

Traditional and Biomedical Approaches to Screening, Assessment, Diagnosis and Treatment of Co-occurring Disorders

Sponsored By Indian Health Services and UNM Center for
Rural and Community Behavioral Health

Based on material from:

New Mexico Native American
Co-Occurring Disorders Workgroup

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What do we mean by traditional?

In this presentation, we use the word traditional to mean ...

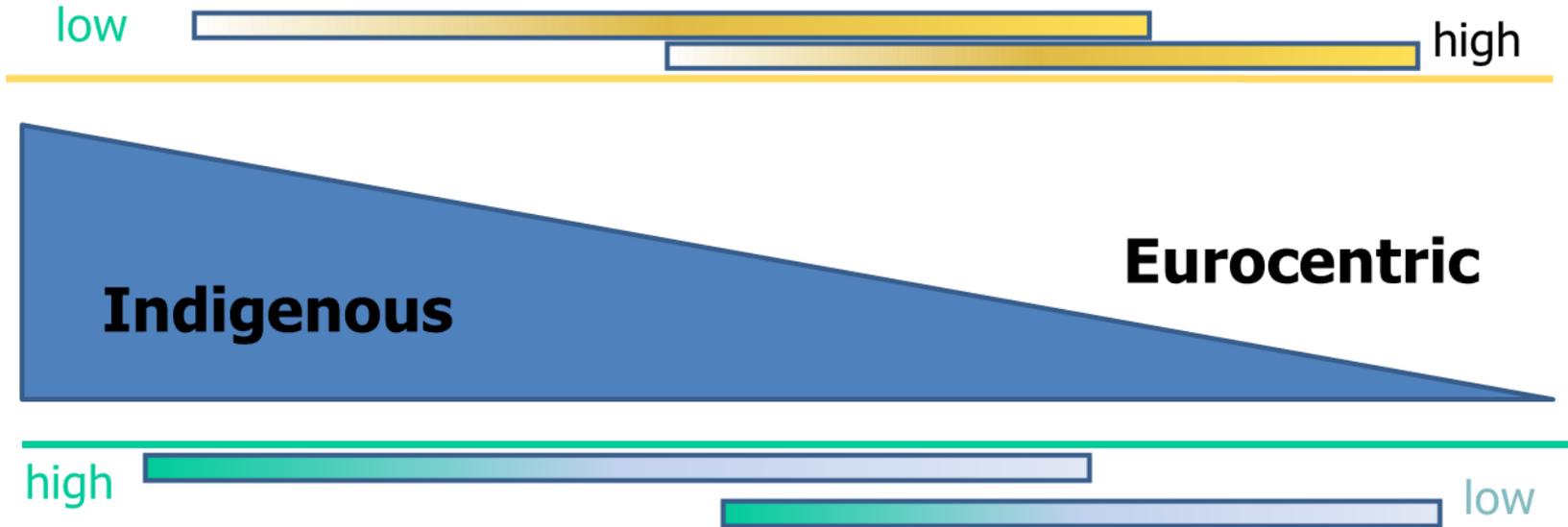
- Indigenous knowledge- Spans the globe
- Perspective of Southwest United States and Native American population- Many tribal perspectives are unique
- American Indian practices- Traditional healing; Ceremonials; Herbs and other Interventions
- Generalities and human nature

What do we mean by Western?

- Medical model
- Biomedical model
- Eurocentric
- Other suggestions?

Acculturation

Low Indigenous acculturation & High Eurocentric acculturation



**High Indigenous acculturation &
Low Eurocentric acculturation**

Acculturation Cont.

- 60% of American Indians are living in urban settings (US Census, 2010)
- However, many individuals travel back and forth between cities, reservations and communities
- Acculturation is not dichotomous
- Regional & Generational differences can influence acculturation

Note the Generational Differences



LIFE, 1943



SFIS, 2012

Culturally Competent Care

Includes:

- **A basic knowledge of local culture & practices-** Customs, greetings, eye contact, taboos, religious & spiritual, health issues, etc.
- **Understanding the local impact of Historical Trauma-** What is the history of the community? Any major events happen lately in the community?
- **Information on the Socio ecological environment-** Health care system, economic environment, family structures, tribal government, community norms, etc.
- **Genuine human presence and compassion!-** Can break through any racial or communication barrier.

Traps in cultural competence:

- Treating culture as static
- Conflating culture with race and ethnicity
- Not acknowledging diversity within groups
- Inadvertently placing blame on a patient's culture
- Emphasizing cultural differences and thereby obscuring structural power imbalances
- Failure to recognize biomedicine as a cultural system

- Carpenter-Song, Schwallie & Longhofer, 2007

Mental Disorders/Mental Illness Definition

- Mental disorders/illness: Health conditions that cause changes in thinking, mood, or behavior (or some combination thereof) which results in distress and/or impaired functioning.

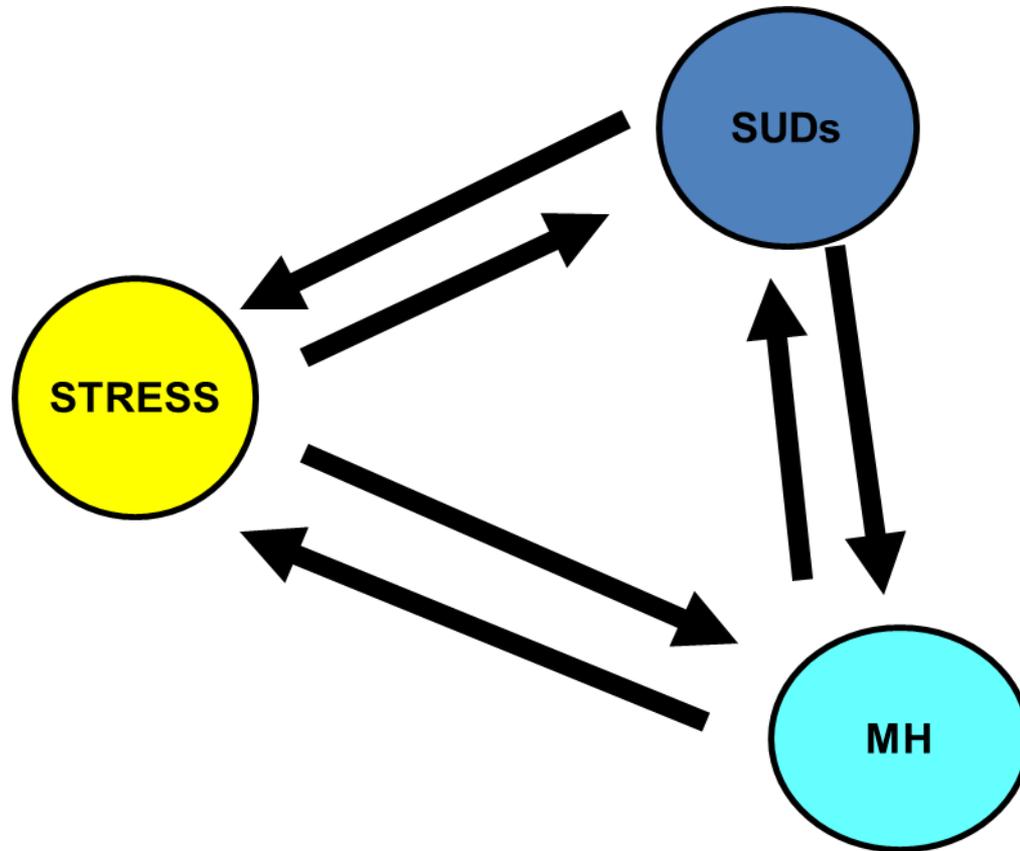
Substance Use Disorder Definition

- A person who experiences negative consequences due to substance use is said to have a substance use disorder.
- This term includes abuse and/or dependence on one or more drugs or alcohol.

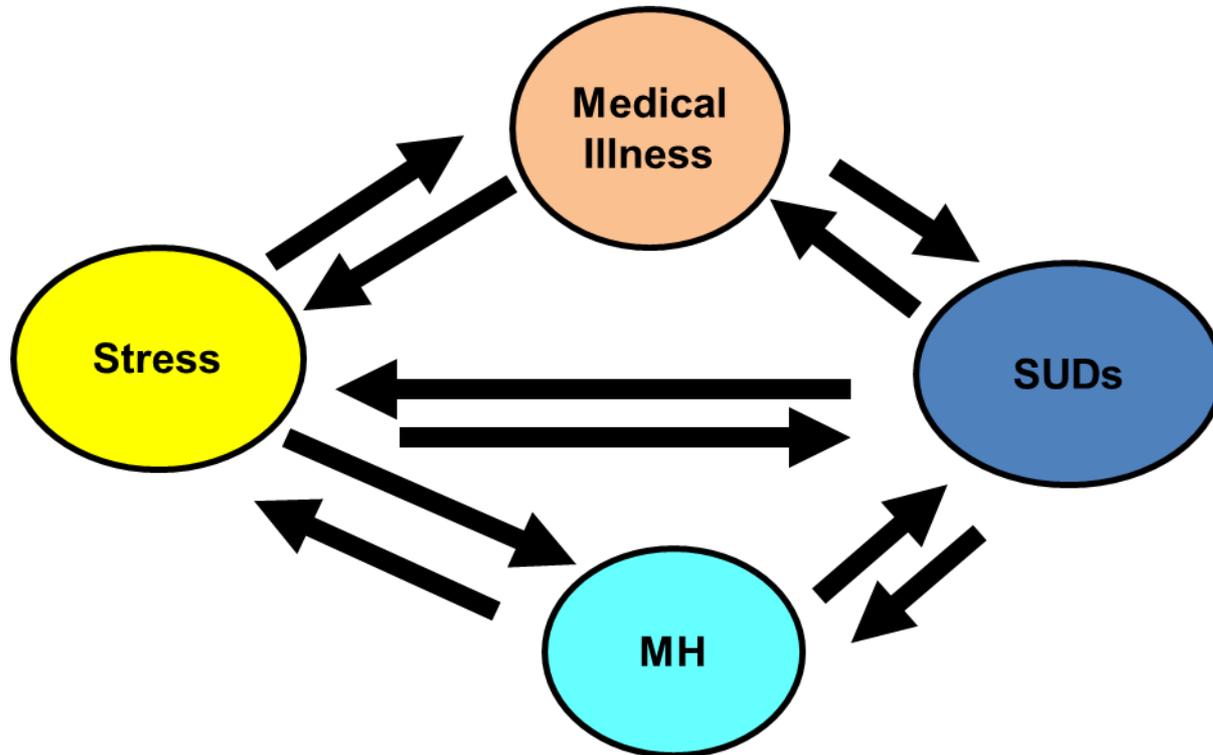
Co-Occurring Disorders

- The presence of both a mental health disorder and a substance use disorder.
- Also called dually diagnosed – but, often more than two disorders.
- Approximately 8.9 million adults in U.S. have co-occurring disorders
- However, only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all

Sometimes they may set up a vicious cycles that worsen all conditions



There may be more than just one problem of any type on board and additional complex interactions, as in this example.



Co-occurring Disorder

low



high

low

high

III
High, Low
High Addiction
Low Mental Illness

IV
High, High
High Addiction
High Mental Illness

I
Low, Low
Low Addiction
Low Mental Illness

II
Low, high
Low Addiction
High Mental Illness

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Myth: Co-Occurring Disorders are rare

- 50-75% of clients in substance abuse programs had some type of COD.
 - Most common are anxiety, depression, and trauma.
- 53% of adults with lifetime alcohol abuse/dependence had one or more lifetime mental disorders.
- 59% of adults with lifetime drug abuse/dependence had a lifetime mental illness.

Definitions

- Engagement: a process of developing a relationship and building trust and acceptance between client/relative and clinician.
- Screening: a process used to determine whether or not a client MAY have a particular disorder and therefore needs a more in-depth assessment.
- Assessment: an in-depth process that results in description and diagnoses of the clients' disorders.
- Diagnosis: Classification of a psychiatric or substance use disorder per DSM-IV criteria.

American Indian and Alaska Native Communities Mental Health Facts

- In 1999 Native Americans made up less than 1% of the U.S. population, yet they accounted for 2.4% of all admissions to publicly funded substance abuse treatment facilities.
- Just under half of Native Americans have job-based health coverage compared to 72% of whites.

Source: National Association for Mental Illness (NAMI)

American Indian and Alaska Native Communities Mental Health Facts

- Very few large-scale epidemiological studies of American Indian and Alaska Natives have been published. (Manson, et al)
- If given the option, Traditional healing would be the method of choice by a majority of Native Americans. (Bird, 2006)
- Native Americans rate their healer's advice 61.4% higher than their physician's advice.

Source: National Association for Mental Illness (NAMI)

Importance of engagement

- Most clients in NM's state BH public system have an average of ONE visit per year to a treatment provider.
- Genuine interest and curiosity can transcend culture and overcome barriers
- Recognition that many, if not most people, are ambivalent about seeking help

Engagement

pertains to all providers and agency staff

Traditional Worldview

- Verbal greeting
- Shake client's hand (optional)
- Welcome client/relative into your agency, as you would your home
- Talk about family members
- Less formal

Western Worldview

- Brief Introduction
- Data Gathering
- Rapport Building
- More Formal
- Emphasis on boundaries
- New emphasis on training admin staff to be welcoming

Traditional Worldview of Engagement

- Creating a comfortable home-like environment.
- Offering client/relative coffee or water.
- Shaking hands, physical contact, hug? Take their lead.
- Ask about feast days, celebrations, gatherings or upcoming community events
- Take time to see community members at their best

Patient Quote

“ I waited until the doctor finally looked up from the clip board before I responded to her question. When she finally looked at me, I said, “Well hello,” and then proceeded to answer her question.”



Other Innovative Western Approaches to Engagement

- **Recovery and Resiliency Philosophy-** Build on strengths, positive aspects to a community/ individual
- **Cultural Competency-** **local knowledge very important!** Can't be competent in all tribes. Each is unique.
- **Trauma Informed System of Care-** Health system works within the knowledge and framework of client exposure to trauma and the resulting barriers that it poses (e.g. distrust, help seeking, response).

“Recovery and Resiliency” Philosophy

- Person-centered model (vs. disease-centered model) that nurtures personal empowerment and supports personal choice.
- Strength-based approach.
- Respect for and sensitivity to different cultural backgrounds.
- Individualized treatment planning.
- Shared decision making.
- Peers as providers, educators, trainers, and evaluators.

Culturally Competent Treatment

- Being aware that therapeutic approaches do not take place in a vacuum, but must include the spiritual, historical, social and cultural contexts of clients, clinicians, and provider organizations.
- Culturally competent care requires understanding of the dynamics of difference (racism and discrimination) and is a constant learning process.
- Take into consideration's client's spiritual aspect of life.
- Consider including extended family members into treatment process.
- Stance of cultural humility rather than expertise

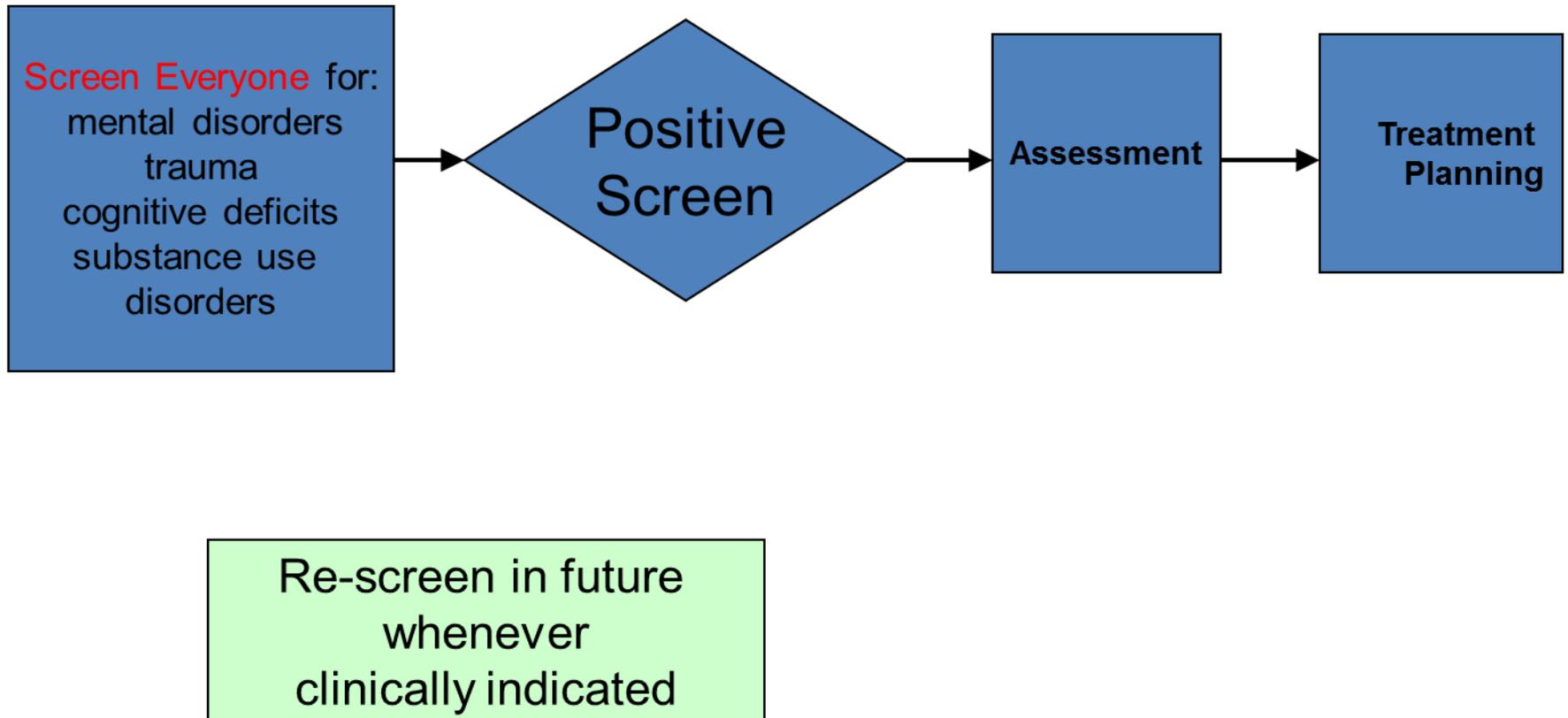
Trauma-Informed System of Care

- Training and education for all staff on how trauma affects their clients/relatives.
- Hiring practices that encourage recruitment of staff with an understanding of trauma.
- Universal screening for trauma.
- Services are provided in a manner that is welcoming and appropriate to the special needs of trauma survivors.
- Recognition that healthcare systems can perpetuate trauma and contribute to ambivalence around help seeking

Screening

- Renewed emphasis on screening with Affordable Care Act
- U.S. Preventive Services Task Force recommends Screening for depression recommended ages 12 and up **when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up**
- Screening programs for substance abuse, (e.g. SBIRT) associated with improved physical health, improved mental health, decreased costs, and decreased substance

“Western” Process of Identification of Disorder(s)



Mental Health Screening Instruments

- Many screens available in the public domain
 - Some require special training
 - Brief/easy to use/no training required are:
 - PHQ-9
 - BDI
 - Screens for substance use disorders include:
 - DAST, AUDIT, CRAFFT
 - Addiction Severity Index (ASI)
- Native American ASI screen available at:
http://www.tresearch.org/resources/instruments/ASI_NAV.pdf

Adaptations to screening instruments

- Most national screening instruments are not normed for Native American populations
- Efforts to validate instruments in regional Native American communities may not always generalize to all tribes
- Consideration of language and relevance to community
 - e.g. PRIME screen for psychosis

Example of locally modified questionnaire

- Original question asked clients to rate whether “My psychiatric symptoms are under control.”
- After consultation with community, question modified to include *“Examples of psychiatric symptoms could be feeling dark or sad, withdrawn or anxious, confused thinking, having the same thoughts over and over and feeling out of balance”*

Important considerations when screening

- Local capacity to provide assessments for positive screens
- When implementing screening, need to have a process for follow up.
- Need for resources to address unmet need identified through screening

Implementing screening

- Debriefing interview for negative screens
- Clinical assessment for positive screens
 - Includes risk assessment and access to emergency care in the case of acute suicidality
 - Also includes holistic assessment of strengths, supports, and resources

Debriefing for negative screens

- 5-10 minute interview
- Conducted by a member of the screening staff
- Provides participants with an opportunity to answer questions
- Allows participants to ask for help with other concerns
- Can reduce stigma

Clinical assessment for positive screens

- 20-30 minute interview with a qualified mental health professional
- Review results of the screen and explore the indicated problem area(s) further
- Assess level of impairment resulting from symptoms endorsed on the screening questionnaire
- Assess for acute safety concerns
- Also assess for strengths and supports
- Decide if referral for a complete evaluation is appropriate
- Does not represent a clinical diagnosis

If positive screen, move to assessment

- What level is your patient at in understanding medications?
 - Education level, dosage levels, options,
- Are they using traditional healing or other practices?
 - Prayer, meditation, massage, how will this interact with Tx
- What is their individual view of the process?
 - Internal or external control
 - for or against medications
 - cultural beliefs about medication

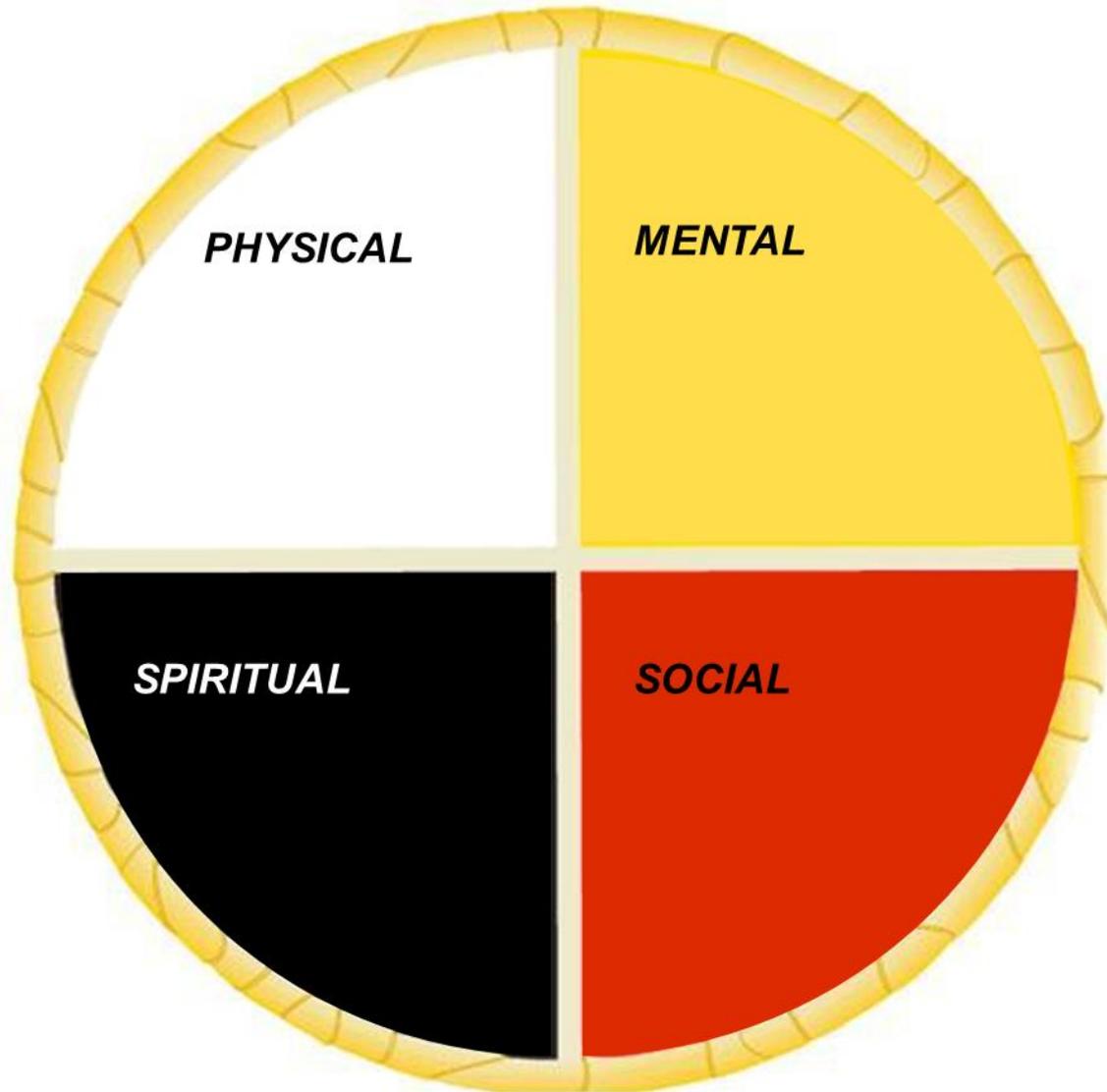
Assess for Strengths & Supports

- Client/relative's talents and interests.
- Existing supportive relationships (peer or family).
- Exploration of what worked in client's past treatment.
- Identification of current successes.
- Involvement in traditional practices or doings.
- Assess for language barriers, problems with literacy.
- Assess for medical, legal, vocational and social aspects of life.

Biopsychosocial model of assessment

- Formulated by Engels in 1976
- Use of biopsychosocial model is encouraged by U.S. medical schools to emphasize holistic approach to individuals
- HOWEVER....

What about the spiritual?



Protective factors associated with religiousness and spirituality

- May protect against disease indirectly by association with healthy lifestyles
- Group members can provide social supports
- Individuals who report having a strong religious faith report being happier and more satisfied with their lives
- Positive religious coping can affect physiological responses (Fetzer, 1999)
- Religiosity and decreased risk of substance use disorders (Edlund et al, 2010)

Understanding beliefs around spirituality is an important component of suicide assessment

- Belief in afterlife
- Taboos related to suicide
- Finding comfort and strength in spirituality and prayer in times of distress
- Or, experiencing feelings of guilt related to religious tenets
- Having access to a supportive network
- Most studies show lower rates of suicide among more religious people (Koenig, 2001), however, many conflicting results depending on definitions of religiosity or spirituality used

Suicidality

- Not a disorder, but a behavior.
 - Can occur due with multiple diagnoses
- Highly associated with co-occurring mental health and substance use disorders
- Recognize and treat early.

Clinical assessment of risk factors for suicidality

- Presence of specific plans, esp. lethal plans
- Previous attempts, esp. within last year
- Recent hospitalizations (medical or psychiatric)
- Family history of suicide attempts
- Access to lethal means
- Presence of anxiety
- Alcohol or drug use
- Age
- Gender
- Psychiatric diagnosis
- New diagnosis of chronic health condition

What to do:

- Assess for suicidal thoughts or plans.
- Treat all suicide threats with seriousness. Develop a safety plan with the client
- Remove the means to attempt suicide (e.g., a gun).
- Avoid sole reliance on “suicide contracts.”

What to do (continued):

- Provide availability of contact for 24 hours per day until psychiatric referral is made.
 - What is your agency's after hours protocol?
- Refer clients with a serious plan, previous attempt, or serious mental illness for psychiatric intervention.
- Know your own skills and limitations in engaging, screening, assessing, and intervening with suicidal clients.
- Work out these issues *before* an emergency.

Protective Factors

“AI/AN youth had higher thresholds of risk before making a suicide attempt. Protective factors buffered the impact of risk, particularly for higher risk youth.” Mackin, Perkins, & Furrer, (2012).

More protective factors...

- Social support- peers, family, community, leaders
- Life skills and coping skills
- Traditional culture and involvement in ceremony
- Having good mental health

Next...

- Diagnosis of co-occurring disorders including discussion of DSM cultural formulation
- Treatment of co-occurring disorders

With thanks to the members of the New Mexico Native American

Co-Occurring Disorders Workgroup:

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