Diagnosis and Treatment of Co-occurring disorders

Caroline Bonham MD and Doreen Bird MPH
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Substance Use Disorders and Mental Illness are Common

National Study on Drug Use and Health, 2010
Individuals with diagnosed mental illness more likely to use illicit substances

National Study on Drug Use and Health, 2010
Substance abuse is associated with severity of mental illness.
Suicide attempts are strongly associated with substance use disorders

National Study on Drug Use and Health, 2010
## Four Quadrant Model

<table>
<thead>
<tr>
<th></th>
<th>Mental Disorder mild</th>
<th>Mental Disorder severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse mild</td>
<td>I: both mild</td>
<td>II: SA mild, MD severe</td>
</tr>
<tr>
<td>Substance abuse severe</td>
<td>III: severe SA, mild MD</td>
<td>IV: both severe</td>
</tr>
</tbody>
</table>
Less than 8% of individuals with COD receive both mental health care and substance use treatment.

National Study on Drug Use and Health, 2010
DIAGNOSIS OF CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS
Introduction to DSM-IV, TR

• Diagnostic and Statistical Manual, version 4
• Purely descriptive
• Does not consider causation
• Based on expert opinion, data re-analyses and field trials
• Goal: Shared, precise language
• Important for treatment planning, billing, and defining outcomes for prevalence studies and clinical trials
• Goal: Shared, precise language
DSM IV, TR Cultural Formulation includes five elements:

• Cultural identity of the individual
• Cultural explanations of the individual's illness
• Cultural factors related to psychosocial environment and levels of functioning
• Cultural elements of the relationship between the individual and the clinician
• Overall cultural assessment for diagnosis and care
Cultural identity of the individual

– Individual’s ethnic or cultural reference groups (likely to include multiple)

– Degree of involvement with culture

– Language abilities, use, and preferences
Cultural explanations of the individual's illness:

- Predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune)
- Meaning and perceived severity of symptoms in relation to norms of the cultural reference group
- Any local illness category used by the individual's family and community to identify the condition
- Perceived causes or explanatory models used to explain the illness, and current preferences for and past experiences with professional and popular sources of care.
Cultural factors related to psychosocial environment and levels of functioning.

- Culturally relevant interpretations of social stressors
- Available social supports, and levels of functioning and disability
- Includes stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support
Cultural elements of the relationship between the individual and the clinician

• Awareness of differences in culture and social status between the individual and the clinician

• Awareness of problems that these differences may cause in diagnosis and treatment, e.g.
  – communicating in the individual's first language
  – eliciting symptoms or understanding their cultural significance
  – negotiating an appropriate relationship or level of intimacy
  – determining whether a behavior is normative or causing problems
DSM IV, TR Cultural Formulation

• Overall cultural assessment for diagnosis and care

• The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.
Criteria for Substance Abuse

• One of the following within 12 months, due to use of a substance
• **W** – recurrent failure to perform at **Work** and other role responsibilities
• **I** – use despite **Impairment** (recurrent problems)
• **L** – Use despite **Legal** consequences
• **D** – Use in **Dangerous** situations
• Never met criteria for dependence
Criteria for Substance Dependence

• 3 or more of the following in 12 months due to substances

A – Important Activities given up (work/social)

D - Dependence/Tolerance

D - Dependence/Withdrawal

I – Continued use despite Impairment

C – Unsuccessful attempts to Cut down use

T – Considerable Time (obtaining, using, recovering)

D – Duration: using more or longer than intended
Mental Health Conditions

• Mood Disorders
  – Major Depressive Disorder
  – Bipolar Affective Disorder
• Anxiety Disorders
  – GAD
  – Panic Disorder
  – PTSD
• Dementia
• Substance induced

• Psychotic Disorders
  – Schizophrenia
  – Schizoaffective Disorder
• Personality Disorders
  – Antisocial PD
  – Borderline PD
• ADHD
• Mental Retardation
• Traumatic Brain Injury
Common Mental Symptoms

• Depressed Mood
• Anxiety
• Poor concentration
• Cognitive difficulties
• Poor interpersonal skills
• Psychosis
• Homicidal ideation/action

• Disorganized thinking
• Impulsivity
• Anger
• Suicidal ideation/action
• Self-injurious behaviors
• Self-neglect
**Principle #1: Diagnosis is established more by history than by current symptom presentation.**

- **Step 1:** review established diagnosis and/or ongoing treatment for an established disorder.
  - If diagnosis and/or treatment recommendations are unclear, get collateral info.
  - If history of a mental disorder diagnosis at admission to substance abuse treatment, presume diagnosis is valid for initial treatment planning, and any existing stabilizing treatment should be maintained.
  - Client's history can provide insight into patterns that may emerge in addition to established diagnosis.
Principle #2: Document prior diagnoses and gather information related to current diagnoses

- Multiple diagnoses are common and confusing.
- Connect symptoms to key time periods in the client's life that are helpful in the diagnostic process—
  - before the onset of a substance use disorder
  - during periods of abstinence (or during periods of very limited use)
  - after the onset of the substance use disorder and persist for more than 30 days
- Determine whether mental symptoms occur only when the client is using substances actively
Clarifying time frame

• For diagnostic purposes, it is almost always necessary to tie mental symptoms to specific periods of time in the client's history, in particular those times when active substance use disorder was not present

• Define with the client specific time periods where substance use disorder was in remission

• Then, get detailed information about mental symptoms, diagnoses, impairments, and treatments during those periods of time
Suicidality

• Not a disorder, but a behavior
  – Can occur due to multiple diagnoses

• Associated with COD, both mental (esp. depression) and substance use (impaired judgement, impulsivity)

• Recognize and treat early

• Not all self-injury is with suicidal intent
  – But still very dangerous
Suicidal Thoughts are Common

- 8.7 Million Adults Had Serious Thoughts of Committing Suicide
- 2.5 Million Made Suicide Plans
- 1.0 Million Made Plans and Attempted Suicide
- 1.1 Million Attempted Suicide
- 0.1 Million Made No Plans and Attempted Suicide

National Study on Drug Use and Health, 2010
Substance use and Suicide

• As many as 70 percent of adolescents who died by suicide had alcohol or substance abuse problems Miller et al. *Journal of addictive diseases*. 1991; 10 (3): 49–61

• In a review of suicides across 16 states, alcohol was involved 1/3 of the time Karch et al. *MMWR Surveill Summ.* 2011;60(SS10):1-49.
INTEGRATED DUAL DISORDER TREATMENT (IDDT) FOR CO-OCCURRING DISORDERS – AN EVIDENCE BASED PRACTICE
Individuals with co-occurring mental health and substance use disorders are more likely to have:

• Medical hospitalizations  (Daratha et al, 2012)
• Psychiatric admissions  (Blow et al, 2008)
• Arrest and incarceration  (Abram and Teplin, 1991)
• Homelessness  (Drake et al, 1991)
• Violence  (Cuffel et al., 1994)
• Infectious diseases  (Cournos et al., 1991)
• Family problems  (Dixon et al., 1995)
Integrated Treatment for Co-occurring Disorders Decreases:

- Mental health symptoms (Barrowclough, 2001)
- Hospitalizations (Mangrum et al, 2006)
- Arrests (Mangrum et al, 2006)
- Utilization of high-cost services (Kofoed et al, 1986)
- Duplication of services
Integrated Treatment for Co-occurring Disorders Increases:

- Continuity of care (Hellerstein and Meehan, 1987)
- Patient rated quality of life (Morrens et al., 2011)
- Stable housing (Drake et al., 1997)
- Days of abstinence (Ritcher, 2002)
IDDT: Integrated Dual Disorder Treatment
13 components of fidelity for best outcomes

1. Multidisciplinary Team
2. Stage-Wise Interventions (stages of change, stages of treatment)
3. Access to Comprehensive Services
4. Time-Unlimited Services
5. Assertive Outreach
6. Motivational Interventions
7. Substance Abuse Counseling
8. Group Treatment
9. Family Psychoeducation
10. Participation in Alcohol & Drug Self-Help Groups
11. Pharmacological Treatment
12. Interventions to Promote Health
13. Secondary Interventions for Treatment of Non-Responders
1. Multidisciplinary Team

- Team leader
- Nurse
- Case manager
- Employment specialist
- Substance abuse specialist
- Housing specialist
- Counselor
- Criminal justice specialist
- Physician/psychiatrist

Meet regularly to discuss progress across all domains and to provide insights and advice to one another.
2. Stage-wise Interventions

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Stage of IDDT Treatment</th>
<th>Clinical Focus</th>
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<tbody>
<tr>
<td>Pre-Contemplation</td>
<td>Engagement</td>
<td>Build working alliance; provide practical support for daily living; assess continuously</td>
</tr>
<tr>
<td>Contemplation and Preparation</td>
<td>Encouragement</td>
<td>Help develop motivation to reduce substance use and to engage in treatment</td>
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Stage-wise Interventions con’t.

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<td>Action</td>
<td>Active Treatment</td>
<td>Help client acquire skills and supports for managing symptoms of both disorders and for pursuing goals</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Relapse Prevention</td>
<td>Help develop and use strategies for maintaining abstinence and recovery</td>
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3. Unlimited Services

- Individuals with co-occurring disorders may experience cycles of relapse and recovery throughout their lives.
- Increased quality of life is associated with improved access to services.
- Avoid discharging individuals from treatment if they stop taking medications or continue using substances – these setbacks are common in cycles of relapse and recovery.
4. Access to comprehensive services

- Case management
- Family services
- Integrated substance abuse
- Assertive community and mental health counseling treatment (ACT)
- Medical services or intensive case
- Housing/residential services management
- Supported employment
5. Assertive Outreach

• Important to help keep clients engaged in relationships with service providers, family members, and friends.
• May include meeting with clients in familiar community locations
• Meeting regularly to offer practical assistance with daily needs and living skills.
• Frequent and helpful interaction helps to develop trust and a working alliance
6. Motivational Interviewing

- Expressing empathy
- Avoiding argumentation
- Rolling with resistance
- Encouraging self-confidence and hope
- Developing discrepancy between goals and current lifestyle/behaviors
- Acknowledging accomplishments and incremental changes
7. Substance Use Counseling

- Identification cues for relapse
- Awareness of consequences of use
- Refusal skills
- Problem-solving skills
- Examination of beliefs about substance use
- Coping skills and social skills training to address symptoms or negative mood states related to substance abuse (e.g., relaxation training, CBT for depression or anxiety or coping strategies for hallucinations)
8. Group treatment

- Better outcomes with stage-wise group treatment that addresses both disorders.

- Groups can help develop peer supports

- Provides a format for sharing experiences and learning effective coping strategies

- Aim to engage approximately 2/3 of clients regularly in a range of group treatments
9. Family Psychoeducation

• Improves substance abuse outcomes for individuals with serious mental illness
• Helps caregivers learn about the symptoms and effects of mental illness and the effects of substance use and abuse, about the medicines used in treatment, and the challenges that consumers face.
• Help reduce caregiver stress.
10. Encourage participation in self help groups

- Alcoholic Anonymous
- Double Trouble in Recovery
- Narcotics Anonymous
- Rational Recovery
- White Bison Wellbriety
- Dual Recovery Anonymous
11. Access to Pharmacological Treatment

- Can include antipsychotics, mood stabilizers, antidepressants
- Most effective when accompanied by comprehensive integrated services
- Can prescribe psychiatric medications despite active substance use with awareness of potential interactions
- Focus on increasing adherence
- Avoid benzodiazepines and other addictive substances
- Consider use of naltrexone, disulfiram, acamprosate, buprenorphine, and methadone to reduce cravings and urges to use.
12. Health Promotion

- Exercise
- Eat nutritious meals
- Find safe and affordable housing
- Avoid high-risk situations and behaviors
- Prevent or seek treatment for infectious diseases
- Decrease involvement in activities that adversely affect health and wellness
- Develop and maintain friendships with people who do not use and abuse alcohol and other drugs
13. Secondary Interventions for higher levels of care

- Examples include
- PTSD interventions
- Monitored use of naltrexone or methadone to address severe craving
- Monitored use of disulfiram to address impulsive drinking
- Intensive monitoring recommended by the legal system (e.g., protective payeeship or conditional discharge)
- Intensive psychosocial interventions (e.g., family treatment, trauma interventions, group programs, long-term residential care)