,2	
Living situation	No-housing problems	94	91	92	ns
	With housing problems	5,2	9	7,3	
Incomes	With incomes	13,2	13,4	13,3	ns
	Without incomes	86,8	86,6	86,7	
Eduacional level	No studies	5,6	9,3	7,5	ns
	Elementary and highschool higher education	86	81	83	
Criminal records		9	10,3	9,7	ns
		24	31	28	

$p<0,05$

Graphic 1.- SUD outcomes in women with and without DD who stayed on treatment at the end of 2022 (n=96%)



* $p=0,032$

Good outcomes: < 20% positive urine controls for main substance in the last 6 months

Bad outcomes: < 20% positive urine controls for main substance in the last 6 months

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Table 2.- Clinical characteristics of women with and without DD attended at CAS Santa Coloma between 2017-2022.

		No DD% 92	DD % 99	Total % 191	P
Family history of SUD		59	71	65	ns
Serologic status	HBV+	0	0	0	ns
	HCV+ (ARN+)	11 (2,2)	14 (4)	12 (3,1)	
	HIV	8,2	3,3	5,5	
Average age drinking problem onset (SD)		29,6 (13)	30,1 (9,5)	29,89(11,8)	ns
Consumption pattern	diary	76	67	71	ns
	binge	21	33	27,3	
Main substance of use	Alcohol	44,6	51,5	48	ns
	Cocaine	22,8	29,2	20,9	
	Opioid	1,5	9	12	
	CNN	13	14	13,6	
	Ansiolitics	2,2	5,1	3,7	
	Others	2,2	0,5	1,7	
Problematic drinking triggers	Social/improve state	23	10	26	ns
	Coping emotional distress	45	47	47	
	Conformity	4,3	3	3,6	
Treatment	Combined: psychotherapy+ pharmacological Treatment	76	71	73,8	ns
Follow-up	Additional follow-up from Mental Health network	4,3	30	18	0,001
Drop out rate %*		28	34	31,4	ns
Motives of discharge	Abandonment	44	55	49	ns
	Geographical change	10	5	7,4	
	Other (transfer, exitus, medical release, expulsion, unknown)	46	40	43	
Women on treatment at the end 2022 (n= 96)		59	42	50	0,0018

$p<0,05$

*Dropout rate: % of patients who have stopped attending due to dropout out of the total number of patients under follow-up.



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Graphic 2.- Main psychiatric diagnoses in women with DD treated at the center between 2017 -2022 (n=99%)

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Alexithymia as a risk factor for addictive behavior

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The present study is to analyze the factors of development of alexithymia in the youth environment in relation to the nature of addiction in order to develop prevention measures and programs of socio-psychological and medical care.

The subject of the study is the process of formation of addictive behavior (AB) as a maladaptive strategy for overcoming a psychological crisis, socio-psychological and clinical predictors and phenomena of the development of AB, a model of the concept of AB prevention, and the development of a program for providing specialized medical and psychological assistance to young people.

The object of research is addictive behavior and pathogenetic mechanisms of its development.

The subject of the study is young people (15-34 years old) from the risk group for addictive behavior (forming dependence on "new PAS" or Internet addiction).

The aim of the work is to develop a system of measures for the sociocultural prevention of addictive behavior of young people and its consequences.

Research objectives:

- 1) identify the negative social consequences of the implementation of various forms of addictive behavior (dependence on "new psychoactive substances", Internet addiction), which developed against the background of alexithymic personality traits;
- 2) collect empirical data (factors of development of alexithymia in the youth environment, its gender characteristics) in relation to the characteristics of various forms of addictive behavior;
- 3) to develop practical recommendations for the prevention of addictive behavior of today's youth and its consequences through socio-cultural resources.

Study Design

The design of the study was an open, randomized, multicenter, analytical, cross-sectional, comparative prospective study with parallel groups (samples of the study - contingents of people aged 15-34 years, at risk for addictive behavior (forming dependence on "new PAS" or Internet addiction)) using methods of observation and "case-control".

Criteria for inclusion of a contingent of individuals in the study (stratified randomization followed by block randomization for each stratum): individuals aged 15-34 years, addictive behavior (forming dependence on "new PAS" or Internet addiction).

Characteristics of the study sample

The subjects were randomized (150 people aged 15-34 years) into 3 groups: the main group (persons with a tendency to the systematic use of "new" surfactants in the form of synthetic cannabinoids) (CG), the comparison group (persons at risk for developing "non-chemical" forms of addiction (Internet addiction) (GS), and the control group (representatives of young people, characterized by normative behavior, without addictions and deviant behavior) (CG).

Socio-psychological questioning was carried out (in all indicated groups, based on the principle of informed consent to participate in the study).

An experimental psychological study was carried out (in all indicated groups) using psychodiagnostic methods:

1. Five-factor personality questionnaire by R. McCray and P. Costa (5PFQ) - to study individual characterological personality traits [Khromov A.B., 2000];
2. Questionnaire "Methods of coping behavior" by A. Lazarus - to identify an individual style of coping with stress, unproductive patterns of behavior and personality resources [Kryukova T.L., Kuftyak E.V., 2007];
3. Beck Depression Scale (BDI) [Beck A. T., Ward C. H., Mendelson M., Mock J., Erbaugh J. An Inventory for Measuring Depression. Archives of General Psychiatry, Vol. 4, June 1961];
4. Toronto Alexithymia Scale (TAS-26-R) - to study the level of alexithymia [Eresko D. B. et al., 2005];
5. Questionnaire for determining the severity of Internet addiction [S.A. Kulakov [Kulakov S.A., 2004].

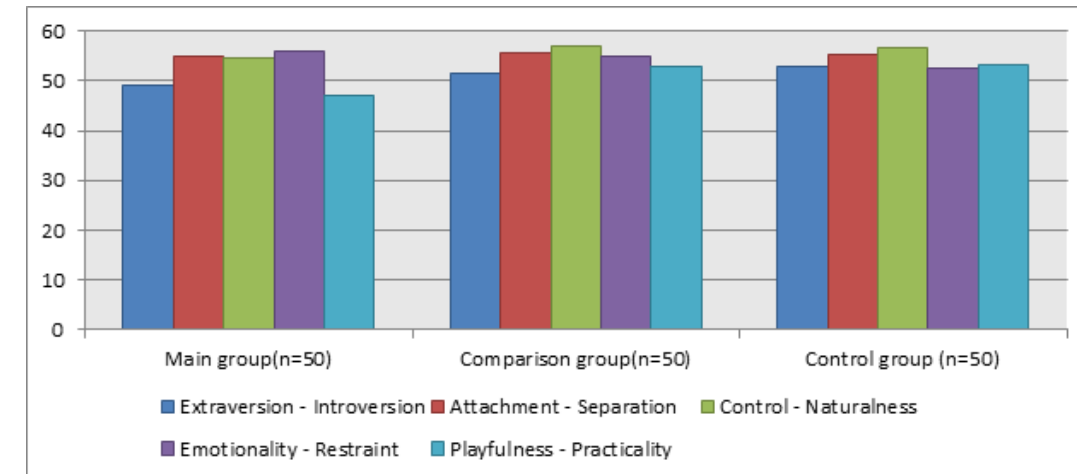
The results of the study

Carried out in comparison of 3 samples using tabular and graphic visual material.

Table 1 - The results of the study of the psychological characteristics of the subjects using the Five-Factor Personality Questionnaire methodology

Evaluation criterion	Main group (n=50)		Comparison group (n=50)		Control group (n=50)	
	M	SD	M	SD	M	SD
Extraversion - Introversion	49,04	8,12	51,39	11,87	52,78	11,20
Attachment - Separation	54,94	11,16	55,68	11,18	55,29	8,54
Control - Naturalness	54,45	8,59	56,89	9,19	56,58	7,20
Emotionality - Restraint	56,03	11,57	55,03	11,42	52,55	9,36
Playfulness - Practicality	47,18	8,72	52,81	7,45	53,12	9,22

Note - The data in the columns are descriptive statistics, where M is the mean value in the group, SD is the standard deviation.

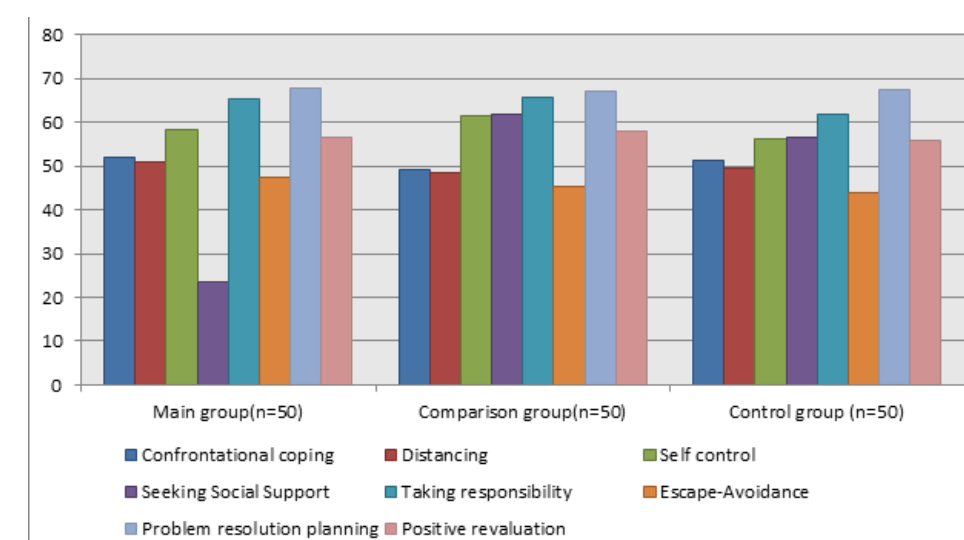


As shown in Table 1, in the Playfulness-Practicality category, the OG, SG, and CG groups differed from each other with a probability $p = 0.000079$; in the Dreaminess-Realistic category, the OG and CG groups differed from each other with a probability $p = 0,0000586$, in the category "Plasticity - Rigidity" groups OG and CG differed from each other with a probability $p = 0.000022$.

Table 2.- The results of the study of methods of coping behavior through the questionnaire "Methods of coping behavior" by A. Lazarus

Coping strategies	Main group (n=50)		Comparison group (n=50)		Control group (n=50)	
	M	SD	M	SD	M	SD
Confrontational coping	51,9	14,8	49,2	15,0	51,2	14,1
Distancing	50,9	15,4	48,6	17,5	49,5	14,8
Self control	58,2	15,7	61,6	13,4	56,1	13,0
Seeking Social Support	23,4	17,1	61,91	15,9	56,62	15,3
Taking responsibility	65,3	19,2	65,7	16,2	61,7	18,2
Escape-Avoidance	47,4	14,4	45,4	16,1	44,0	14,1
Problem resolution planning	67,7	17,0	67,0	17,5	67,5	14,9
Positive reevaluation	56,7	14,8	57,9	16,2	55,9	14,1

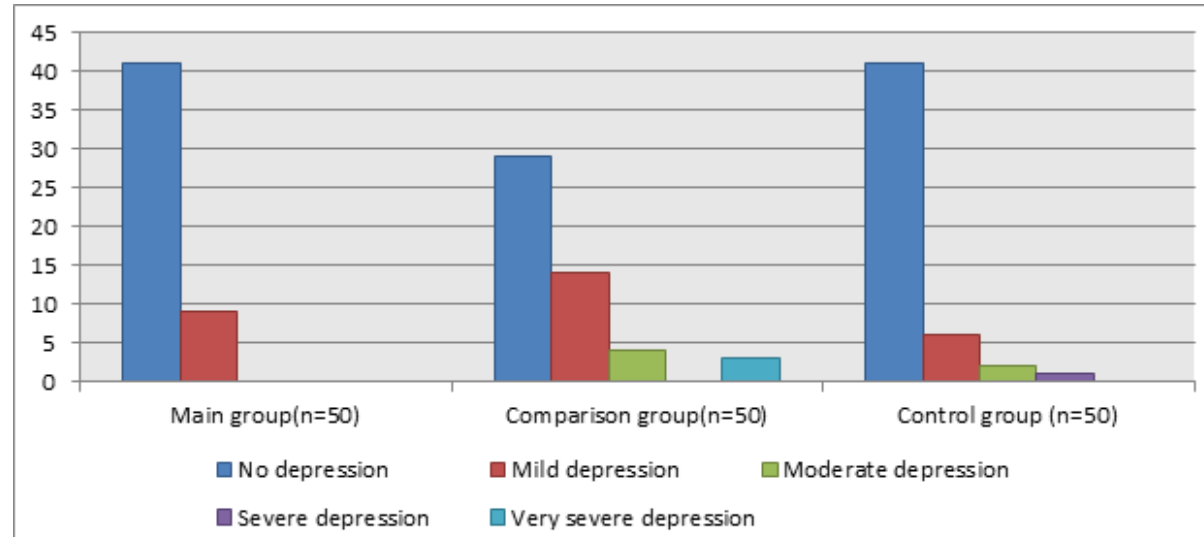
Note - The data in the columns are descriptive statistics, where M is the mean value in the group, SD is the standard deviation.



According to the results of the study of methods of coping behavior, shown in Table 2, in the category "Search for social support", the groups of the MG and the CG differed from each other with a probability of $p = 0.036934$.

Table 3.- The results of the study of the level of depression using the A. Beck Depression Scale (BDI)

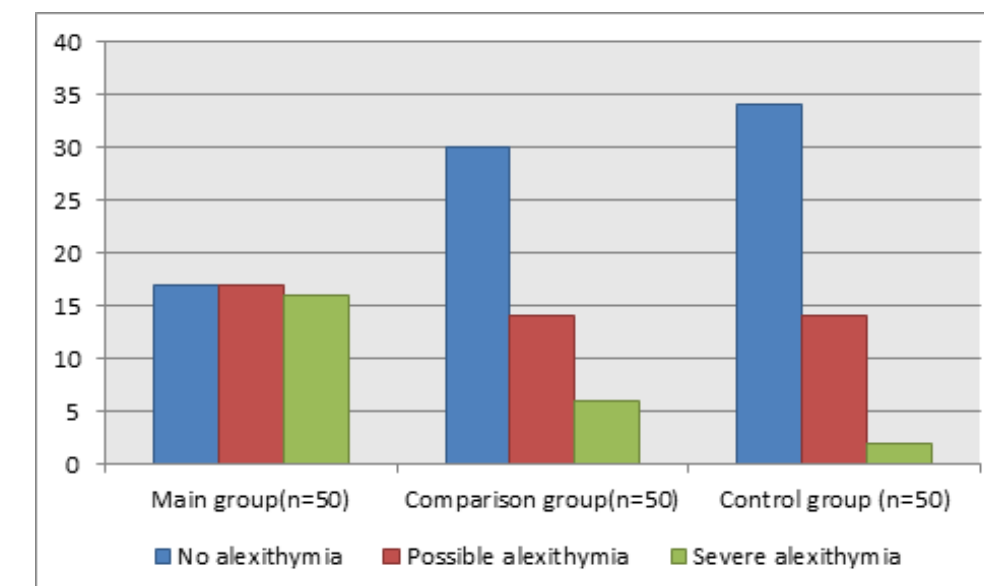
Factor	Main group (n=50)		Comparison group (n=50)		Control group (n=50)	
	n	%	n	%	n	%
Score (M±SD)	6,2	4,0	9,5	8,2	5,8	5,0
No depression	41	82,0	29	58,0	41	82,0
Mild depression	9	18,0	14	28,0	6	12,0
Moderate depression	0	0,0	4	8,0	2	4,0
Severe depression	0	0,0	0	0,0	1	2,0
Very severe depression	0	0,0	3	6,0	0	0,0



As noted in Table 3, the rates of depression in both groups are approximately equal.

Table 4 - Results of the study of alexithymia using the Toronto Alexithymia Scale (TAS-26-R)

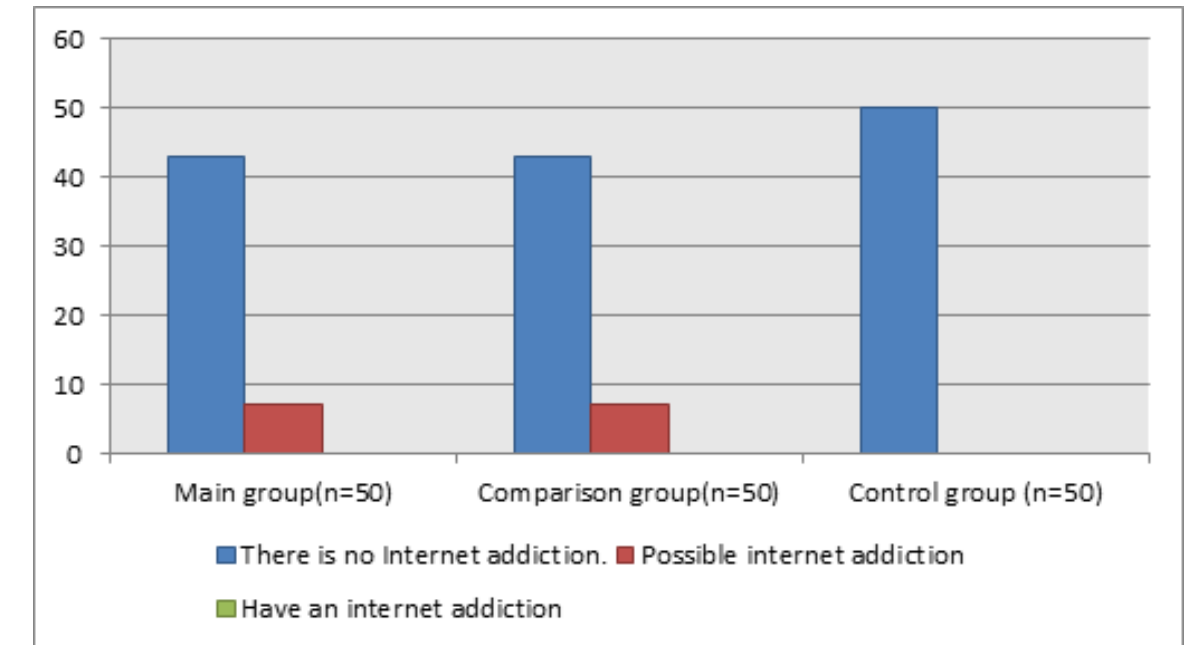
Evaluation criterion	Main group (n=50)		Comparison group (n=50)		Control group (n=50)	
	n	%	n	%	n	%
Score (M±SD)	67,66	8,01	59,24	11,83	58,92	8,36
No alexithymia	17	34,0	30	60,0	34	68,0
Possible alexithymia	17	34,0	14	28,0	14	28,0
Severe alexithymia	16	32,0	6	12,0	2	4,0



According to the results obtained on the Toronto Alexithymia Scale (TAS-26-R), the total scores of the MG (mean value 67.66) and CG (mean value 58.92) are significantly different from each other, and the indicators of severe alexithymia noticeably predominate in the MG.

Table 5.- The results of the study of Internet addiction using a questionnaire to determine the severity of Internet addiction (S.A. Kulakov, 2004)

Factor	Main group (n=50)		Comparison group (n=50)		Control group (n=50)	
	n	%	n	%	n	%
Score (M±SD)	37,3	10,1	38,5	10,5	34,0	7,4
No Internet addiction	43	86,0	43	86,0	50	100,0
Possible internet addiction	7	14,0	7	14,0	0	0,0
Have an internet addiction	0	0,0	0	0,0	0	0,0



In the category "Degree of severity of Internet addiction, severity of Internet addiction", the groups of MG and CG differed from each other with a probability $p = 0.038401$.

Conclusions

1. The participants in the group of respondent-consumers of PAS are characterized by a tendency to play activities in relation to practical ones, which can be expressed in the desire for idleness, entertainment and avoidance of activities that do not bring direct pleasure, which can be explained by the influence of the hedonistic type of PAS use motivation. They are also characterized by a tendency to daydreaming, the desire to treat their thoughts and fantasies as meaning more and deserving more attention than the surrounding reality. They have a more pronounced need to be in a group and receive feedback, while members of the control group are more practical and tend to autonomy and willingness to make individual decisions.
2. There is a certain trend towards the occurrence of depressive symptoms in the risk group for Internet addiction).
3. Indicators of severe alexithymia noticeably predominate in the group of PAS users, which can be expressed in significant difficulties in recognizing and expressing one's own feelings and emotions, reflection, difficulty in empathy, as well as in violations of building emotionally stable relationships with others, which can also be the reason for using surfactant.
4. There is a risk of formation of other, non-chemical (in this case, Internet addiction) addictions in people with already diagnosed chemical addiction, which can be expressed in a constantly high need to be online, anxiety, disorientation in the absence of access to network resources.

What differences can dedicated nurses do for dual disorder patients? A qualitative research project of 'social nurses' in Denmark

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WHAT IS A 'SOCIAL NURSE'?

INEQUALITY IN HEALTH

Inequality in health is high on the political agenda in Denmark and so is initiatives that can reduce this inequality.¹ Socially marginalized patients are often stigmatized and perceived as complex patients and they have a significantly higher degree of mortality.² Patients with dual disorders are one example of socially marginalized patients and have a reduced life expectancy of 22 years compared with the Danish background population.³

FORMAL DESCRIPTION

One attempt to remedy the inequality that social marginalized patients experience in the Danish health care system is the employment of social nurses. A social nurse is a registered nurse with in-depth knowledge of socially marginalized patients and competences in rehabilitation.² "A social nurse contributes with specific knowledge about marginalization, disparities, health inequality, pain and/or abstinence treatment and with a profound understanding of the unique problems marginalized patients are often facing".²

In a former study of what social nurses are and do the following four themes have been identified: I) Coordination towards a common goal to reduce patients' vulnerability, II) to see and understand patients as whole persons, thereby assuring successful treatment, III) working with the system to avoid losing the patients, and



Social marginalized citizens outside a shelter in Copenhagen

IV) a unique expertise encompassing experience and evidence-based knowledge.² Social nurses have primarily been employed at somatic hospitals, but in 2021 it was decided also to employ this kind of nurses in the mental health services in the Capital Region and funding for 10 positions was granted. In spring 2022 the first social nurses in the mental health services started working. Patients with dual disorders are one of their primary target groups.



'This way to the emergency unit'. Mental Health Services, Copenhagen

METHODS

DATA COLLECTION

This poster presents results from the first – qualitative – round of data collection in a multi-method study researching social nurses in mental health service. In the spring 2023, I have conducted 7 days of participant observation at four different locations and interviewed 7 social nurses. Background data consists of reading of policy documents and participation in the workgroup describing the function prior to its implementation.

ANALYSIS

Fieldnotes and transcriptions of interviews have been coded after the principles of a thematic content analysis.⁴ The data has been coded after the following themes: *Where do social nurses do a difference* and *Where do social nurses meet barriers/obstacles for their work*. Only results from the first coding is presented here.

RESULTS: WHERE DO SOCIAL NURSES DO A DIFFERENCE?

COMMUNICATION, INTEREST AND RESPECT

Social nurses are very aware of the way they talk to the dual diagnosis patients. By showing an interest in the patients – also in their use of substances – they can communicate to the patients that they respect them as individuals and that they will try to help them. This is, unfortunately, sometimes in opposition to how other staff members treat them.

DE-STIGMATISATION

The way social nurses talk about the patients with their colleagues plays a part in de-stigmatizing the dual disorder patients. They talk about the patients as someone who belongs in the psychiatric departments and as someone that deserves to be helped. They also often points out that addiction is a psychiatric diagnosis, again highlighting that dual disorder patients are proper patients.

AGENCY

In some situations, the social nurse has a role as the dual disorder patients' advocate: Pointing out that they also deserve treatment, trying to delay discharge, and securing proper treatment, including sufficient substitution treatment for those in opioid maintenance treatment.

KNOWLEDGE ON DRUGS, ADDICTION ETC.

Many staff members in psychiatry lack knowledge on the different substances, on what addiction is, and how people with substance use disorder often must live their lives. Social nurses are thus also a knowledge resource.

NETWORK

Social nurses work on building a large network on where social marginalized patients can get help and support when they are discharged.

Often the social nurse establishes personal connections with these support possibilities that can make referral of patients easier. The patient can 'borrow' the relations from the social nurse.



Entrance to the emergency unit, Mental Health Services, Copenhagen

BRINGING SYSTEMS TOGETHER

The modern Danish welfare system is made up of specialized silos⁵ and patients whose problems go across these silos often experience problems getting help. In these situation the social nurse can play a part in connecting the silos thus preventing the dual disorder patient from getting lost in the system.

A PERSON TO CONTACT WITHIN THE SYSTEM

To many health professionals and social workers outside the psychiatric treatment system, this system is perceived as very complex and difficult to navigate. The social nurse will for many of these partners function as a contact person, that can facilitate cooperation with the system.

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IMPACT OF PANDEMIA COVID 19 ON DUAL DISORDERS (P15)

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Abstract

Introduction: COVID-19 and lockdown measures negatively impacted mental health globally and had a particular impact on patients with substance use disorders, especially on those with dual disorders. The COVID-19 pandemic also impacted drug markets (e.g. changes in types of drugs at the street level, price increase for consumers on the black market and reductions in purity).

Methods: A systematic review of the literature with PubMed following Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to obtain an overview on impact of pandemia covid 19 on dual disorders.

Results: The COVID-19 pandemic has serious implications for individuals with mental disorders and for individuals with substance use disorders. Both new psychiatric symptoms and general worsening of existing symptoms were frequent during the lockdown. Comorbidities and risk environments for substance use disorders are likely risk factors for COVID-19.

It seems that there has been a shift in drug market and drug use patterns during the pandemic, use of several psychoactive substances increased, other risks represented by increasing variability in drug purity (e.g. adulteration, contamination of heroin supply with synthetic opioids). In addition social isolation, loneliness, grief and prolonged bereavement negatively impact on mental health.

Conclusions: In response to the long-lasting and heterogenous challenging effects of the pandemic there is a need for patient tailored interventions.

Key words: dual disorder, covid 19, pandemia

Introduction

COVID-19 and lockdown measures negatively impacted mental health globally and had a particular impact on patients with substance use disorders, especially on those with dual disorders. The COVID-19 pandemic also impacted drug markets (e.g. changes in types of drugs at the street level, price increase for consumers on the black market and reductions in purity).

Methods

A systematic review of the literature with PubMed database following Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to obtain an overview on impact of pandemia covid 19 on dual disorders was performed.

Results

Publications in the PubMed database according to selected keywords and selected time period

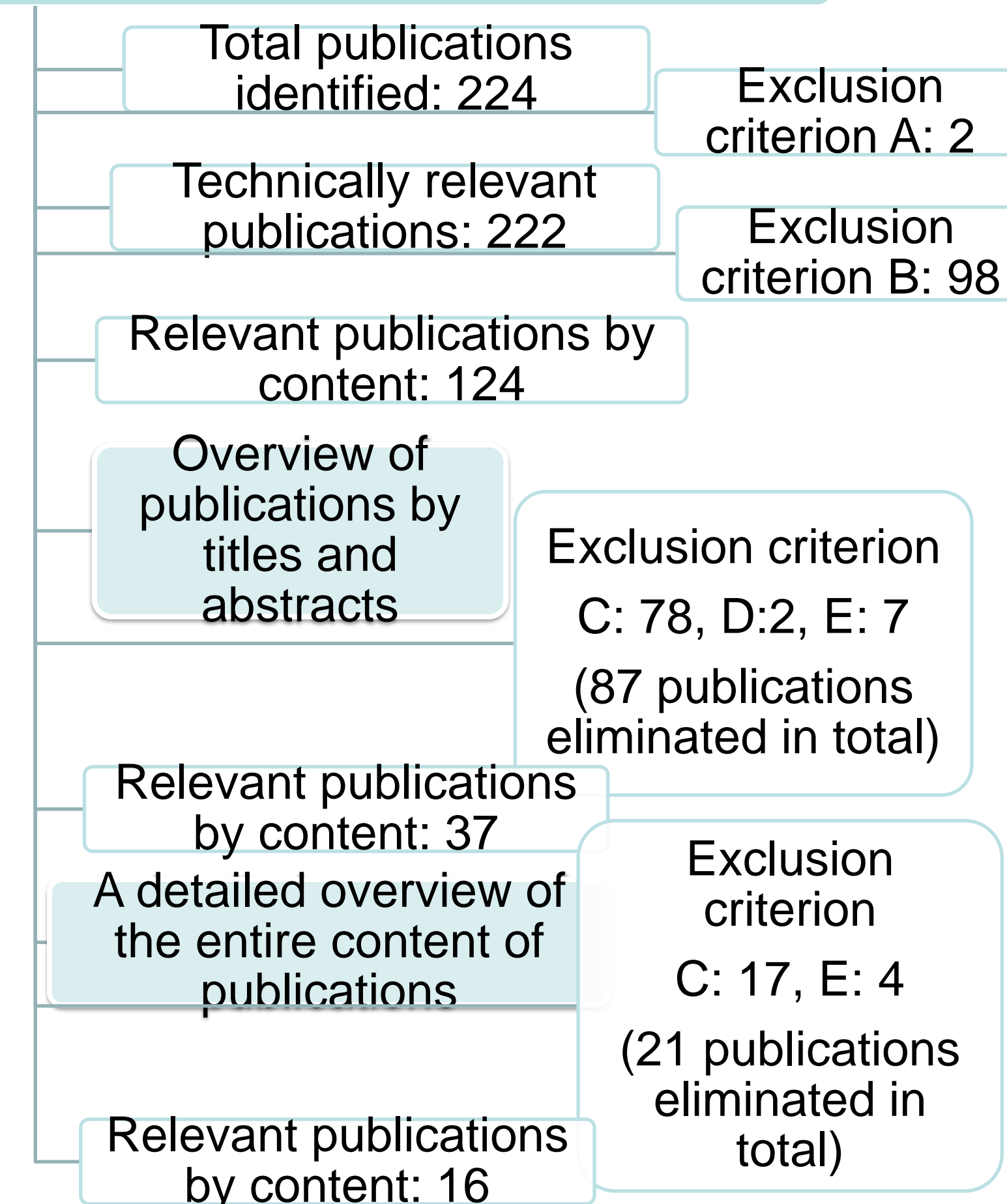


Fig. 1. Flowchart of the literature review process.

LEGEND OF EXCLUSION CRITERIA:

A: Not in the English language.

B: Related to alcohol addiction.

C: Not relevant in terms of content (not illicit substances, not dual diagnosis, biomedical treatment, telemedicine, not consequences of Covid-19, about education, burnout).

D: Duplication.

E: Not accessible or only an abstract is accessible.

The COVID-19 pandemic has serious implications for persons with mental disorders and for persons with substance use disorders, new psychiatric symptoms and worsening of preexisting symptoms were both frequent during the lockdown (1-27). Covid-19 pandemic lead to decrease in treatment access with deterioration in mental health and risky behavior among drug use persons. Comorbidities and risk environments for substance use are likely risk factors for COVID-19 (6,7,15,21,27).

The COVID-19 pandemic also impacted drug markets with changes in availability, accessibility of drugs, prices (4, 24) and changes in drug use patterns, use of several psychoactive substances increased, other risks represented by increasing variability in drug purity (e.g. reduction purity, adulteration, contamination of heroin supply with synthetic opioids, potency of drugs), price increases, shifts to more at-risk drug using behaviours (4,6,15,24,26). Usually crisis is likely to increase the need to access drug treatment and services. During COVID-19 pandemic in 2020 a worsening of the opioid overdose crisis was observed with an increase in drug-related deaths due to poorer access to treatment services, toxicity in the unregulated drug supply, physical distancing policies that have resulted in many people started using opioids (2,27).

The increase in black market synthetic opioids (fentanyl, carfentanil), caused by Covid-19 pandemic, have led to rapid increases in deaths (15). In seems that COVID-19 favored the use of fentanyl even among those who preferred other drugs, because of availability and price (cheaper than heroin) (26). An overdose survivors reported changes or disruptions in treatment and that substance use had increased due to the pandemic (13). Reduced availability of prescription opioids could mean that those with prescription opioid dependence seek illicit opioids, such as heroin (22). Disruptions in drug markets and trafficking patterns due to the pandemic may also increase overdose risk and multi-substance use by leading to an increase in more harmful, domestically produced substances and increased use of pharmaceutical products that may be more readily available (e.g. benzodiazepines)(6).

Among drug users an increase in levels of drug use, a shift to other substances and a relapse in drug use was observed (1-27).

Conclusions

In response to the long-lasting and heterogenous challenging effects of the pandemic there is a need for patient tailored interventions (e.g. take home medications, controlled substance prescribing, telemedicine, telehealth, virtual support groups).

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Metabolic syndrome in psychotic patients treated with NAP and substance users

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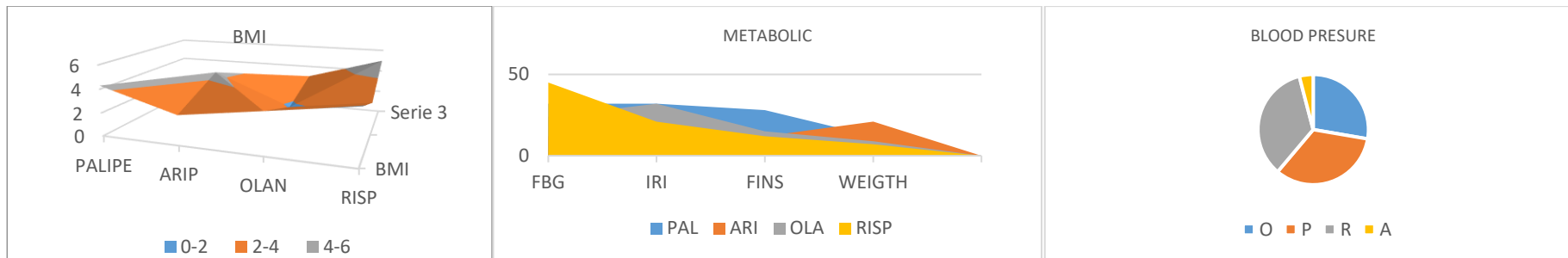
Metabolic syndrome is defined by The National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP III) guidelines, as a pathologic condition characterized by blood glucose greater than 100 mg/dl or drug treatment for elevated blood glucose, HDL cholesterol < 40 mg/dl in men and < 50 mg/dl in women or drug treatment for low HDL, blood triglycerides > 150 mg/dl or drug treatment for elevated triglycerides, Waist > 102 cm (men) or > 88 cm (women), and blood pressure > 130/85 mmHg or drug treatment for hypertension. Moreover, these disorders appear to be related to an unhealthy diet, lack of exercise, adverse effects of psychotropic drugs, and to undefined risk factors. [1]

Long-active injectable antipsychotics are an essential tool in the treatment schizophrenia and psychotic disorders. Second-generation antipsychotics have been associated with fewer extra-pyramidal effects (motor problems) than first-generation antipsychotics. However, they have been associated with a higher prevalence of metabolic abnormalities, such as insulin resistance, weight gain, hyperlipidemia and type 2 diabetes [2, 3]. Some meta-analytic studies revealed that individuals treated with olanzapine had significantly higher insulin resistance index (IRI), fasting blood glucose (FBG), and fasting insulin (FINS) levels than those treated with aripiprazole, ziprasidone, or risperidone [2].

The objective of the present research is to carry out a retrospective, descriptive and observational study. The participants are a sample of patients treated with long-active injectable antipsychotics (first and second-generation antipsychotics) in a mental health center in Spain (province of Soria). We analyze the following parameters: lipid profile, glucose, blood pressure, BMI and abdominal perimeter. In addition, the sociodemographic data of the sample, such as age, gender and job activity, are exposed.

Currently, the majority injectable treatment in the mental health center is second-generation antipsychotics. Specifically, we found a higher percentage of patients with aripiprazole and paliperidone. There is a higher percentage of men than women in depot treatment. The results show a high prevalence of overweight/obesity in patients treated with long-active injectable antipsychotics. As main results, we highlight that there is a majority of patients with a BMI between 25-30%.

In addition, it is highlighted that the abdominal perimeter is high in both groups of patients (first and second generation antipsychotics). Finally, the practical implications are discussed, are analyzed and the main limitations are exposed., future lines of research are analyzed and the main limitations of the study that arise from the significant metabolic alterations that derive from the multitemporal injection of long-acting neuroleptics are exposed. These initial conclusions will allow us to design future comparative studies between the different presentations of long-acting neuroleptics, to establish the profile of that product whose incidence of metabolic alterations is lower and thus be able to establish protocols of use appropriate to the characteristics of each patient.



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Keywords: Schizophrenia; Long-Active Injectable Antipsychotics; Metabolic syndrome; Psychotic Disorders

Consumption pattern in Psychotic Patients According to the Type of Treatment

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Introduction: It was decided to try to find out the level of toxic consumption among the group of patients with schizophrenia who are users of a residential device. Depending on the type of neuroleptic medication they receive, also taking into account parameters such as age, sex and number of years of treatment.

The study is carried out on 42 patients of both sexes between 21 and 67 years old, all of them residing in an open residential facility of the Psychiatric Mini-Residence type.

Methods

A conventional determination of toxicants in urine is used, which includes the detection of Cannabis, Cocaine, Methamphetamine and Opiates. Urine collection is performed without prior notice and simultaneously to all study candidates, in such a way that an attempt is made to collect it under normal living conditions, eliminating the prior warning factor. A data collection form is established that includes a demographic item, the type of current treatment and the number of years elapsed since the first neuroleptic treatment.

Sample:

42 patients: 26 men and 16 women, Ages between 21 and 67 years (mean age 47.3)

Diagnosics. 36 patients with Schizophrenia (85.7%), 3 patients with Bipolar Disorder (7.14%), 3 patients with schizoaffective disorder (7.14%)

Type of treatment

26 patients receive injectable treatment; 16 patients receive oral treatment

Goals

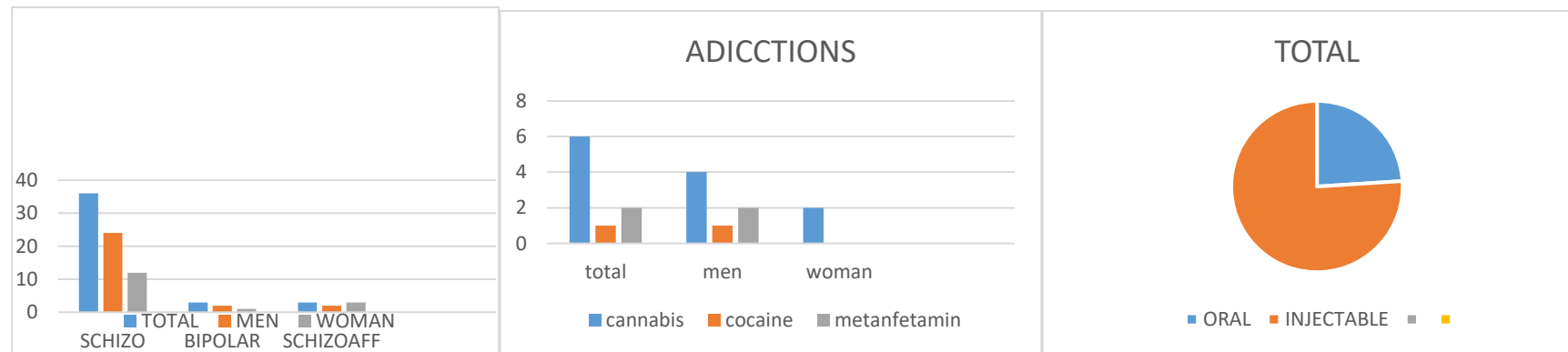
The percentage of consumers is higher in Men. Patients with oral treatment have a higher consumption pattern, due to the small size of the sample, none of the results is statistically significant and only shows a trend in a group of patients admitted to an open mini-residence.

9 patients tested positive in total, 6 patients tested positive for Cannabis, 2 patients tested positive for methamphetamine, 1 patient tested positive for Cocaine

1 of these patients tested positive for Cannabis Cocaine and Methamphetamine

Of the 7 patients, 5 were men and 2 women. All patients who tested positive were under 35 years of age.

Of the 7 patients who tested positive, 3 were taking NL depot medication and 4 only oral medication.



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Bipolar Disord, 2002 vol. 4(6) pp. 406-11. Quetiapine in bipolar disorder and cocaine dependence.

How does the consumption of toxins affect the cognitive state of psychotic patients?

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Introduction: An attempt is made to verify the possible influence of the consumption of toxic substances on the cognitive functioning of patients who are referred to Active Rehabilitation programs, taking advantage of the measurement of the baseline cognitive state that we have established as a starting point in the Cognitive Rehabilitation program.

Sample characteristics: The sample is made up of 17 patients referred to the Rehabilitation Area from January 1 to September 30.

- **Age:** Men: 8; mean age 43.6 years (23-65), Women: 9; mean age 41.6 (21-58)
- **Diagnostics:** Schizophrenia: 9 patients (5 women and 4 men), Schizoaffective: 2 patients (2 women) Bipolar: 1 patient (1 woman), T. Personality: 5 patients (4 men and 1 woman)
- **Toxic consumption:** 6 patients (3 women and 3 men)

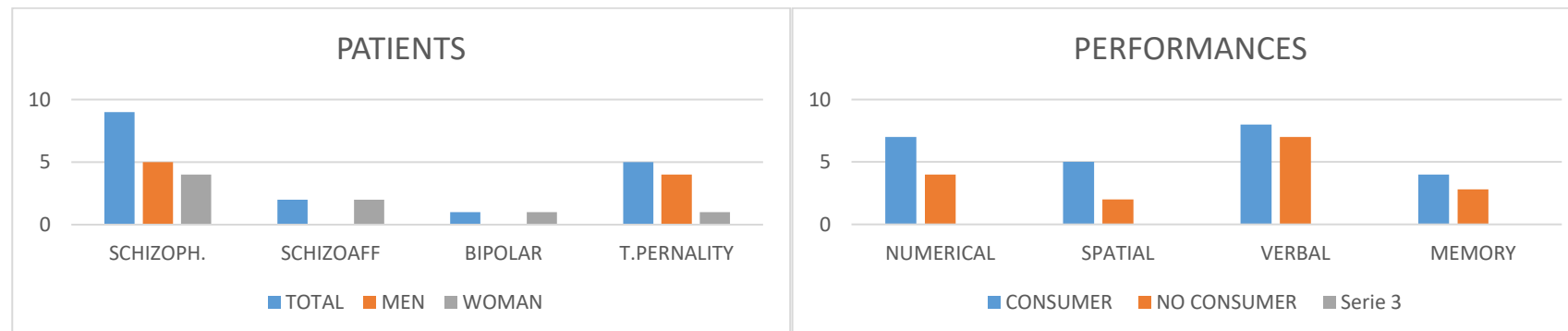
Methodology :

- To assess cognitive status:
- The "Brain Trainer" program is used in its version 2, which allows an approximate assessment of cognitive performance in the areas: verbal, numerical, spatial, memory and logic.
- To determine consumption: weekly DAU control

Results

• The results show statistically significant differences in favor of the consumer patients in the numerical and spatial areas, there are no significant differences in the verbal area between the two groups and there is better performance, not significant, of the consumer patients in the areas of memory and logic

- Conclusion
- As a main conclusion, and contrary to what might seem, the consumption of toxins does not have a decisive influence on the cognitive functioning of patients who suffer from an added mental disorder.
 - Only the convincing results in the numerical and spatial areas in favor of non-consumers guide in the sense that consumer patients would have a significantly better management in these two areas.



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RESULTS OF THE USE OF CARIPRAZINE IN THE TREATMENT OF SCHIZOPHRENIA AND SUBSTANCE USE DISORDER

A CASE SERIES IN BOTH INPATIENT AND OUTPATIENT REGIME

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INTRODUCTION AND BACKGROUND

In the past few years we have witnessed the emergence of new therapeutic agents for the treatment of dual pathology, specifically new antipsychotics that apparently show more effect over substance use along with their antipsychotic effect and therefore increase our pharmacological arsenal for the treatment of psychotic disorders associated with substance use. We present in the following communication a series of cases of patients diagnosed with Schizophrenia and Substance Use Disorder treated with cariprazine at different doses.

METHODS

This series consists of an observation of a total of 20 patients, 5 of them treated on an outpatient basis and 15 of them who were admitted on a mid-term basis to a sub-acute treatment and rehabilitation unit of a psychiatric hospital.

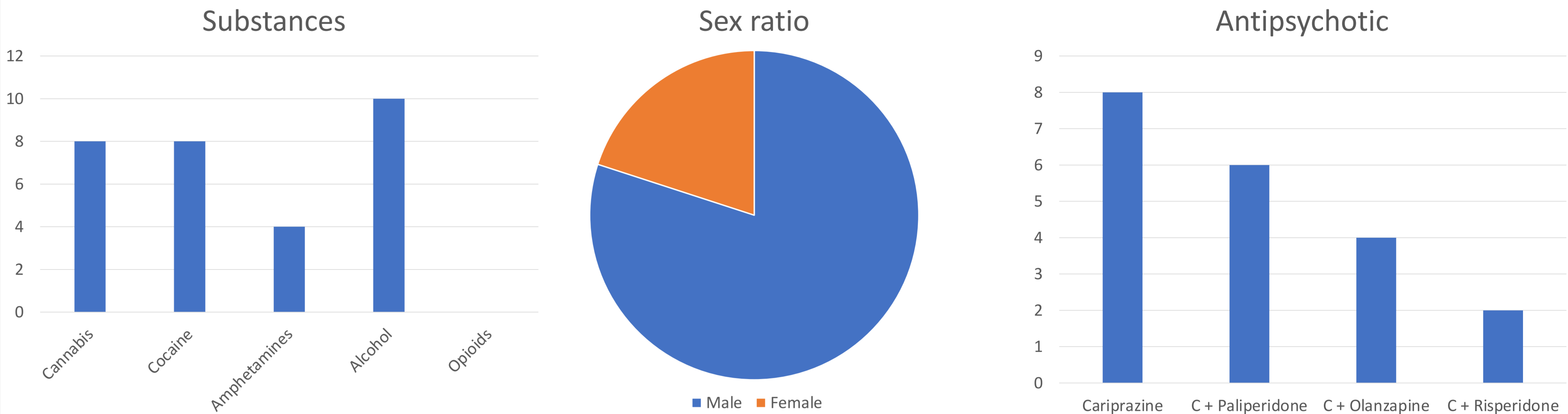
Regarding sex ratio, 16 were male and 4 were female. All of them had a diagnosis of Schizophrenia meeting the DSM-5 criteria, as well as a Substance Related Disorder meeting the DSM-5 criteria. Regarding the specific substance, nicotine was not considered, and we did take into consideration drugs measurable in urine tests by our laboratory: cannabis, cocaine, opioids and amphetamines; and alcohol.

All of them received treatment with cariprazine in different doses from 1,5mg to 6mg per day, as a solo treatment or as an adjuvant to another previous antipsychotic treatment when antipsychotic augmentation was justified.

We observed patients that had started cariprazine in the past three months and that had active drug use or had had one in the past three months. 8 out of the 20 patients received monotherapy with cariprazine. When not in monotherapy, the most frequently associated antipsychotic was monthly paliperidone (6 patients), olanzapine (4 patients) and risperidone (2 patients). Not being this a clinical study, we simply monitored the tolerance to the treatment, the clinical response in terms of positive and negative symptoms of schizophrenia, affective symptoms, disruptive behavior, and the response in terms of substance use.

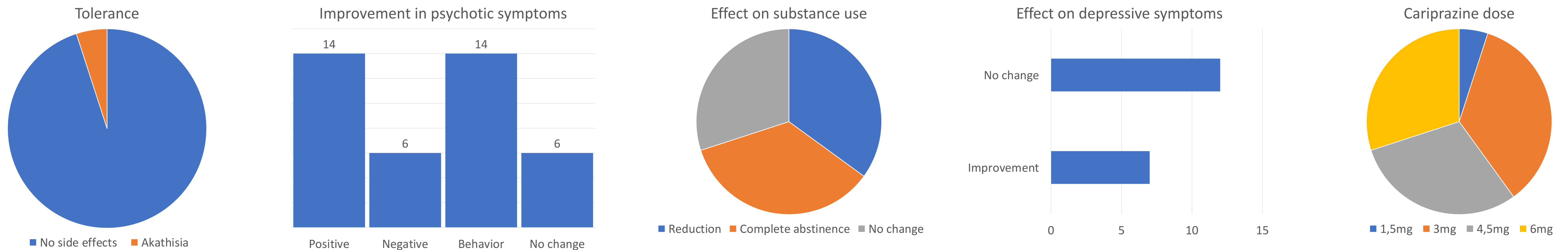
We did this for a period of 1 year of follow-up, with psychiatric consultation at least every 15 days and nurse consultation every week in our hospital.

Cariprazine was introduced at a dose of 1,5mg, then increased to 3mg after a week and then evaluating the response after three weeks of that increasement. Dose was then adjusted individually according to their clinical state and response.



RESULTS

In terms of tolerance, 19 out of the 20 patients (95%) did not present any side effect related to cariprazine. In one patient (5%) the treatment had to be stopped due to akathisia that did not disappear after two weeks and symptomatic treatment with benzodiazepines. In terms of substance use, 60% of patients either stopped using (50%) or reduced their use frequency (50%). This was especially significant with cocaine and amphetamines. As for psychotic symptoms and disruptive behavior, 70% of the patients presented an improvement in positive symptoms and behavior. Also, one third of them presented a slight improvement in negative symptoms. Regarding affective symptoms, around 20% of patients referred a significant improve in depressive symptoms that was equally observed by their psychiatrist.



CONCLUSIONS

The main conclusion of this case series is that cariprazine is both effective and well tolerated in patients suffering from Dual Disorders, especially with the combination of Schizophrenia and Substance Use Disorder. In our clinical practice, either the treatment in monotherapy with cariprazine or the augmentation of a previous antipsychotic treatment with cariprazine at any dose between 3mg and 6mg per day has a positive outcome, both in the psychotic domain and the substance use disorder. Obviously, this is only a series of cases, but we hope it could help our colleagues treat their patients suffering from these pathologies in an optimal way. This could also set a basis to encourage a proper clinical trial to assess if new antipsychotics such as cariprazine could be a new standard for the treatment of Dual Disorders.

HOW TO MATTER: PROMOTING SOCIAL INCLUSION AND PARTICIPATION AMONG YOUNG ADULTS WITH COMPLEX PROBLEMS IN FACT TEAMS

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BACKGROUND: Being a part of and contributing to the local community, and feeling as though one matters, works as a facilitator in recovery processes for people with mental illness and/or substance abuse (e.g. Rowe & Ponce, 2020). Current clinical practice has been criticized for having insufficient focus on people's life in the community. Social inclusion and participation are core goals of FACT (Flexible Assertive Community Treatment). While inclusion of these goals in the work of FACT teams may lead to improvement in services to and outcomes for the target group, greater practical knowledge of how to achieve them is needed (e.g. Brekke et al., 2021). Yet few studies of social inclusion and participation of young adults in FACT teams have been undertaken.

AIMS: (1) To explore the perspectives of young adults (18-29 years old) with complex problems in terms of what they need to feel as though they matter and how they perceive their opportunities for social inclusion and participation in their local communities, and (2) To investigate how FACT team staff perceive their abilities to promote social inclusion and participation, based on the perspectives and needs as presented by their young adult clients.

DESIGN, RESEARCH QUESTIONS, METHODS, ANALYSIS: The overall design is qualitative, participatory, exploratory and phenomenological.

1. What are the barriers and facilitators for social inclusion and participation among people with dual diagnosis? Scoping review.
2. What do young adults with complex problems need in order to feel that they matter and to see themselves as socially included and participating? Qualitative interviews with young adults in FACT teams, content analysis.
3. How can FACT teams promote their client's social inclusion and participation and to see themselves as mattering? Focus group interviews with FACT team staff, content analysis.

DISSEMINATION: The results from this ongoing Ph.D. project (2022-2025) will be published in international peer reviewed journals and presented at relevant conferences.

Exploring the bricks in the wall and how to break through them

According to Pink Floyd, the "wall" is the self-isolating barrier we build over the course of our lives, and the "bricks in the wall" are the people and events that turn us inward and away from others.

"All in all
it's just another
brick in the wall"

CLINICAL FEATURES AND FACTORS RELATED TO LIFETIME SUICIDAL IDEATION IN ADULT ADHD PATIENTS WITH SUBSTANCE USE DISORDERS

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Introduction

Attention deficit and hyperactivity disorder (ADHD) has been associated with suicidal ideation (SI) in general population (1). However, this association has been scarcely studied in adult ADHD patients with substance use disorders (SUD).

Objectives

To explore the clinical features, and factors related to lifetime SI in ADHD patients with SUD.

Methods

A cross-sectional study was conducted in an outpatient center for addiction treatment between 01/01/2015 and 12/31/2021. Patients who met criteria for active SUD and adult ADHD according to DSM-5 were included in the analysis. All patients were evaluated with the European Index of Addiction severity (EuropASI), The Structured Clinical Interview for axis I and II of DSM-IV, Diagnostic Interview for ADHD in adults (DIVA 2.0), Beck depression inventory (BDI), Short form 36 for Health-related Quality of Life, and Ad Hoc questionnaire.

Patient characteristics	All sample	No SI group (n=101; 43.0%)	SI group (n=134; 57.0%)	χ^2, t	p	
Sociodemographic characteristics						
Age, $m \pm SD$	35.97±10.59	35.07±11.95	36.65±9.44	1.116	0.266	
Sex, %	Male	79.1	45.7	54.3	2.693	0.101
	Female	20.9	32.7	67.3		
Lifetime emotional abuse, %	42.6	31.5	68.5	10.098	0.001	
Lifetime physical abuse, %	29.6	32.8	67.2	4.605	0.032	
Lifetime sexual abuse, %	11.1	16.7	83.3	8.176	0.004	
Substance use variables						
Amount of lifetime SUDs, $m \pm SD$	4.0±1.98	3.92±2.00	4.06±1.96	0.535	0.593	
Alcohol use disorder, %	89.2	43.0	57.0	0.082	0.775	
Cannabis use disorder, %	77.4	44.2	55.8	0.350	0.554	
Cocaine use disorder, %	82.9	42.8	57.2	0.001	0.974	
Opioid use disorder, %	30.8	37.5	62.5	1.165	0.281	
Benzodiazepine use disorder, %	35.6	34.9	65.1	3.350	0.067	
Psychiatric features						
Any psychiatric diagnosis other than SUD, %	69.3	36.8	63.2	3.688	0.055	
Amount of psychiatric disorders, $m \pm SD$	1.91±1.02	1.66±0.87	2.10±1.08	3.427	0.001	
Mood spectrum disorders, %	42.4	25.9	74.1	13.816	0.000	
Anxiety spectrum disorders, %	30.4	31.0	69.0	3.662	0.056	
Psychotic spectrum disorders, %	19.4	42.9	57.1	0.733	0.392	
Any personality disorders, %	46.4	31.0	69.0	5.730	0.017	
Assessment instruments						
EuropASI, $m \pm SD$	Medical	0.18±0.31	0.18±0.30	0.18±0.31	0.060	0.952
	Employment	0.57±0.31	0.57±0.30	0.58±0.32	0.294	0.769
	Alcohol	0.21±0.23	0.19±0.23	0.22±0.23	0.994	0.322
	Drugs	0.18±0.15	0.19±0.14	0.18±0.16	0.806	0.421
	Legal	0.12±0.21	0.12±0.21	0.11±0.21	0.385	0.701
	Familiar	0.40±0.28	0.35±0.28	0.43±0.28	2.141	0.033
	Psychological	0.41±0.23	0.35±0.22	0.46±0.22	3.534	0.001
BDI, $m \pm SD$	18.97±11.08	15.37±9.52	21.30±11.43	3.850	0.000	
Physical component summary HRQoL, $m \pm SD$	50.43±9.83	51.46±9.99	49.74±9.71	1.139	0.256	
Mental component summary HRQoL, $m \pm SD$	33.47±13.23	35.53±13.20	32.11±13.14	1.683	0.095	

Results

285 patients were included (79.1% males; M age 35.97±10.59years). SI was reported in 57% of the patients. Several clinical factors were related to SI (see Table 1).

Conclusions

The prevalence of SI in ADHD patients with SUD is high and is related to several clinical factors. Those factors should be taken into account in daily clinical practice, research, and any health policies on suicide. Further research on this issue should be developed.

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Conflicts of interests

RFFA has received speaker honorariums from Angelini, Exeltis, Lundbeck, MSD, Mundipharma, Rubió, Servier, and Takeda. ERC has received speaker honorariums from Janssen-Cilag, Lundbeck, Otsuka, Pfizer, Lilly, Servier, Rovi, Juste. She has received financial compensation for projects with Lundbeck, Esteve, Pfizer, Rovi, Exeltis, Servier, and Eisai. She has received financial compensation for her participation as a board member of Janssen-Cilag. GOH has received speaker honorariums from Rubió, Lundbeck, Casen Recordati. CR has received fees to give lectures for Janssen-Cilag, Ferrer-Brainfarma, Pfizer, Indivior, Lundbeck, Otsuka, Servier, GSK, Rovi, Astra, Gilead, MSD, Sanofi and Exeltis. He has received financial compensation for his participation as a board member of Janssen-Cilag, Lundbeck, Gilead, MSD, Indivior and Mundipharma. He has carried out the PROTEUS project, which was funded by a grant from Reckitt-Benckiser/Indivior. He received a medical education grant for Gilead. JARQ has been on the speakers' bureau and/or acted as consultant for Janssen-Cilag, Novartis, Shire, Takeda, Bial, Shionogi, Sincrolab, Novartis, BMS, Medice, Rubió, Uriach and Raffó. LGL has received fees to give talks for Janssen-Cilag, Lundbeck, Servier, Otsuka, and Pfizer. The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Introduction

Clozapine presents a differential pharmacological profile with a weak affinity for D2 and D1 receptors and greater affinity for D4, 5-HT_{2A}, 5-HT_{2C}, 5-HT₆, and 5-HT₇ receptors. There is plenty of evidence about its superiority over other antipsychotics in addressing refractory symptoms, being the standard of efficacy in non-responders. It also improves aggressive behaviour, suicidal intent, and substance abuse. In recent years, its effectiveness on affective symptoms, both manic and depressive, has been demonstrated. Even so, there is little research that evaluates the effect of the drug on affective psychopathology. The aim of this work is to examine the antidepressant potency of the drug in a sample of patients with dual psychosis.

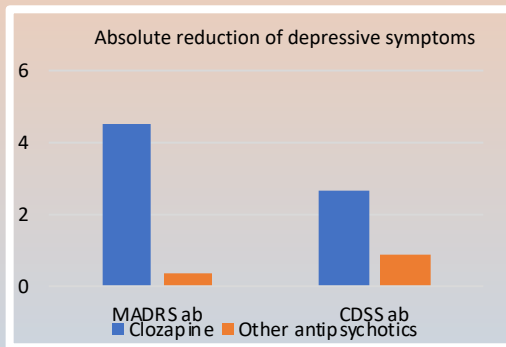
Methods

Longitudinal study, during a month of follow-up, of patients with **dual psychosis** (schizophrenia and schizoaffective disorder), recruited from hospital and outpatient samples. A population of 55 patients (75% men, 25% women) is included, with a mean age of 37.7 years. The most frequently consumed substances are cigarettes (80%), alcohol (63%), THC (55%) and cocaine (33%). Medication prescription, antipsychotic load (converted to chlorpromazine) and **depressive symptoms** (using the Montgomery Asberg Depression Rating Scale and the Calgary Depression Scale) were evaluated.

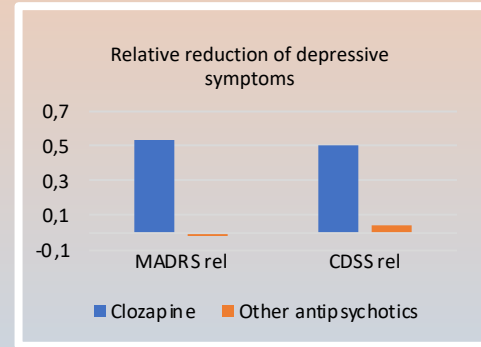
Results

Gender	Male: 42 (76.4%)	Female: 13 (23.6%)
Age average	37.49 years old (SD: 12.80)	
Diagnosis	Schizophrenia: 35 (63.6%)	Schizoaffective: 20 (36.4%)
Cigarettes (80%)	15.42 cigarettes (SD: 13.45)	
OH (63%)	5.40 UBE (SD: 8.17)	
THC (55%)	2.98 UPE (SD: 5.03)	
Cocaine (33%)	0.40 grams (SD: 0.92)	

Clozapine reduces the absolute (-4.52) and relative (-54.22%) punctuation of the MADRS, and the absolute (-2.65) and relative (-51.31%) punctuation of the CDSS, both with **statistical significance**, in comparison with other neuroleptics (t: 4.409, p: <0.001; t: 2.70, p: <0.005), including long-acting antipsychotics. It also makes it possible to reduce the total antipsychotic burden of patients (-297 mg, -16.9%), reducing and simplifying the drug regimen.



-296mg
Burden reduction
-16,9%



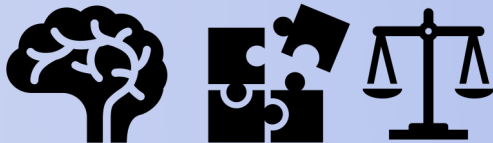
Conclusions

Our study shows the **antidepressant efficacy of clozapine**, compared to other antipsychotics, in a sample of patients with dual psychosis and during a month of follow-up. These findings could be a product of the receptor profile of the neuroleptic, with its special affinity for serotonergic receptors, and help explain its antisuicidal efficacy. Previous publications have evidenced the antisuicidal effect of clozapine, but there are few studies that explore its antidepressant effect in the psychotic population. The investigation demonstrates the antidepressant efficacy of the drug, in doses lower than 300 mg, with a faster action than traditional antidepressants. Our work constitutes a starting point to reinforce this hypothesis, as well as to broaden other applications of the drug, such as its effect as a mood stabilizer.

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I HAVE PSYCHOSIS BUT, WHAT ABOUT MY ADDICTION?



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INTRODUCTION

Dual disorders, or the co-occurrence of substance use and psychiatric disorders, are prevalent among individuals with psychotic disorders and can worsen the course of illness. Treatment often focuses solely on managing psychiatric symptoms, neglecting substance use issues. This highlights the need for integrated treatment approaches that address both conditions.

In this context, a comprehensive review of the literature is necessary to better understand the comorbidity of substance use disorder and psychotic disorder, its impact on the course of illness, and the available pharmacological treatments to optimize patient care.

OBJETIVES AND METHODS

The **methods** involved conducting a literature review and evaluating pharmacological treatments for dual disorders, including drugs targeting dopaminergic receptors.



Objetives:

1. Review comorbidity of substance use disorder and psychotic disorder.
2. Evaluate drugs for dual disorders targeting dopaminergic receptors.
3. Emphasize comprehensive treatment for dual disorders.

RESULTS

The results of the project include the finding that **addiction disorders are present in almost 40% of patients with a psychotic diagnosis** (figure 1).

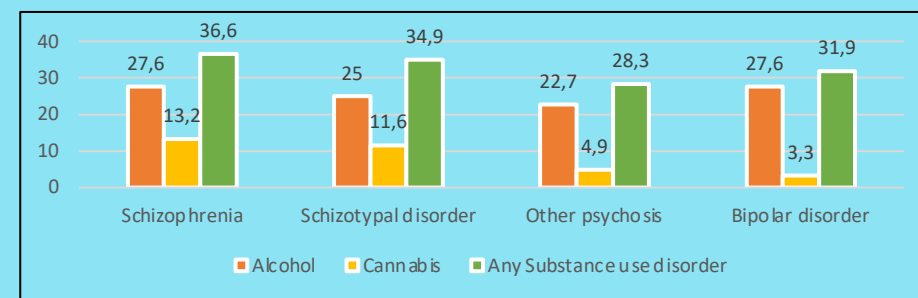


Figure 1. Percentage of substance use according to diagnosis, adapted from (2).

Additionally, the existence of a substance use disorder **worsens the course of the psychotic illness**, underscoring the importance of accurate diagnosis and comprehensive treatment for individuals with dual disorders.

The review of pharmacological treatments highlighted the potential benefits of drugs that target **dopaminergic receptors (D3 specifically)**, such as **cariprazine**, for improving both psychotic symptoms and substance use.

Finally, the project emphasized the need for integrated **treatment approaches that address both conditions**.

CONCLUSIONS

1. Dual disorders in psychosis are **highly prevalent** and **worsen** the course of illness.
2. Accurate **diagnosis** and comprehensive **treatment** of **both** psychotic symptoms and substance use are essential.
3. Drugs that target **dopaminergic receptors**, such as cariprazine, may offer benefits for individuals with dual disorders.
4. Integrated treatment approaches that address both conditions are needed to optimize outcomes for these patients.
5. New treatments that address both substance use and psychiatric symptoms are needed. **Partial agonists** like cariprazine show promise and should be further investigated.



Introduction

Between 20 and 33% of patients with schizophrenia are resistant to treatment. The most effective drug for this clinical profile is clozapine, an atypical antipsychotic with a weak affinity for D2 and D1 receptors and greater affinity for D4, 5-HT_{2A}, 5-HT_{2C}, 5-HT₆, and 5-HT₇ receptors, that showed its superiority over other antipsychotics in addressing psychotic and affective refractory symptoms while also improving aggressive behaviour, suicidal attempt, and substance abuse. However, the seriousness of the potential adverse effects and the lack of knowledge about their management mean that the drug is underused. The aim of this study is to investigate the efficacy and tolerability of clozapine in patients with resistant schizophrenia and schizoaffective disorder, evaluating and comparing the clinical response obtained.

Methods

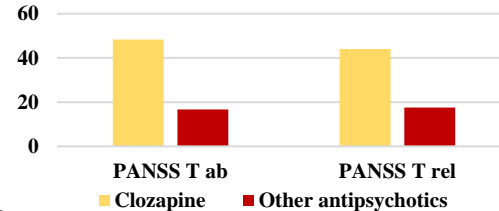
This is a longitudinal study with a sample of 55 patients with dual psychosis (Schizophrenia and Schizoaffective Disorder) recruited from hospital and outpatient samples of Castellón. We assessed medication prescription, antipsychotic load converted to chlorpromazine, positive and negative symptoms using Positive and Negative Syndrome Scale (PANSS) and pharmacological side effects using Udvalg für Kliniske Undersogelser (UKU) Scale.

Results

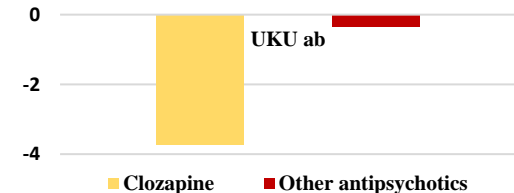
Gender	Male: 42 (76.4%)	Female: 13 (23.6%)
Age average	37.49 years old (SD: 12.80)	
Diagnosis	Schizophrenia: 35 (63.6%)	Schizoaffective: 20 (36.4%)
Cigarettes (80%)	15.42 cigarettes (SD: 13.45)	
OH (63%)	5.40 UBE (SD: 8.17)	
THC (55%)	2.98 UPE (SD: 5.03)	
Cocaine (33%)	0.40 grams (SD: 0.92)	

63.6% (n=35) of the sample had Treatment-Resistant Schizophrenia while 36.4% (n=20) had Schizoaffective Disorder. The most frequently consumed substances were tobacco (80% of the sample; n=44), alcohol (63%; n=33), cannabis (55%; n=30) and cocaine (33%; n=21). Within 1 month, **Clozapine reduced absolute (-48.32) and relative (-44.04%)** score of the **PANSS** with statistical significance in comparison with other neuroleptics. Furthermore, patients taking **Clozapine reported fewer side effects** than those taking other antipsychotics as they scored lower punctuation in **UKU Scale (-3.74)**.

Positive and negative symptom reduction



Side effect differences



Conclusions

Our study showed the benefits of treatment with clozapine, compared to other antipsychotics, in reducing positive and negative symptoms in a sample of patients with dual psychosis in one month, in addition to having better tolerability. These findings could be a product of the receptor profile of the antipsychotic. Same as in other studies, efficacy of clozapine was superior on overall and positive symptoms compared to other Second-Generation Antipsychotics (Mizuno et al., 2020) and on treatment-resistant negative symptoms compared to First-Generation Antipsychotics (Essali et al., 2009) while showing lower risk of all-cause discontinuation compared with other Second-Generation Antipsychotics (Masuda et al., 2019).

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SUBSTANCE USE TRENDS AND TREATMENT DEMANDS

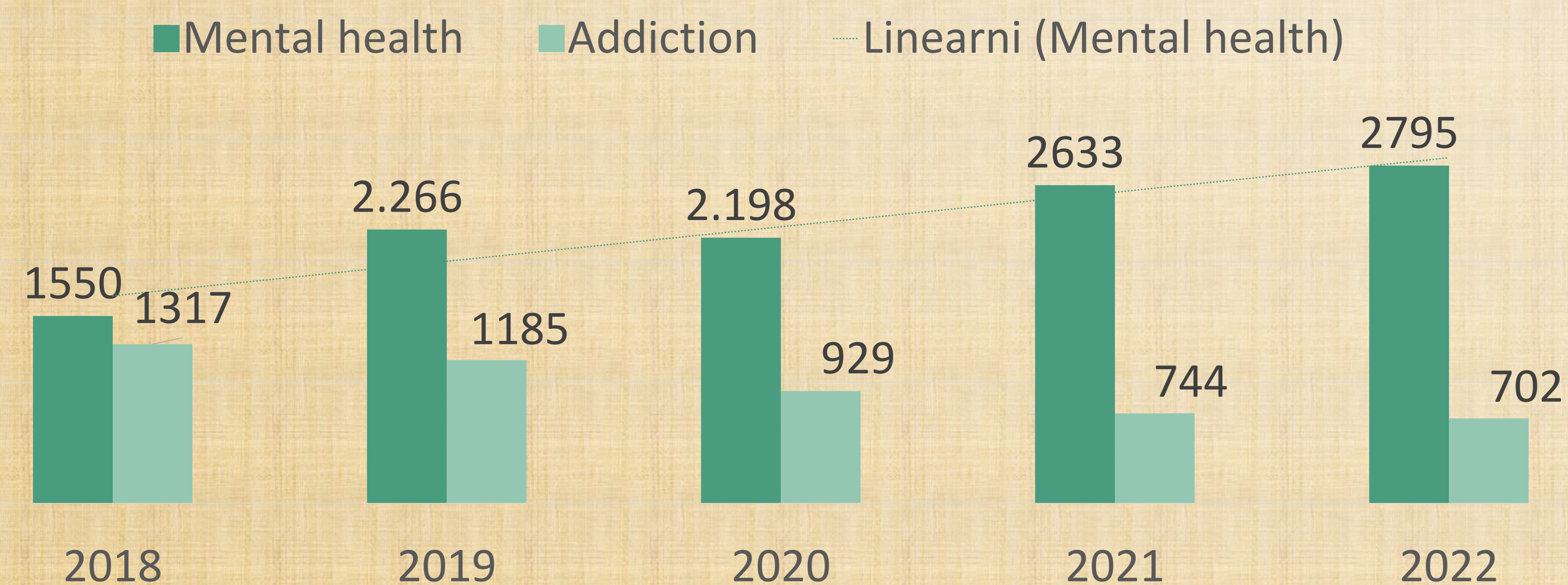
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INTRODUCTION: According to the recent data, drug consumption is at high levels throughout the European Union with increasing availability and use of stimulants. Study of wastewater in the city of Zagreb indicated a multiple increase in the consumption of cannabis, MDMA, amphetamines and cocaine, with an upward trend and high consumption in the last few years. Monitoring the dynamics of psychoactive substance use is essential for providing effective response in prevention and treatment programs.

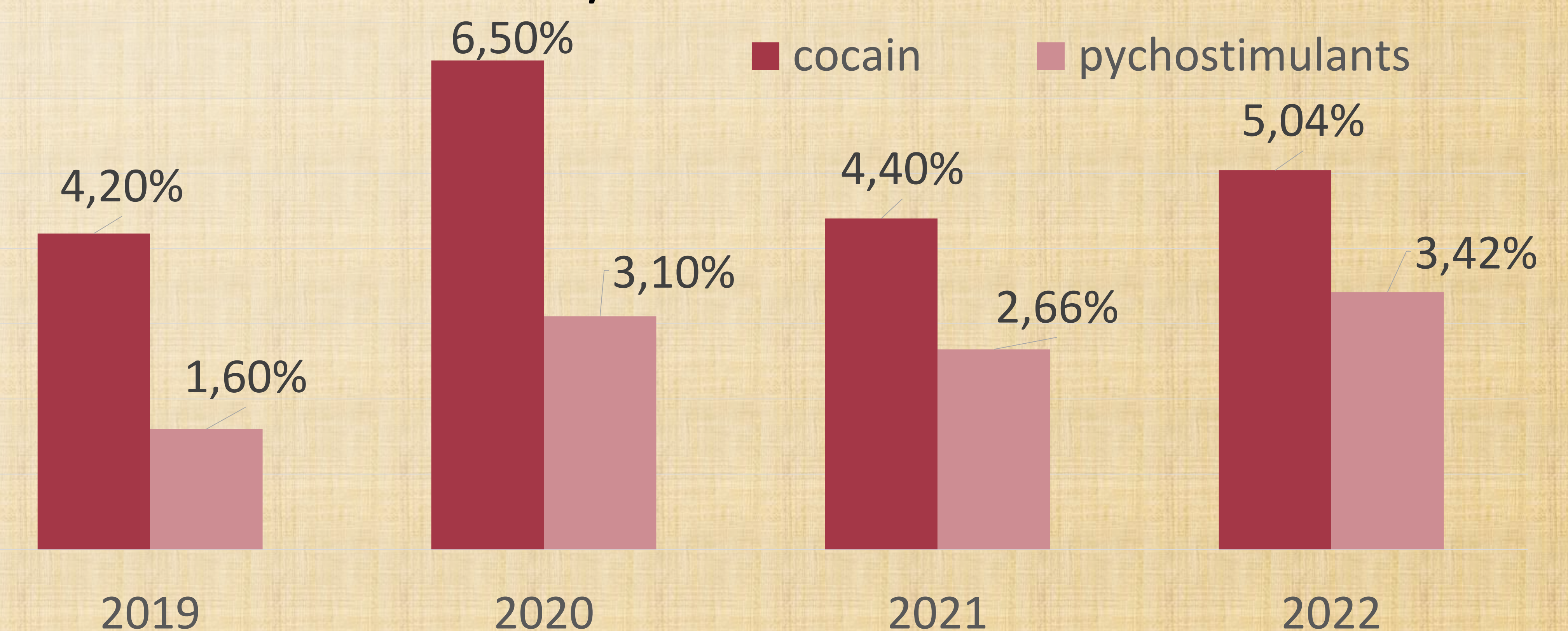
METHODS: Linear trend model analysis of treatment demands in outpatient care system in the Department of Mental Health and Addiction Prevention of the Andrija Štampar Teaching Institute of Public Health in the period from 2018 to 2022.

RESULTS: There is a continuously higher proportion of men in treatment for addiction and drug consumption, and the most represented are opiate addicts with a high prevalence of comorbidities. The second represented in the treatment are cannabinoid users with a continuous decrease in the total number and a decrease in referrals by institutions (they rarely seek help on their own initiative). A slight increase in psychostimulant users in treatment does not follow a pronounced trend of use in real time. There is an increase in demand for treatment due to mental health problems, where drug use is often an incidental finding, unrecognized from the persons in the treatment as a primary problem.

Graph 1. Treatment demands from 2018 to 2022 in the total sample



Graph 2. Trends of cocaine and psychostimulants use from 2019 to 2022 in the addiction sample



CONCLUSION: In order to reduce health risks and other serious drug related consequences it is important to analyze the trends of psychoactive substance use as it is dynamic process. Treatment programs should follow the trends of substance use and take care of comorbidities. For the problem of psychostimulants, new strategies are needed to bridge the gap between current trends and practice, so prevention and treatment activities should be strengthened.

Immigrants from Russian and outcome in methadone maintenance treatment

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Anat Sason, Miriam Adelson, Einat Peles



BACKGROUND

Methadone maintenance treatment (MMT) is the best treatment to most individuals with opioid use disorder. Success in treatment outcome is reflected by retention in treatment. Immigrants from the former Soviet Union are more prevalent among the substance disorder in comparison to their percentage in the general population of Israel.

AIMS

To compare the characteristics and outcome in MMT, between Russian immigrants, other immigrants, and Israeli born patients.

METHODS

Patients were prospectively followed up from first admission (between June 1993 - June 2022) until leaving or end of follow-up (December 2022). Sociodemographic and medical variables were taken from patients chart. Urine for drug abuse were tested routinely. Characteristics differences using chi square for categorical variables and ANOVA for continues variables were performed. Cumulative retention was analyzed using Kaplan Meier model.

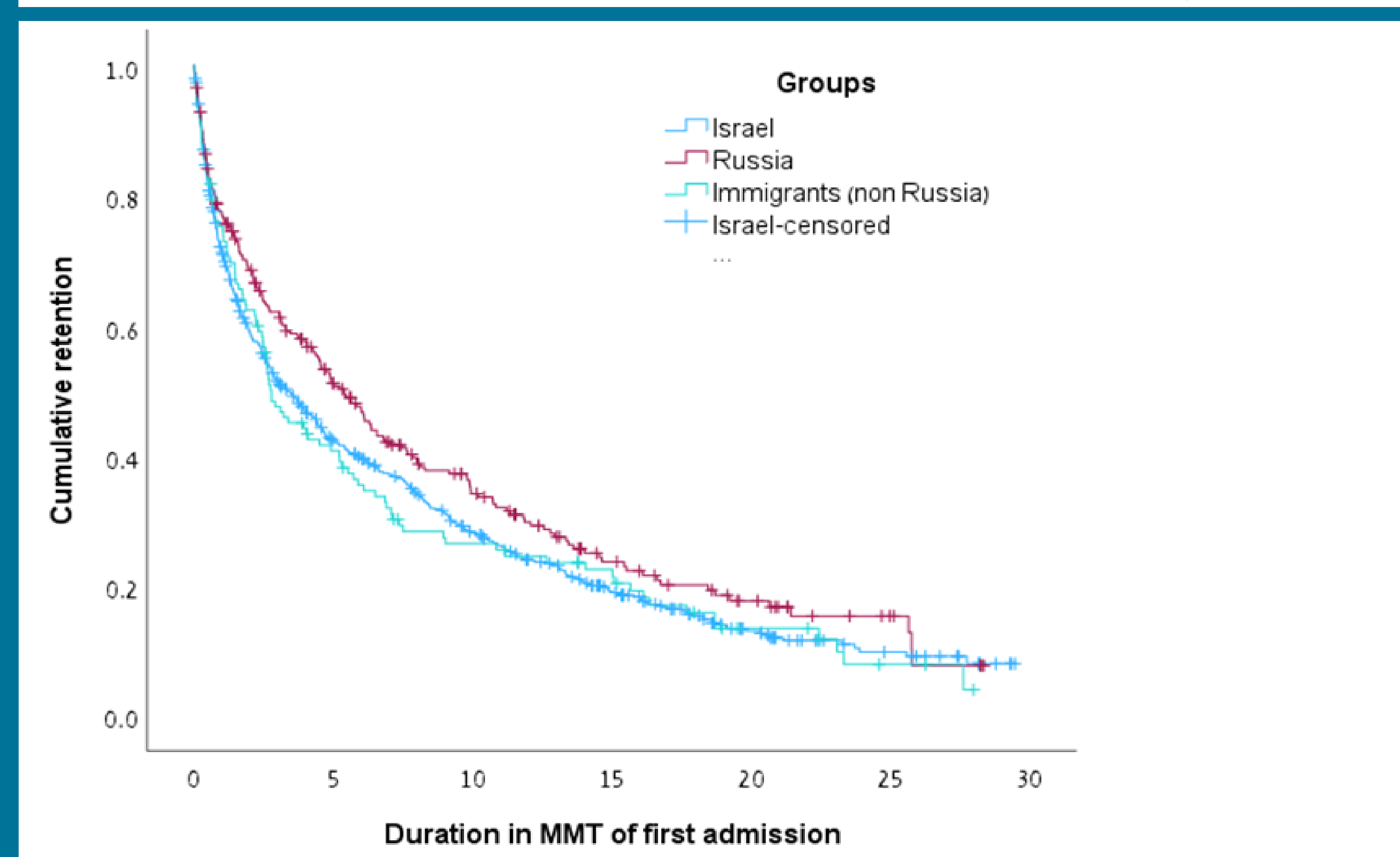
RESULTS

The Russian immigrants (N=266) were compared with non-Russian immigrant (N=121) and Israeli born (N=688). The Russian immigrants had more females (p=0.003). They were more educated (p<0.001), admitted treatment at younger age (p<0.001), started opioid usage at younger age (p=0.001), following a shorter duration of opioid usage (p<0.001). More of them ever injected drugs (p<0.001), ever drunk alcohol (p<0.001) that started at youngest age (p<0.001), and less abuse BDZ (p=0.02). One year retention did not significantly differ (77.2% vs. 75.6% and 72%, p=0.2) as did stop opioids in those who stayed (73% vs. 70% and 66.3%, p=0.2). Russian immigrants had longer cumulative retention 9.2y (95%CI 7.9-10.5) vs. 7.5y (95%CI 5.8-9.2) and 7.6y (95%CI 6.9-8.4, p(chi square 6.0)=0.05), but comparable overall retention (1st to latest admission; 10.2y (95%CI 9.4-11.0), 10.3y (95%CI 9-11.6) and 10.1y (95%CI 8.4-11.8) respectively.

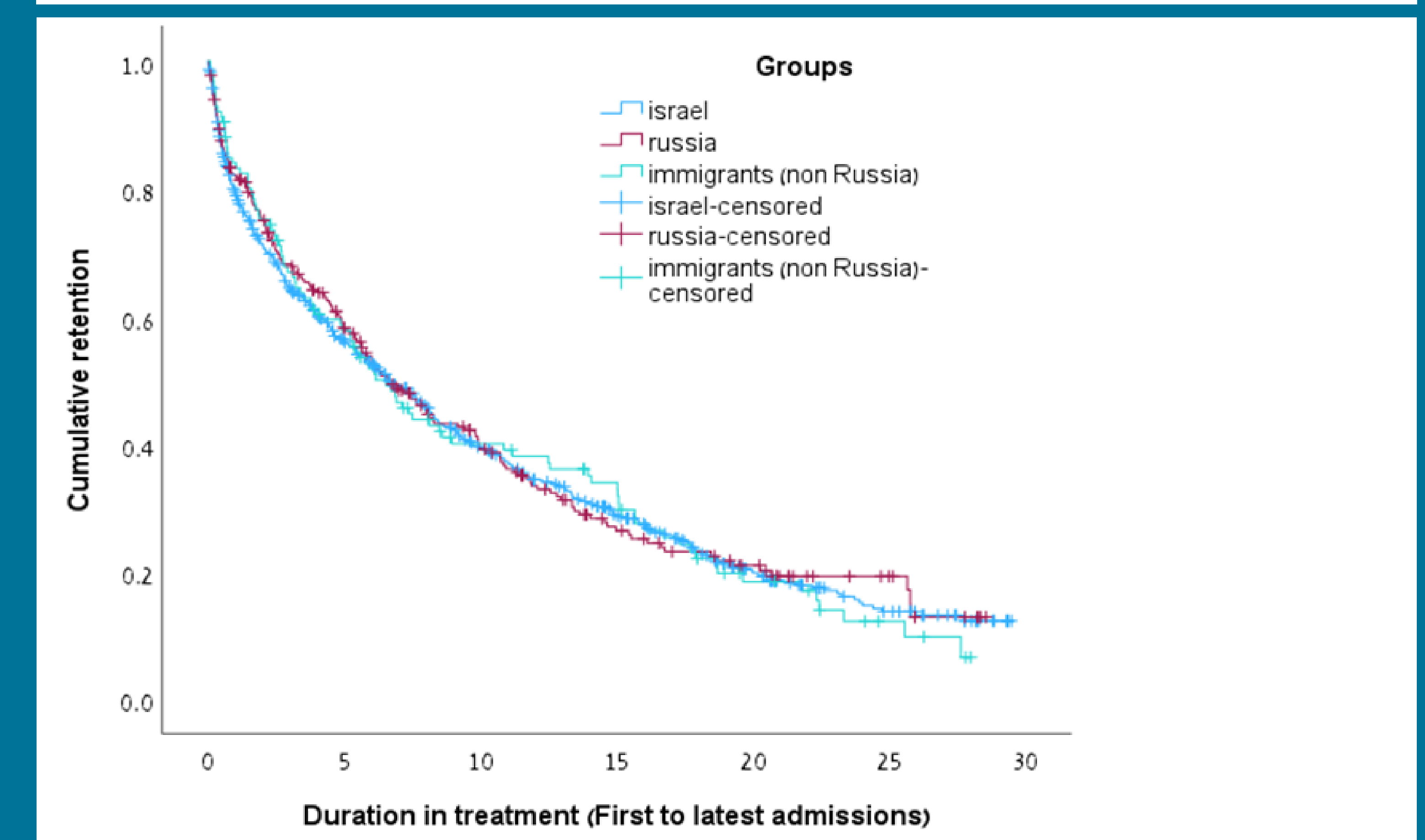
Comparison between Russian, other immigrants, and Israel-born patients

	Russian	Others	Israeli	P value
N	266	121	688	
Female %	29.3	14	22.8	0.003
Educated ≥12 y %	46.1	28	20.9	p<0.001
Admission Age y	35.7±9.2	44.1±11.1	42.3±10.1	p<0.001
Opioids onset < 21y %	61.6	41.7	57.6	p=0.001
Opioid usage ≥20 y %	27.1	48.3	51.7	p<0.001
Ever injected drugs %	86.2	52.5	50	p<0.001
Ever drunk alcohol %	79	67.7	58.1	p<0.001
Alcohol onset y	16±4.1	16.1±4.5	18.4±7	p<0.001
Never used BDZ %	9.6	1.6	5.5	p=0.02

Cumulative retention of 1st admission between groups



Cumulative retention until latest admission between groups



CONCLUSIONS

Russian immigrants showed a better adherence to MMT, reflected by their longer cumulative retention in their first admission, lower rate of readmissions, and a comparable overall retention in treatment. High education, psychological and cultural causes may be correlated with their success

EFFECT OF EARLY SOCIAL ISOLATION ON ALCOHOL-RELATED BEHAVIORS IN ALCOHOL-PREFERRING MSP AND NON-PREFERRING WISTAR RATS

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INTRODUCTION

Early stressful experiences represent a critical predictor of excessive alcohol consumption later in life. Maternal separation (MS) of rodent pups has been widely used to study the consequences of early life stress on the vulnerability to develop excessive drinking. However, the majority of prior studies have used severe MS protocols and at very early time points and stressors experienced by rodents during this developmental period do not properly mimic similar stressors experienced by humans at comparatively developmental stages. Here, we explored the long-term consequences of a novel protocol of social deprivation on later vulnerability to develop alcohol-related behaviors.

METHODS

Male and female Marchigan Sardinian alcohol preferring (msP) and Wistar rats were used. From postnatal day (PND)14 to PND21 half of the pups from each experimental group was socially isolated for 30 min a day. Control animals were left undisturbed in their home cage with their mothers and littermates. Operant responding for alcohol under fixed ratio 1 (FR1) and progressive ratio (PR) schedule of reinforcement were then determined at adolescence starting from PND35. The effect of the pharmacological stressor yohimbine in increasing alcohol self-administration (SA) as well as the vulnerability to relapse after stress exposure (yohimbine) were also evaluated.

RESULTS

1 EFFECT OF EARLY SOCIAL ISOLATION (ESI) ON ALCOHOL SELF-ADMINISTRATION

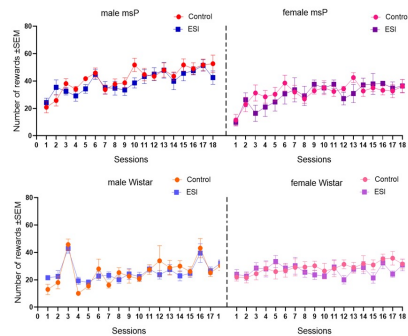


Figure 1. Effect of early social isolation on alcohol self-administration in male and female msP and Wistar rats. Acquisition pattern of alcohol SA in male and female msP and Wistar rats. In msP rats (upper panel) a three-way ANOVA revealed an overall effect of sessions [$F_{(17,486)} = 9.3$; $p < 0.0001$] and sex [$F_{(1,486)} = 78.5$; $p < 0.0001$], but no significant effect of ESI [$F_{(1,486)} = 3.5$; $p > 0.05$] and interactions. Similarly, a three-way ANOVA of self-administration data in male and female Wistar rats (lower panel) found a significant effect of sessions [$F_{(17,450)} = 5.2$; $p < 0.0001$] and sex [$F_{(1,450)} = 28.9$; $p < 0.0001$] and sessions x sex interactions [$F_{(17,450)} = 3.5$; $p < 0.0001$], but no significant effect of ESI [$F_{(1,450)} = 0.6$; $p > 0.05$] and other interactions. Data are presented as mean \pm SEM of number of rewards (0.1 ml 10% ethanol) gained by animals. Where not indicated differences from controls were not statistically significant.

2 EFFECT OF EARLY SOCIAL ISOLATION (ESI) ON ALCOHOL SELF-ADMINISTRATION ON A PROGRESSIVE RATIO SCHEDULE OF REINFORCEMENT

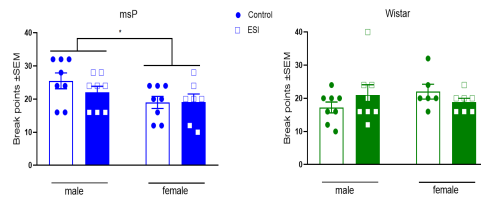


Figure 2. Effect of early-social isolation on alcohol self-administration on a progressive ratio schedule of reinforcement in male and female msP and Wistar rats. In male and female msP rats a two-way ANOVA showed a main effect of sex [$F_{(1,27)} = 4.9$; $p < 0.05$], but no significant effect of ESI [$F_{(1,27)} = 0.6$; $p > 0.05$] and sex x ESI interaction [$F_{(1,27)} = 0.7$; $p > 0.05$] (left panel). In male and female Wistar rats ANOVA revealed no significant effects of sex [$F_{(1,25)} = 0.3$; $p > 0.05$], ESI [$F_{(1,25)} = 0.02$; $p > 0.05$] and sex x ESI interaction [$F_{(1,25)} = 2.4$; $p > 0.05$] (right panel). Data are presented as mean \pm SEM of number of a) reinforced responses (rewards) at the active lever and b) responses at the inactive lever. Main effect of sex: * $p < 0.05$. Where not indicated differences from controls were not statistically significant.

3 EFFECT OF EARLY SOCIAL ISOLATION (ESI) ON ALCOHOL SELF-ADMINISTRATION FOLLOWING YOHIMBINE ADMINISTRATION

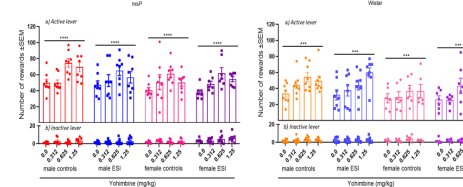


Figure 3. Effect of early social isolation on alcohol self-administration following yohimbine administration in male and female msP and Wistar rats. In msP rats, a three-way ANOVA revealed an overall effect of treatment [$F_{(3,108)} = 11.02$; $p < 0.0001$], sex [$F_{(1,108)} = 7.2$; $p < 0.01$], but no significant effect of ESI [$F_{(1,108)} = 0.9$; $p > 0.05$] and no interactions (a, upper panel). ANOVA applied to inactive lever responding showed a significant effect of sex [$F_{(1,108)} = 7.7$; $p < 0.01$] and sex x ESI interaction [$F_{(1,108)} = 6.2$; $p < 0.05$], but no effect of treatment [$F_{(3,108)} = 2$; $p > 0.05$], ESI [$F_{(1,108)} = 3.8$; $p > 0.05$] and other interactions (b, lower panel). Similar to msPs, in Wistar rats the three-way ANOVA showed a significant effect of treatment [$F_{(3,100)} = 6.9$; $p < 0.001$], sex [$F_{(1,100)} = 12.3$; $p < 0.001$], but no significant effect of ESI [$F_{(1,100)} = 0.002$; $p > 0.05$] and no interactions (a, upper panel). ANOVA applied to inactive lever responding showed no significant effect of treatment [$F_{(3,100)} = 2.2$; $p > 0.05$], sex [$F_{(1,100)} = 0.01$; $p > 0.05$] and ESI [$F_{(1,100)} = 0.07$; $p < 0.05$] and no significant interactions (b, lower panel). Data are expressed as the mean \pm SEM of number of a) reinforced responses (rewards) at the active lever and b) responses at the inactive lever. Main effect of yohimbine treatment: *** $p < 0.001$, **** $p < 0.0001$. Where not indicated differences from controls were not statistically significant.

4 EFFECT OF EARLY SOCIAL ISOLATION (ESI) ON YOHIMBINE-INDUCED REINSTATEMENT OF ALCOHOL SEEKING

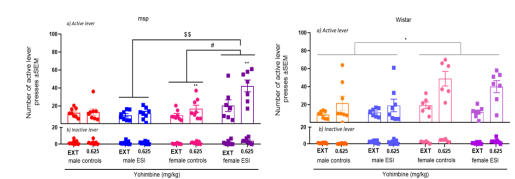


Figure 4. Effect of early social isolation on yohimbine-induced reinstatement of alcohol seeking in male and female msP and Wistar rats. Extinction (EXT): mean number of lever presses during the last 3 days of extinction (EXT). In male and female msP rats a three-way ANOVA revealed a significant treatment x sex interaction [$F_{(1,27)} = 11.9$; $p < 0.01$], treatment x ESI [$F_{(1,27)} = 4.4$; $p < 0.05$], sex x ESI [$F_{(1,27)} = 9.6$; $p < 0.01$], but lack of the treatment x sex x ESI interaction [$F_{(1,27)} = 3.06$; $p > 0.05$] (a, upper panel). Inactive lever responding was unaffected and ANOVA revealed no effect of treatment [$F_{(1,27)} = 2.2$; $p > 0.05$], sex [$F_{(1,27)} = 0.2$; $p > 0.05$] or ESI [$F_{(1,27)} = 2.3$; $p > 0.05$] and no interactions (b, lower panel). In Wistars, ANOVA revealed an overall effect of treatment [$F_{(1,25)} = 29.5$; $p < 0.0001$], sex [$F_{(1,25)} = 12.3$; $p < 0.01$], but no significant effect of ESI [$F_{(1,25)} = 0.9$; $p > 0.05$]. Overall ANOVA also revealed a significant treatment x sex interaction [$F_{(1,27)} = 6.9$; $p < 0.05$], but no significant treatment x ESI [$F_{(1,25)} = 0.2$; $p > 0.05$], sex x ESI [$F_{(1,25)} = 0.9$; $p > 0.05$] and treatment x sex x ESI interactions [$F_{(1,25)} = 0.07$; $p > 0.05$] (a, upper panel). Inactive lever presses were negligible and not significantly affected by yohimbine treatment [$F_{(1,25)} = 4.01$; $p > 0.05$], sex [$F_{(1,25)} = 6.7$; $p < 0.05$], ESI [$F_{(1,25)} = 0.3$; $p > 0.05$], treatment x sex [$F_{(1,25)} = 14.3$; $p < 0.001$], treatment x ESI [$F_{(1,25)} = 0.003$; $p > 0.05$], sex x ESI [$F_{(1,25)} = 7.7$; $p < 0.01$], treatment x sex x ESI [$F_{(1,25)} = 0.008$; $p > 0.05$] (b, lower panel). Data are expressed as mean \pm SEM of a) total responses at the active; b) inactive levers. Main effect of sex x treatment interaction: * $p < 0.05$, ** $p < 0.01$; main effect of treatment x ESI interaction: # $p < 0.01$; main effect of sex x ESI interaction \$\$\$ $p < 0.01$. Where not indicated differences from controls were not statistically significant.

CONCLUSIONS

Overall, results indicate that repeated mild social deprivations experienced during the third week of postnatal life did not affect later susceptibility to increase the motivation for alcohol and that, independently from ESI exposure, administration of yohimbine increased alcohol self-administration in male and female msP and Wistar rats. Females showed increased sensitivity to a stress challenge which is selectively increased by ESI in female msPs, a rodent strain with an innate anxiety-like phenotype and high stress-sensitivity.

RISPERIDONE IN TREATMENT METHADONE MAINTENANCE PATIENTS WITH DUAL DIAGNOSIS

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INTRODUCTION

Dual diagnosis (DD) is traditionally defined as the co-occurrence of a Substance Use Disorder (SUD) and a Severe Mental Illness (1,2). Some researchers reported that dual diagnosis such as schizophrenia are quite represented in methadone maintenance patients (MMT). So larger number of studies focused on use atypical antipsychotic (AAP) such as clozapine, olanzapine, risperidone and quetiapine in treatment of dual diagnosis in MMT found that AAP were be effective in treating both psychiatric symptoms and substance use(3,4). The AIM of this study is to determinate the efficacy of risperidone therapy in MMT with dual diagnosis

MATERIALS AND METHODS

The prospective studies was evaluated 15 male methadone maintenance patients with dual diagnosis (F11.22 and F20-ICD 10) treated in Day Hospital of drugs addiction department of Psychiatric Hospital Skopje. The patients were evaluated before treatment and after one month of treatment with risperidone mean dosage $\pm 2\text{mgr/day}$ and mean daily doses of methadone $\pm 80\text{mgr}$. All the patients was written informed consent. The patients were assess using the sociodemographic information by semi structured questionnaires' specially designed for the Study. The sociodemographic data was: age, marital status, education status and employment. Urinary test for determination of psychoactive substances. The psychiatric function-positive symptoms of schizophrenia was assess by PANSS Scale. This scale contains 7 items (delirium, disorganization, hallucinations, agitation, megalomania, frenzy, hostility) which are rated from 1 (absence of symptom) to 7 (extremely present). The maximum score on this scale is 49. The results of this study were determinate by descriptive methods and t-test for independent simplex

RESULTS

In our study we got not statistical significance results of the sociodemographic data between treatment and after one month treatment with risperidone in MMT. (Table 1) Table 1. Socio-demographic characteristics of patients between examination groups

Parameter	Group 1 (N=15)	Group 2 (N=15)	t-test	P level
Employment Y/N(%)	32,0/68,0	33,0/67,0	1,19	0,08
Marital status M/S(%)	33,9/66,1	34,3/65,7	2,15	0,07
Education (years)	11,1 \pm 2,72	12,11 \pm 2,19	1,14	0,05

Recidivism of heroin and benzodiazepine use was higher in methadone maintenance patients before treatment with risperidone but without statistical significance (table 2).

Table 2. Distribution of use psychoactive substances.

Parameter	Group 1 (N=15)	Group 2 (N=15)	t-test	P level
Use benzodiazepine Y/N (%)	63,0/37,0	32,0/68,0	2,26	0,02
Recidivism of heroine Y/N (%)	59,0/41,0	35,0/65,0	1,44	0,05

The results in our study show that use of methadone therapy and risperidone diminished score of psychiatric symptoms with statistically significance ($p=0,03$) Table 3 Table.3 score of positive symptoms –PANSS scale in MMT patients

Score of positive symptoms – PANSS scale	Mean \pm SD	T-test	P level
MMT patients before treatment with risperidone	45,0 \pm 25,17	1,96	0,03
MMT patients after one month of	25,98 \pm 4,02		

DISCUSSION

Our study show that the treatment with atypical antipsychotic risperidone in MMT patients with dual diagnoses reducing the use of psychoactive substance and positive symptoms of schizophrenia. This results correlate with several case reports, case series, open studies and controlled studies who have evaluated the efficacy of risperidone in treating patients with DD (4,5,6). Also one Spanish group after conducted a 6-month follow-up study with a sample of 180 psychotic patients with opioid abuse or dependence, reported that use of risperidone (0.5-12mg/day) improved disability, psychotic symptoms and tolerability of these patients (7). Two-month therapy with risperidone (8mg/day) was also found to be effective in reducing cocaine craving and cocaine use, as well as psychiatric symptoms, after switching from TAP in SCH patients with comorbid cocaine dependence (4). But, some studies report that risperidone had less effect on positive psychotic symptoms than another atypical antipsychotic such as clozapine (2,3)

CONCLUSIONS

The treatment with atypical antipsychotic risperidone in MMT patients with dual diagnoses it has been found to be effective in treating psychotic symptoms as well as in reduction of the use of psychoactive substance, probably due to their mechanism of action, which includes less dopamine DA antagonism and pharmacological action on serotonin (5HT), histamine (HIS), and norepinephrine (NE) pathways So in this way it increases treatment adherence.

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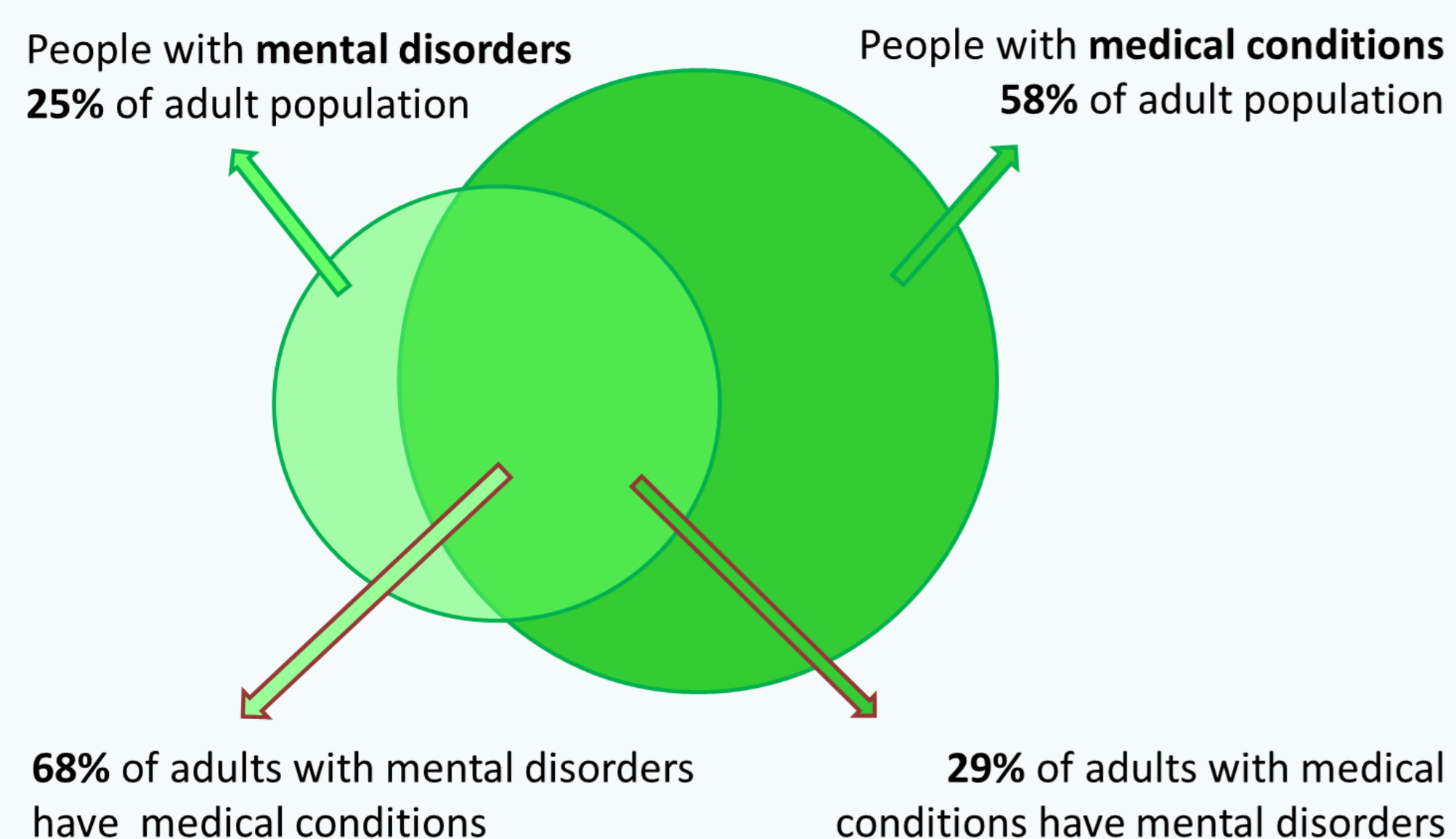
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INTRODUCTION

Comorbidity between mental and medical illnesses is the rule rather than the exception. It is estimated that 25% of the adult population suffers from a mental illness, and 68% of them have a comorbid medical condition. In this context, physical comorbidity can have a significant impact on readmission rates for psychiatric patients.

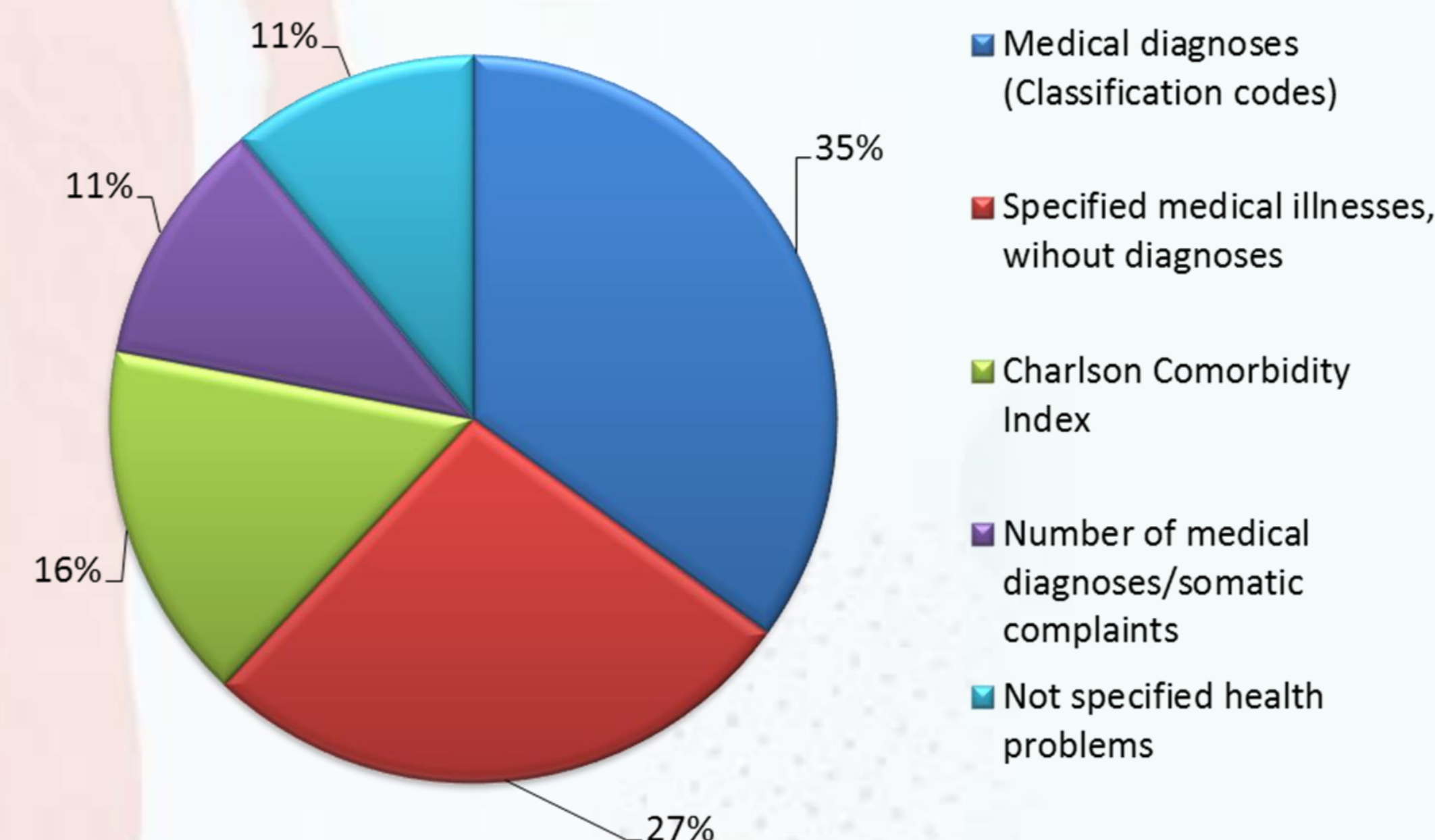
The main objective of this study was to review and describe the impact of physical comorbidity variables on readmission after discharge from inpatient psychiatric or general health in-patient care with a psychiatric diagnosis.



Comorbidity between mental health and medical conditions
(adapted from the National Comorbidity Survey Replication, 2001–2003)

RESULTS

Although psychiatric readmission has been studied in different clinical settings and for different diagnostic groups of mental disorders, most studies listed the presence of concomitant physical illness as an exclusion criterion. Physical comorbidity was most frequently examined in studies that addressed substance use disorders. Physical comorbidity was assessed at the discharge level in only 11 of the studies examined, and 17 studies also examined it as a covariate that may influence readmission. The Charlson Comorbidity Score, number of medical diagnoses, diabetes, and cardiovascular disease were most frequently cited as variables that might be associated with an increased likelihood of hospital readmission. Not all studies in our review showed a similar trend! Comorbidity with medical conditions may also reduce the readmission risk of psychiatric patients (protective effect of medical comorbidity). Conversely, exposure to certain mental disorders does not necessarily increase medical readmission.



Comorbid physical variables have been documented in a variety of forms.

METHODS

A comprehensive database search was conducted on the following bibliographic databases, which included papers published from January 1990 to June 2014: Ovid Medline, PsycINFO, ProQuest Health Management, OpenGrey, and Google Scholar. All relevant publications were included and evaluated by two independent reviewers. Of the 49 publications identified, only 28 studies met the inclusion criteria (ie, included information or data on physical comorbidity) and were subsequently considered for comprehensive review.

DISCUSSION / CONCLUSION

The pathways leading to comorbidity of mental and physical disorders are complex and often bidirectional. The course of comorbid mental and physical disorders can interact to worsen mental and/or physical status, leading to hospital readmission. There is a large body of evidence that people with persistent mental health problems are more likely to also develop physical problems than the general population. Conversely, poor physical health can have a negative impact on mental health. In conducting this review, several gaps in the literature on mental health and medical comorbidity became apparent, indicating an inconsistent understanding of the concept of comorbidity. In this regard, further high-quality research is needed to understand the associations between physical comorbidities and psychiatric readmissions, as the pathways leading to comorbidity of mental health and medical disorders remain poorly understood.



How to define and measure the concept of comorbidity?



Šprah L, Dernovšek MZ, Wahlbeck K, Haaramo P.
Psychiatric readmissions and their association with physical comorbidity: a systematic literature review.

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