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

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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

I
Low, Low
Low Addiction
Low Mental Illness

II
Low, high
Low Addiction
High Mental Illness

III
High, Low
High Addiction
Low Mental Illness

IV
High, High
High Addiction
High Mental Illness
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 clipboard 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)

Screen Everyone for:
mental disorders
trauma
cognitive deficits
substance use disorders

Positive Screen

Assessment

Treatment Planning

Re-screen in future whenever clinically indicated
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.
"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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