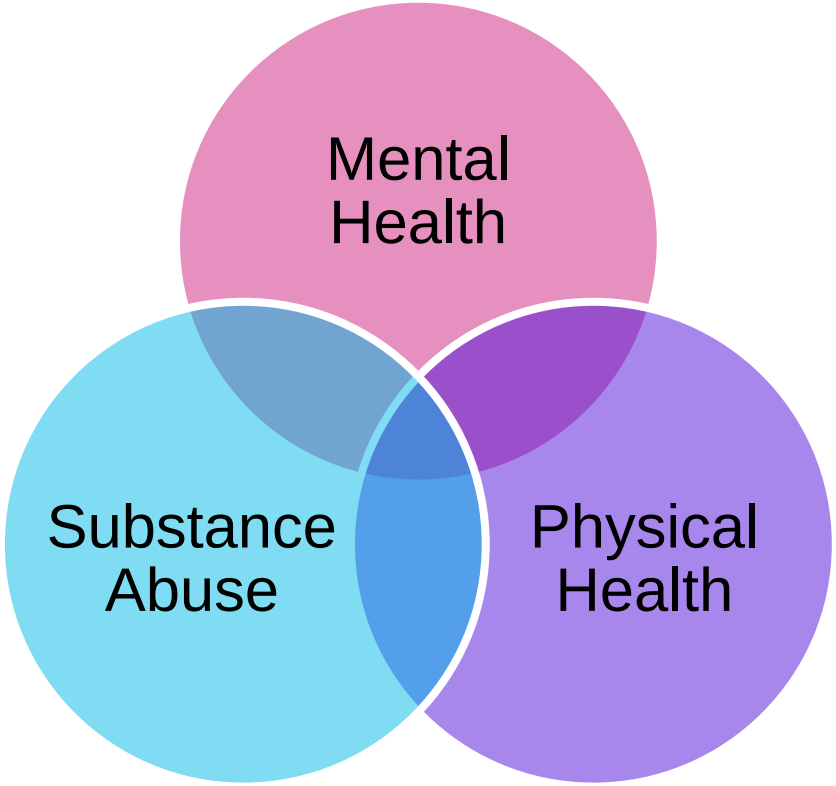
Co-Occurring Disorders

Substance Use and Mental Health Disorders

Learning Objectives

- Discuss the relationship between substance use disorders and mental health disorders
- Examine the stages of change and helper tasks in working with members living with co-occurring disorders
- Identify evidence-based practices and integrated care opportunities for co-occurring disorders

Defining Co-Occurring Disorders

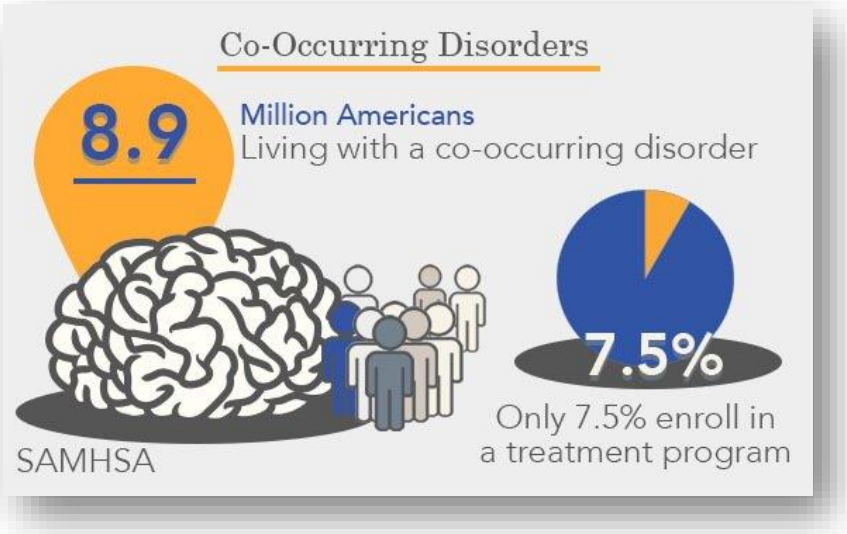


Scope of Co-Occurring Disorders in the U.S.

- 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness
- 20.2 million adults (8.4%) had a substance use disorder
- Of these, 8.9 million people had both a mental disorder and substance use disorder

(SAMHSA, 2014)

Prevalence of Co-Occurring Disorders



(SAMHSA, 2013)

Risk and Protective Factors for Developing Co-Occurring Disorders

Which Comes First: SUD or MH Disorders?

Biological Factors

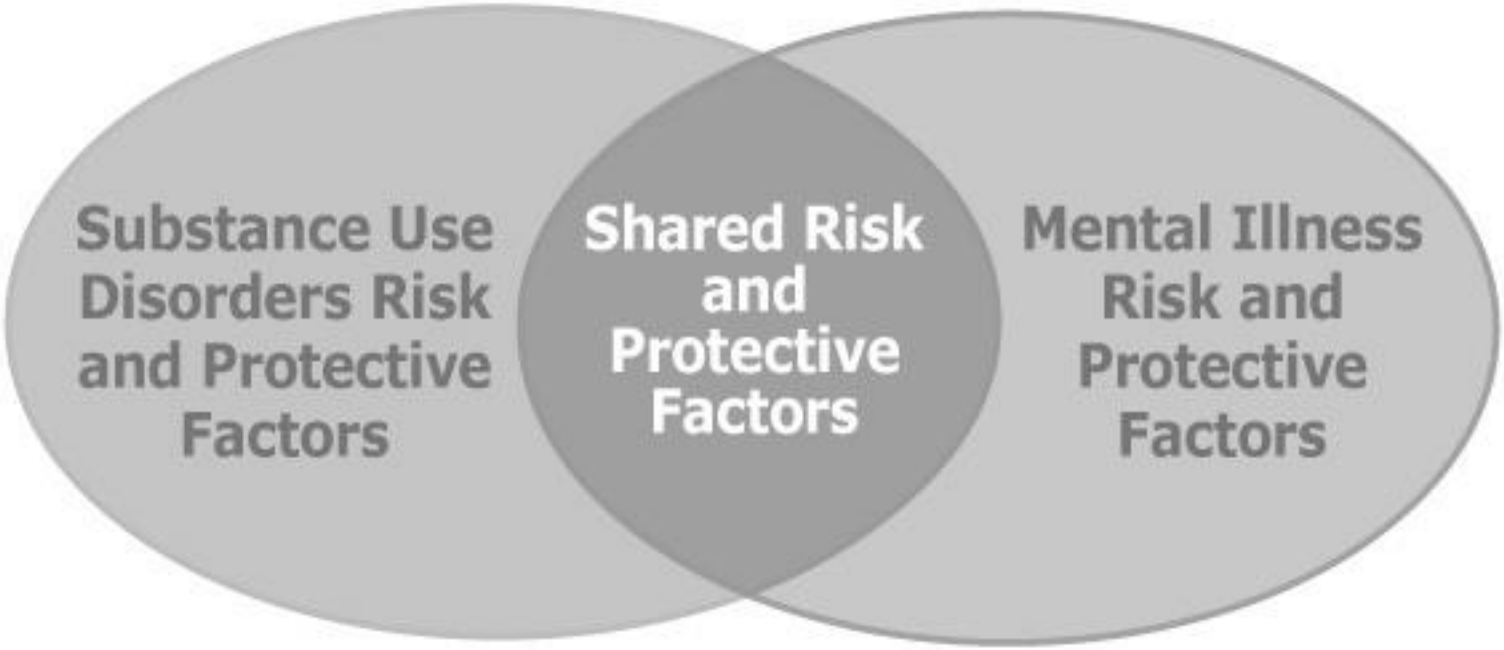
Social Factors

Environmental Factors

(American Addiction Centers, 2017)

Risk and Protective Factors for Co-Occurring Disorders

magnolia health™



Risk and Protective Factors for Co-Occurring Disorders

magnolia health

Risk factors

- Characteristics at the biological, psychological, family, community, or cultural level
- Are associated with a higher likelihood of negative outcomes

Protective factors

- Characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact
- Protective factors may be seen as positive countering events

Biological Risk and Protective Factors for Co-Occurring Disorders

- Prenatal development
- Early childhood exposures
- Gender
- Injury

(American Addiction Centers, 2017)

Genetic Risk and Protective Factors for Co-Occurring Disorders

magnolia health™

Risk Factors

- Close relative with SUD
- Close relative with MH disorder

Protective Factors

- Family sanctions against drugs and alcohol

(American Addiction Centers, 2017)

Social Risk and Protective Factors for Co-Occurring Disorders

magnolia health

Risk Factors

- Exposure to trauma / Abuse
- Natural disaster / Wartime experiences
- Racism / Lack of economic opportunity
- Norms / laws favorable to substance use

Protective Factors

- After-school activities
- Hate crime laws
- Policies limiting availability of alcohol
- Strong social supports/community engagement

(American Addiction Centers, 2017)

Environmental Risk and Protective Factors for Co-Occurring Disorders

Risk Factors	Life stressors
	Relationship issues
	Health & mental health
Protective Factors	Coping skills (reduce stress)
	Treating substance use & mental health problems

magnolia health™

Common Co-Occurring Disorders

Five Most Common Co-Occurring Disorders

- Alcoholism and Anti-Social Personality Disorder
- Marijuana Addiction and Schizophrenia
- Cocaine Addiction and Anxiety Disorders
- Opioid Addiction and PTSD
- Heroin Addiction and Depression

Alcoholism and Anti-Social Personality Disorder

Alcohol abuse is associated with a number of mental health concerns, including:

- Mania
- Dementia
- Schizophrenia
- Drug addiction

(http://www.dualdiagnosis.org, 2017)

Marijuana Addiction and Schizophrenia

"People who have a greater risk of developing schizophrenia are more likely to try cannabis, according to new research, which also found a causal link between trying the drug and an increased risk of the condition."

- University of Bristol
December 19, 2016

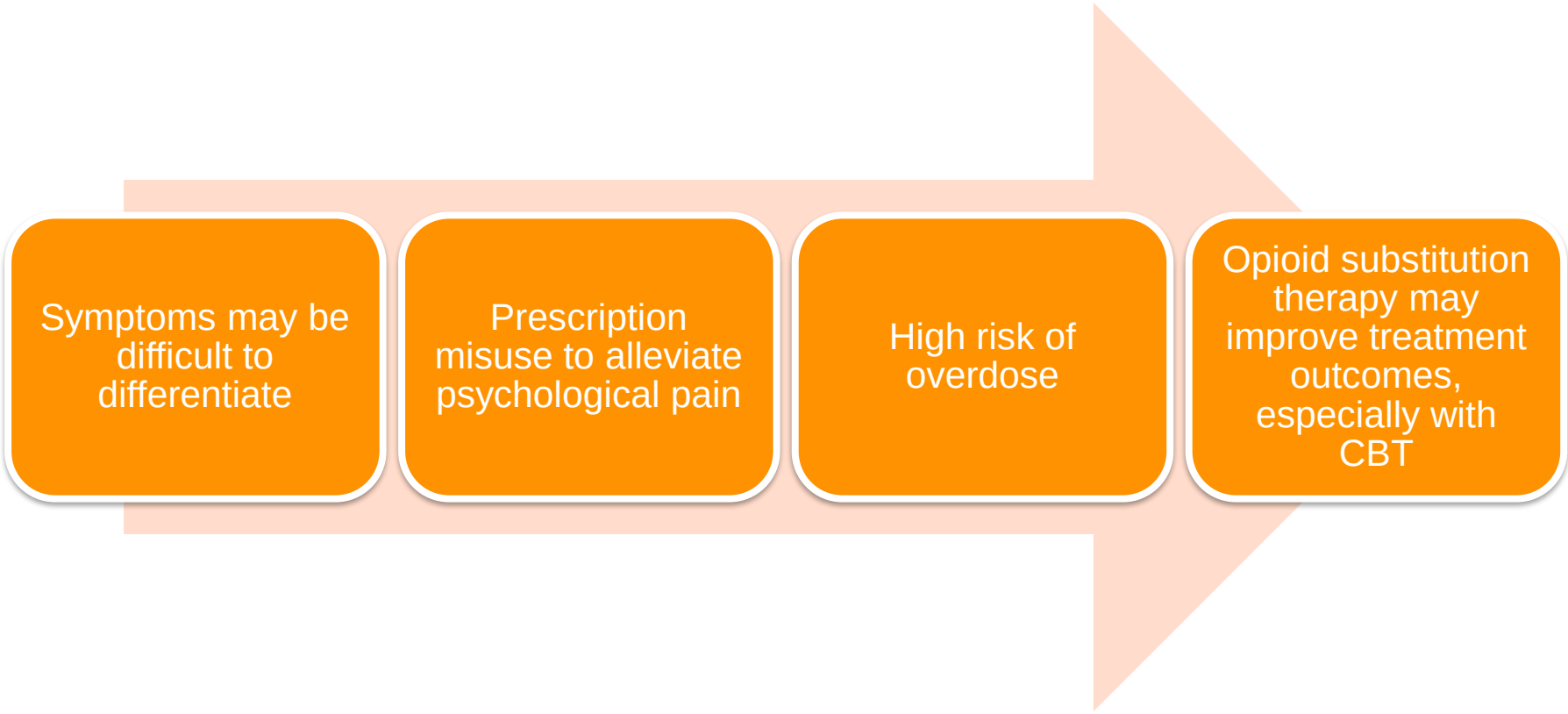
(*Psychological Medicine*, 2016; 1 DOI: 10.1017/S0033291716003172)

Cocaine Addiction and Anxiety Disorders

Continued use seems to lead to symptoms that are more indicative of an anxiety disorder, including:

- Paranoia
- Hallucinations
- Suspiciousness
- Insomnia
- Violence

Opioid Addiction and PTSD



Heroin Addiction and Depression

Data suggests prevalence of major depression ranges from 2x-5x higher among heroin-addicted individuals than in the general population (Brady & Sinha, 2005a)

Both conditions have several commonalities in symptoms and impairments in brain regions:

- Pleasant effects of heroin use and depressive symptoms are exerted by stimulating or desensitization of the brain reward system
- Depression may result from repeated desensitization of the brain reward system as a response to intermittent withdrawal from heroin dependence

magnolia health™

Stages of Change and Helper Tasks

Pre-Contemplation - Not Ready to Change

Member says and does:	Helper task	Level of resistance

• "What problem?"
• Unaware their behavior is problematic
• Not intending to take action
	• Raise doubt
	• Build discrepancies
	• Increase rapport
		• High; all 4 "r's"
		  • Reluctance
		  • Rebelliousness
		  • Resigned
		  • Rationalizing

Stages of Change - Shawna

Shawna admits she's been feeling very depressed 4-5 times per week.

She's been missing work, no longer interested in activities she used to enjoy, and friends have noticed that she is having personality and mood changes. Shawna has been using marijuana to help her sleep several times a week over the last few months.

Friends have tried to talk to her about their concerns, but she continues to defend her behavior changes as just "being tired" because of her poor sleep patterns and assures them she does not have a problem with marijuana or depression and doesn't need any help.

Contemplation - Getting Ready to Change

Member says and does:	Helper task	Level of resistance
• "Is this behavior a problem?" • Beginning to recognize their behavior as problematic • Starting to look at the pro/cons of continued actions	• Evoke reasons to change by amplifying ambivalence • Ask about "the good and not-so-good" things about the behavior	• They may express interest in achieving outcomes but don’t show readiness to work

Preparation - Ready to Change

Member says and does:	Helper task	Level of resistance
• "What can I do? I need something that can work for me…" • Wants options • Needs hope • Taking small steps toward changing behavior	• Help member find best course of action • Clarify member's own goals and strategies for change	• Lower, but still present

Stages of Change - Louis

Louis has been concerned about his anxiety for the past six months; at times it's debilitating. He only feels relief when he drinks some whiskey with his Lexapro and Xanax.

This week he called a counseling center in his community, and made an appointment to talk to a counselor about the underlying causes of his anxiety. He also made an appointment with his PCP to check for any medical issues and ask about medications to help him function better at work and home. He did not tell the PCP about his drinking behavior.

Today, Louis is making excuses about going to his appointments, stating his daughter is "probably too busy to take him to his appointments", and that his anxiety "isn’t really that bad, anyway".

Action - Doing the Change

Member says and does:	Helper task	Level of resistance
• "Look! I am doing something." • Modified their behavior and acquired new behaviors	• Help them find best course of action • Reinforce the pros	• Low; But they may not be successful

Maintenance of Change

Member says and does:	Helper task	Level of Resistance
• "I am successful because I have changed." • Able to sustain action for at least six months and working to prevent relapse	• Help them prevent returning to previous behavior	• Low, but still present

Stages of Change - George

George, a 47 year old man, has chronic diabetic neuropathic pain, alcohol abuse history and a diagnosis of bipolar disorder.

George was referred to intensive case management last year because of suicidal ideation where he was drinking heavily during a bipolar episode. The CM connected him to a SUD counselor, inpatient CD treatment and referred him to his health plan for diabetic education, which George said was helpful for managing his neuropathy. The CM also provided psycho-education regarding alcohol use and bipolar disorder.

George admitted that he knew that drinking was not good for his diabetes or mental health. He was able to utilize his recovery supports, CM and Magnolia coach to keep himself sober for the last seven months.

magnolia health™

Integrated Screenings and Assessments

Purpose Of The Assessment

magnolia health™

To obtain a chronological history of symptoms and treatment for both mental and substance use disorders

To obtain a description of current strengths, supports, limitations, and cultural barriers that will impact treatment

Find out what the individuals want, what they want to change, and how they think that change will occur

Establish formal diagnoses, evaluate level of functioning to understand the impact on treatment, and determine readiness for change

Make initial decisions about appropriate care

Integrated Screening

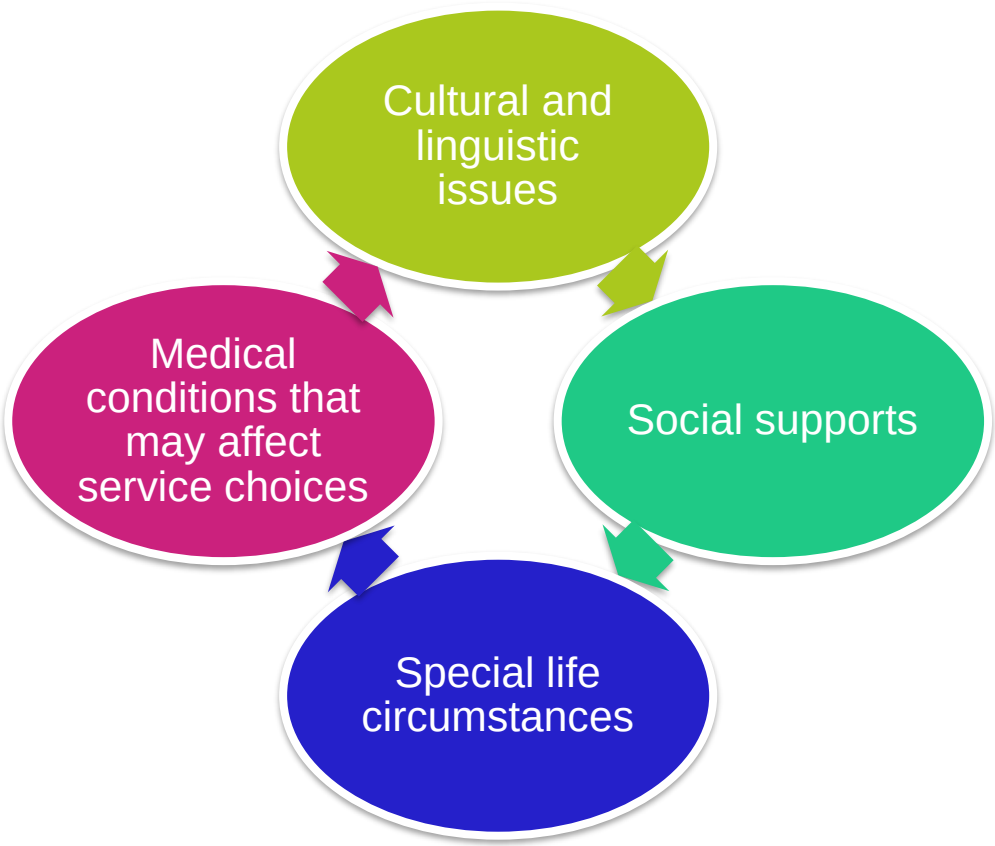
SBIRT	• Screening Brief Intervention And Referral To Treatment (alcohol and drugs) – only trained personnel can complete
CAGE AID	• A version of the CAGE alcohol screening questionnaire, adapted to include drug use
GAD-7	• Generalized Anxiety Disorder 7 item scale which screens for anxiety
PHQ-2 (or 9)	• Patient Health Questionnaire for depression screening

(SAMHSA, 2017)

Integrated Assessment

- Begin the development of an appropriate treatment relationship
- In-depth assessments provide information that is used by the practitioner and the individual to create a treatment plan.
- Integrated screening and assessment should occur when an individual enters either service system. It can be conducted by the same practitioner or by different practitioners.
- An individual who screens positive for co-occurring disorders may be seen at the same or a different agency for an integrated assessment.

Integrated Assessments



Assess Using Multiple Approaches

In addition to the assessment instruments, the assessment process may include:

- A clinical examination of the functioning and well-being of the individual
- An in-depth interview

Assess Using Multiple Approaches

Areas assessment instruments may not cover:

- A social and treatment history
- Interviews with friends and family (with permission)
- A review of medical and psychiatric records
- A physical examination
- Laboratory tests
- A diagnosis is established by referral to a psychiatrist, clinical psychologist, or other qualified healthcare professional

Evidence-Based Treatment for Co-occurring Disorders

Integrated Treatment

magnolia health™

"The high rate of comorbidity between drug abuse and addiction and other mental disorders argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed."

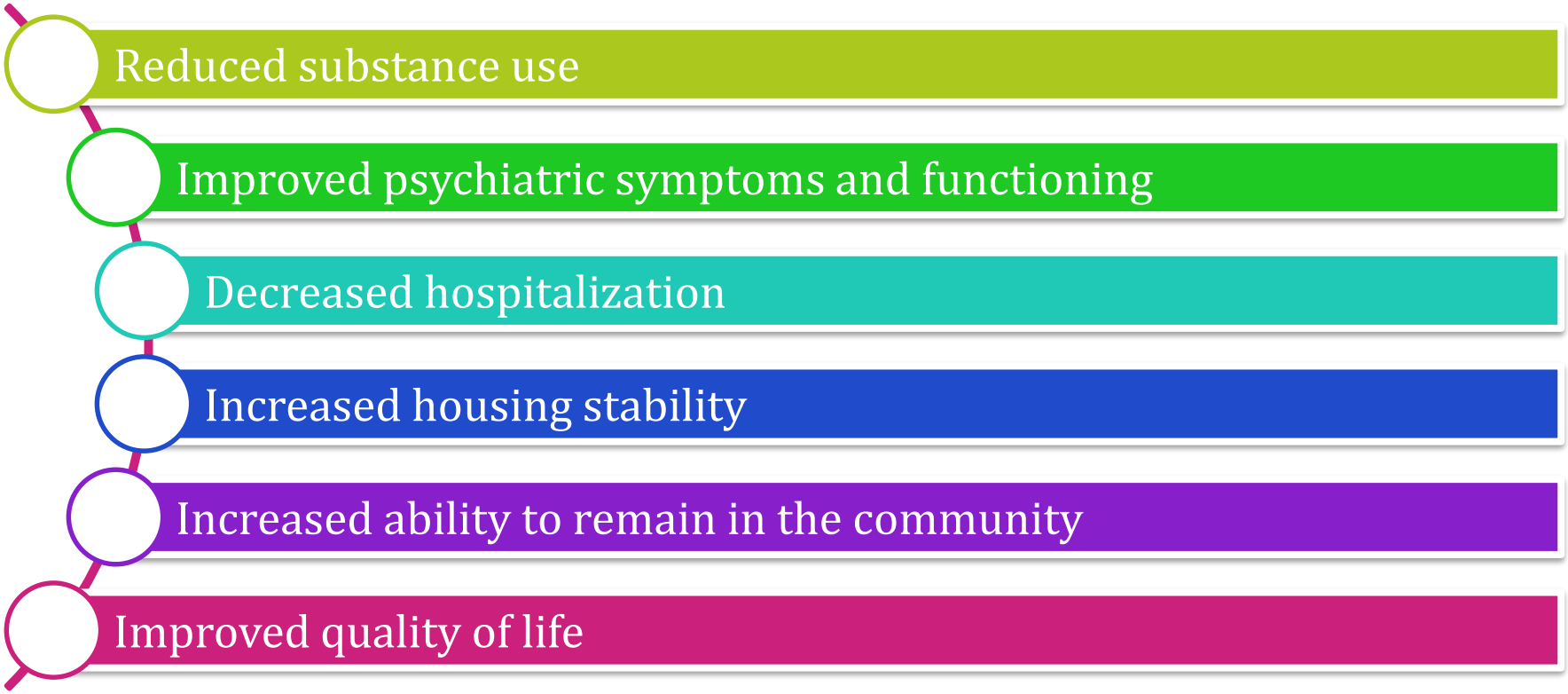
- National Institute on Drug Abuse, "Comorbidity: Addiction and Other Mental Illnesses", 2010

Treating Co-Occurring Disorders

According to the National Alliance on Mental Illness (NAMI):

- Integrated intervention
- Withdrawal management (detoxification)
- Inpatient rehabilitation
- Supportive housing
- Psychotherapy
- Medications
- Self-help and support groups

Integrated Treatment Benefits



(SAMHSA.gov)

magnolia health™

Recovery from Co-Occurring Disorders

Recovery

Involving members and their families or supports in:	Service/Treatment planning
	Screening/Assessment
	Treatment process
Involvement in the assessment and treatment process can:	Enhance the effectiveness of services
	Yield better outcomes
	Promote self-determination and choice
	Empowerment

Promoting Recovery

1. Help members think about the role that alcohol and other drugs play in their life.
2. Offer members education on co-occurring disorders
3. Help members become involved with supportive employment and other services that may help the process of recovery.
4. Help members identify and develop recovery goals.
5. Link to BH services.

Strategies For Engagement in Recovery

Strategies for involving members:

- Self-directed, consumer-operated services which are operated by consumers and generally emphasize self-help
- Peer support services which are delivered by consumers
- Mutual support groups, such as12-step programs
- Consumer advocacy — involvement in policy and planning activities at all levels

Strategies for involving families/supports:

- Family psycho-education
- Peer-based family education programs
- Family therapy and consultations
- Linkage with the National Alliance on Mental Illness (NAMI) and other local support organizations

Things to Remember

Remember the Stages of Change tasks of the helper when considering the needs of the member

Integrated screenings and assessments help us understand the member's needs, strengths, and barriers

Recovery is possible - look for ways to enhance opportunities for harm reduction, treatment, and after-care

Learning Objectives Revisited

- Discuss the relationship between substance use disorders and mental health disorders
- Examine the stages of change and helper tasks in working with members living with co-occurring disorders
- Identify evidence-based practices and integrated care opportunities for co-occurring disorders

Resources

- Abram, K.M., Teplin, L.A., & McClelland, G.M. (2003). Comorbidity of severe psychiatric disorders and substance use disorders among women in jail. American Journal of Psychiatry, 160, 1007-1010.
- Centre for Addiction and Mental Health. Retrieved from http://www.camh.ca/en/hospital/Pages/home.aspx
- Coalition against Drug Abuse retrieved from http://drugabuse.com/library/mental-health-and-drug-abuse/
- National Alliance on Mental Illness. Retrieved from http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049
- Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/