Assessment and Treatment of Members with Co-occurring Disorders (Serious Mental Illness (SMI) and Substance Abuse (SA))

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Learning Objectives

- Discuss concept of Co-Occurring Disorders
- Define the etiology of mental illness and substance abuse
- Recognize symptoms and risk factors of Mental illness and Substance Abuse
- Identify assessment procedures for mental illness and substance abuse
- Identify treatment options
Statistics

- An estimated 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness.
- In the past year, 20.2 million adults (8.4%) had a substance use disorder.
- Of these, 7.9 million people had both a mental disorder and substance use disorder.
Co-Occurring Disorders

- Co-occurring disorders were previously referred to as “dual diagnoses”
- Co-occurring disorders include mental disorder and substance use disorder
- According to SAMHSA’s 2014 National Survey on Drug Use and Health (NSDUH) approximately 7.9 million adults in the United States had co-occurring disorders
Definitions

- SMI: serious mental illness
- Affective disorders ≈ mood disorders
- Bipolar disorders ≈ manic-depressive disorder/manic depression
- Major depressive disorders ≈ major depression
- Anxiety disorders: panic disorder, obsessive compulsive disorder, posttraumatic stress disorder
- Psychotic disorders: schizophrenia, delusional disorder, schizoaffective disorder, bipolar disorder with psychotic symptoms, depression with psychotic features
Specialized Knowledge

- Etiology of SMI and SA
- Prevention and early Intervention
- Understanding of certain societal, cultural, economic, racial, ethnic, and gender issues
- Psychopharmacology
- Knowledge and understanding of various systems of care for persons with SMI and SA
- Ethics, legal issues and civil rights
- Understanding of basic research principles and methods
Etiology of SMI

- Inherited traits
- Environmental exposures before birth
- Brain chemistry
Etiology of Substance Abuse/Dependency

1. Family Relationships and Structure
2. Peer Influence
3. Individual Characteristics
4. Gateway Effect
5. Community Influence
SMI Prevention

1) Pay attention to warning signs
2) Get routine Medical Care
3) Get Help when you need it
4) Take good care of yourself
Health Care and SMI

- Poor physical health of people with severe mental illness
- Disparities in healthcare provision
- Barriers: system-level issues, provider issues and patient-related factors
- Possible solutions
Risk Factors for SMI

- Having a blood relative
- Stressful life situations
- An ongoing (chronic) medical condition
- Brain damage
- Traumatic experiences
- Use of alcohol or recreational drugs
- Being abused or neglected as a child
- Having few friends or few healthy relationships
- A previous mental illness
Symptoms

- Feeling sad or down
- Confused thinking or reduced ability to concentrate
- Excessive fears or worries, or extreme feelings of guilt
- Extreme mood changes of highs and lows
- Withdrawal from friends and activities
- Significant tiredness, low energy or problems sleeping
- Detachment from reality (delusions), paranoia or hallucinations
- Inability to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Alcohol or drug abuse
- Major changes in eating habits
- Sex drive changes
- Excessive anger, hostility or violence
- Suicidal thinking
Come into the light!
Risk Factors for Substance Abuse

- Genetic predisposition
- Certain brain characteristics that can make someone more vulnerable to addictive substances than the average person
- Psychological factors
- Environmental
- Starting alcohol, nicotine or other drug use at an early age
## Symptoms of Substance Abuse

- Withdrawal from friends and family
- Sudden changes in behavior
- Using substances under dangerous conditions
- Engaging in risky behaviors
- Loss of control over use of substances
- Developing a high tolerance and withdrawal symptoms
- Feeling like you need a drug to be able to function
Red Flags of Substance Misuse

- Change in appetite
- Changes in hygiene/appearance
- Lethargic or “spaced-out”
- Pupils bigger or smaller than normal
- Change in sleep patterns
- Significant financial changes
- Change in personality
- Loss of interest
- Lack of motivation
"I grew up in the drug culture but now I get the same effect by standing up too fast."
Why Do These Disorders Often Co-occur?

Drug abuse may bring about symptoms of another mental illness. Increased risk of psychosis in vulnerable marijuana users suggests this possibility.

Mental disorders can lead to drug abuse, possibly as a means of “self-medication.” Patients suffering from anxiety or depression may rely on alcohol, tobacco, and other drugs to temporarily alleviate their symptoms.
Risk Factors for COD

- Overlapping genetic vulnerabilities
- Overlapping environmental triggers
- Involvement of similar brain regions
- Drug use disorders and other mental illnesses are developmental disorders
Risk Factors in Older Adults

- Prior personal or family history of substance abuse
- Loss of housing or sense of independence
- New onset medical problem
- Grief related to loss of loved one
- Recent retirement
- Social isolation
- Mental Health Issues - Especially depression

(David Meshorer, Ph.D. Psychological Health Psychological Health Roanoke)
Assessment

- Standard conventional assessment instruments
- Assessment of functional capabilities
- Neuropsychological assessment of specific cognitive deficits and strengths
Assessment for Persons with COD

- Screening to detect the possible presence of COD in the setting where the client is first seen for treatment
- Evaluation of background
- Diagnosis of the type and severity of substance use and mental disorders
- Initial matching of individual client to services
- Appraisal of existing social and community support systems
- Continuous evaluation
American Society of Addiction Medicine
ASAM Criteria/ASI

- **Dimension 1: Acute Intoxication and/or Withdrawal Potential**
  This life area explores past and current experiences of substance use and withdrawal.

- **2 Dimension 2: Biomedical Conditions/Complications**
  In this life area, think about physical health, medical problems and physical activity and nutrition.

- **3 Dimension 3: Emotional/Behavioral/ Cognitive Conditions and Complications**
  This life area helps explore thoughts, emotions and mental health issues.

- **4 Dimension 4: Readiness to Change**
  This life area identifies what one is motivated for and their readiness and interest in changing.

- **5 Dimension 5: Relapse/Continued Use/ Continued Problem Potential**
  This life area addresses concerns one might have about ones continued substance use, mental health or a relapse.

- **6 Dimension 6: Recovery Environment**
  This life area explores y living situations and the people, places and things that are important to people.
**Decisional Flowchart**

**Assessing:**
- What does the person want? Why now?
- Does the person have any immediate needs?
- Assess risks, needs and strengths in all life areas
  - Identify Diagnoses

**Identifying:**
- Identify the level and severity of functioning
- Identify which life areas are currently most important to determine treatment priorities
- Choose a specific focus and target for each life focus
- What specific services are needed for each life focus

**Providing/Evaluating:**
- Identify the intensity of services needed for each life area
- Identify where the services can be provided, in the least intensive but safe level of care
- What is the progress of treatment?
Levels of Care

- **Level 0.5**: Early Intervention
- **Level I**: Outpatient Treatment
- **Level II**: Intensive Outpatient/Partial Hospitalization Treatment
- **Level III**: Residential/Inpatient Treatment
- **Level IV**: Medically Managed Intensive Inpatient Treatment
Quadrants of Care

- **Category I**: Less severe mental disorder/less severe substance disorder (primary health care setting)
- **Category II**: More severe mental disorder/less severe substance disorder (mental health system)
- **Category III**: Less severe mental disorder/more severe substance disorder (substance abuse system)
- **Category IV**: More severe mental disorder/more severe substance disorder (state hospitals, prisons, jails, emergency rooms, etc.)
“No Wrong Door” Policy

1. Assessment, referral, and treatment planning for all settings must be consistent with a “no wrong door” policy.
2. Creative outreach strategies may be needed to encourage some people to engage in treatment.
3. Programs and staff may need to change expectations and program requirements to engage reluctant and “unmotivated” clients.
4. Treatment plans should be based on clients’ needs and should respond to changes as they progress through stages of treatment.
5. The overall system of care needs to be seamless, providing continuity of care across service systems.
Assessment of Functional Capabilities

- Activities of Daily Living ADLs
- Instrumental activities of daily living IADLs
World Health Organization Model

Health Condition
  e.g., Patient has schizophrenia

Impairment
  e.g., problems remembering facts

Activity Limitation
  e.g. problems using public transportation

Participation Restriction
  e.g. Problems socializing

Personal Factors
  e.g. old age, low income

Environmental Factors
  e.g., patient lives in board and care and is not given freedom travel alone
Neuropsychological Assessment

- Cognitive Functioning
- Sensorimotor and psychomotor functioning
Access to mental health care.
Guiding Principles in Determining Treatment

1. Consider the Whole person
2. Design treatment for the specific person
3. Individualize treatment times
4. “Failure” is not a treatment prerequisite
5. Provide a spectrum of services
6. Reconceptualize the definition of addiction
Essential Components of COD Treatment

- Enhanced staffing
- Psychoeducational classes
- Double trouble groups
- Dual recovery mutual self-help groups
Interventions

- Assertive Community Treatment/Intensive Case Management
- Family psychoeducation
- Motivational Interviewing
- Psychotherapy, especially Cognitive Behavioral Therapy
- Training in social skills and illness management
- Cognitive remediation
- Relapse Prevention
- Supported employment and supported education
- Comprehensive Social learning Programs (including token economies)
- Integrated treatment for co-occurring substance use disorders
- Treatment for co-occurring traumatic stress
Assertive Community Treatment
ACT

Principles
1. Primary provider of services
2. Out-of-office treatment
3. Individualized treatment
4. Long-term services
5. Vocational expectations
6. Psychoeducational services
7. Family support
8. Community integration
Intensive Case Management
ICM

Goals:
▸ Engage individuals in a trusting relationship
▸ Assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community
Family Psychoeducation Principles

1. Participants define who family is
2. The practitioner-participant-family alliance is essential
3. Education and resources help families support participants’ personal recovery goals
4. Participants and families who receive ongoing guidance and skills training are better able to manage mental illnesses
5. Problem solving helps participants and families define and address current issues
6. Social and emotional support validates experiences and facilitates problem solving
Illness Management

- Becoming involved in self-help programs
- Staying active
- Developing a support system
- Maintaining physical health
- Being aware of the environment and how it affects you
- Making time for leisure and recreation
- Expressing creativity
- Expressing spirituality
- Following through with treatment choices
Co-occurring Traumatic Stress

- The relation between substance use and trauma
- Additional mental or physical health problems associated with traumatic stress
- Treatment for people with traumatic stress and substance use problems
Treatment

**Medication** may be utilized to manage certain psychiatric disorders or to mitigate the withdrawal symptoms associated with **detox**.

**Behavioral modification therapies and experiential therapies** can augment a treatment regime, helping to alter thoughts and behaviors to better manage both disorders.
Veterans Mental Health Issues

Panic → Stress → Anxiety → Anger → Insomnia → Nightmares → Flashbacks → Depression → Suicide

I hear ya, man... fully funding your health care gives me the same symptoms...
6 Guiding Principles in Treating persons with COD

1. Employ a Recovery Perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Address specific real-life problems early in treatment
5. Plan for the participant’s cognitive and functional impairment
6. Use supportive systems to maintain and extend treatment effectiveness
Resources

- Learn more about Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit - 2010 as well as SAMHSA’s efforts to grow the nation’s behavioral health workforce.
- General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-occurring Mental and Substance Use Disorders - 2012
- Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-occurring Opioid Use Disorders - 2012
- TIP 42: Substance Abuse Treatment for Persons with Co-occurring Disorders - 2008
- TIP 45: Detoxification and Substance Abuse Treatment - 2015
- TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women - 2015
Thank you all for being here and for your commitment to enhancing the care provided to your participant, clients and members.

Through advocacy, care coordination, and teamwork we can ensure the health and well-being of our clients.
Questions
References

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  *Inequalities in healthcare provision for people with severe mental illness* David Lawrence¹ and Stephen Kisely

- **SAHMSA: TIP 3 42**: Substance Abuse treatment for Persons with Co-occurring Disorders DHHS Publication No. (SMA) 05-3992 Printed 2005

- **SAHMSA: A Treatment Improvement Protocol - Trauma-Informed Care in Behavioral Health Services** Tip 57 Nov 18, 2016 by U.S. Department Of Health And Human Services