

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

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Behavioral Health

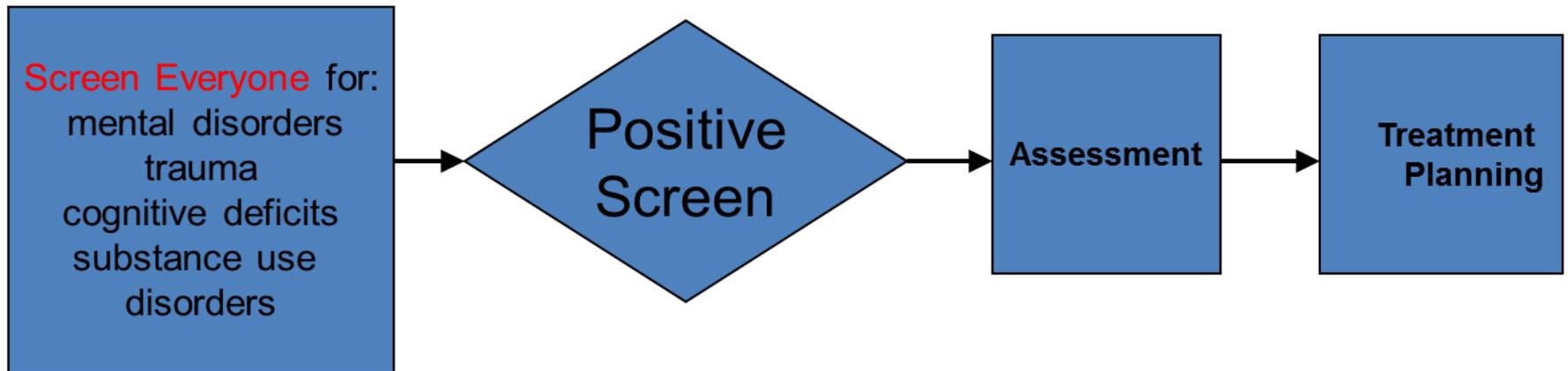
Based on material from:
New Mexico Native American
Co-Occurring Disorders Workgroup

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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)



Re-screen in future
whenever
clinically indicated

Mental Health Screening Instruments

- Many screens available in the public domain
- Some require special training
- Screens for depression include:
 - PHQ-9 and PHQ-TM
 - CES-D, Zung SDS, Geriatric Depression Scale
- Screens for substance use disorders include:
 - DAST, MAST, AUDIT, CRAFFT, ASSIST, CAGE, CAGE-AID
 - Addiction Severity Index (ASI) – more of an assessment

Adaptation vs. Validation

- Few instruments have been adapted for Native American populations
 - One example is the ASI available at:
http://www.tresearch.org/resources/instruments/ASI_NAV.pdf
- Validity and Reliability of some screens have been assessed in Native American populations
 - CRAFFT (Cummins et al., 2003)
 - AUDIT and CAGE-AID (Leonardson et al., 2005)

Addiction Severity Index 5th Edition

http://www.tresearch.org/resources/instruments/ASI_5th_Ed.pdf

FAMILY/SOCIAL RELATIONSHIPS

F1 Marital Status

1 - Married 4 - Separated
2 - Remarried 5 - Divorced
3 - Widowed 6 - Never Married

F2 How long have you been in this marital status? YRS. MOS.
(If never married, since age 18).

F3 Are you satisfied with this situation?

0 - No
1 - Indifferent
2 - Yes

*** F4** Usual living arrangements (past 3 yr.)

1 - With sexual partner and children
2 - With sexual partner alone
3 - With children alone
4 - With parents
5 - With family
6 - With friends
7 - Alone
8 - Controlled environment
9 - No stable arrangements

F5 How long have you lived in these arrangements. YRS. MOS.
(If with parents or family, since age 18).

F6 Are you satisfied with these living arrangements?

0 - No
1 - Indifferent
2 - Yes

Do you live with anyone who:
0 = No 1 = Yes

F7 Has a current alcohol problem?

F8 Uses non-prescribed drugs?

F9 With whom do you spend most of your free time:
1 - Family 3 - Alone
2 - Friends

F10 Are you satisfied with spending your free time this way?
0 - No 1 - Indifferent 2 - Yes

F11 How many close friends do you have?

Direction for F12-F26: Place "0" in relative category where the answer is clearly **no** for all relatives in the category; "1" where the answer is clearly **yes** for **any** relative within the category; "X" where the answer is **uncertain** or "I don't know" and "N" where there **never was a relative from that category**.

Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

F12 Mother

F13 Father

F14 Brothers/Sisters

F15 Sexual Partner/Spouse

F16 Children

F17 Friends

Have you had significant periods in which you have experienced serious problems getting along with:

0 - No 1 - Yes

F18 Mother

F19 Father

F20 Brothers/Sisters

F21 Sexual partner/spouse

F22 Children

F23 Other significant family

F24 Close friends

F25 Neighbors

F26 Co-Workers

Did any of these people (F18-F26) abuse you: 0 = No, 1 = Yes

F27 Emotionally (make you feel bad through harsh words)?

F28 Physically (cause you physical harm)?

F29 Sexually (force sexual advances or sexual acts)?

How many days in the past 30 have you had serious conflicts:

F30 with your family?

F31 with other people? (excluding family)

FOR QUESTIONS F32-F35 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

F32 Family problems

F33 Social problems

How important to you now is treatment or counseling for these:

F34 Family problems

F35 Social problems

INTERVIEWER SEVERITY RATING

F36 How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

F37 Patient's misrepresentation? 0 - No 1 - Yes

F38 Patient's inability to understand? 0 - No 1 - Yes

Comments

ASI-NAV Cont.

Differences from ASI

- **Asks for Tribe, Enrolled?, religious/spiritual preference** (Added native American Spiritual Practices), currently practicing?
- **After TX environment-** supportive of recovery? offers community services? Accessibility to self-help meetings?
- **Living on Reservations-** years lived on rez? Satisfied living on rez?
- **Have YOU ever abused anyone?** ASI only asks if they have been abused emotionally, physically, sexually.

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

Structured Assessments

- Some public domain structured assessments available
- Longer than screens and generally require administration by clinician
- Examples include:
 - CIWA-AR
 - MINI
 - BPRS

Assessments

- 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

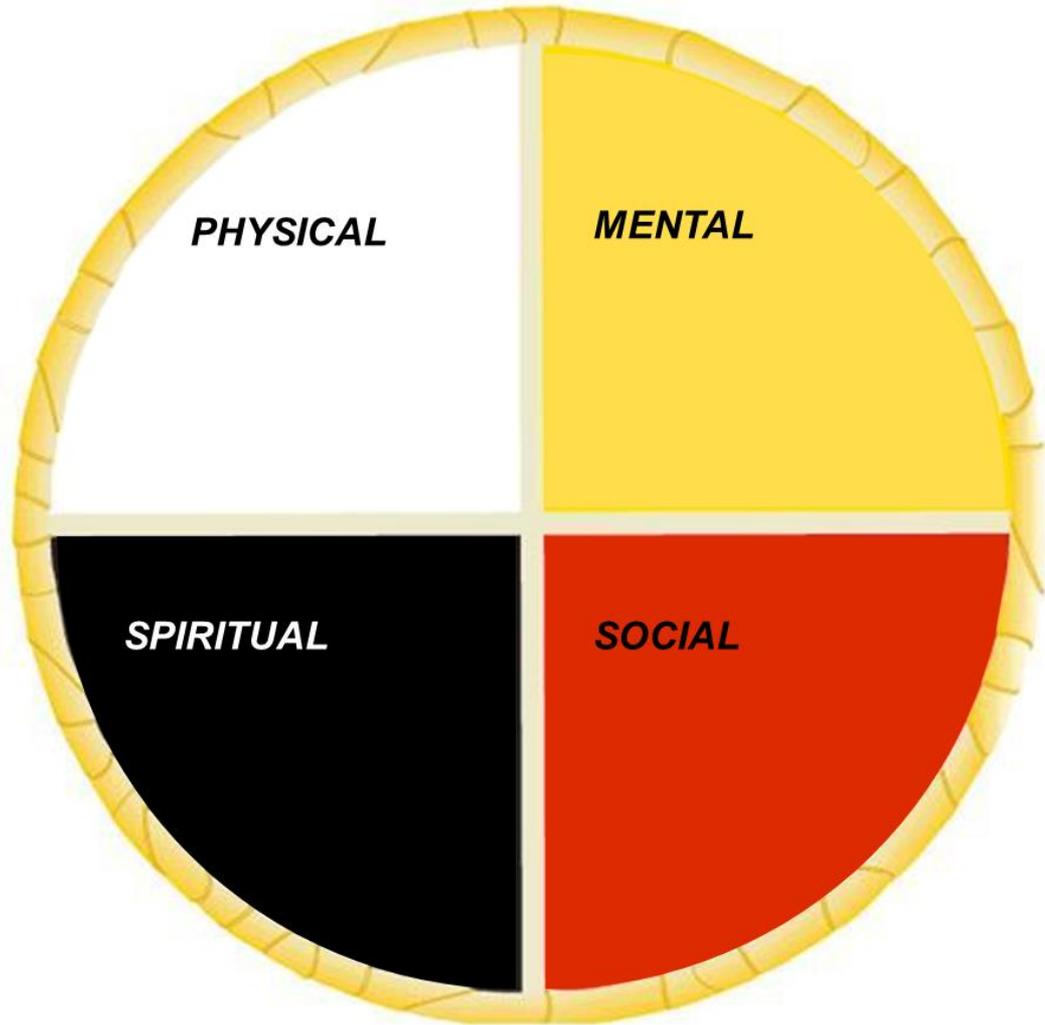
Assess for Strengths & Supports

- 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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