Intro to Addressing Co Occurring Disorders (COD) in Mental Health Setting

Background:

- What is a COD? – Two diagnosable problems that are inter-related and occur simultaneously in a person. Most common use of this term is with regard to Co-Occurring Substance Abuse and Mental Health issues

- History of COD treatment:

    - Early in the substance abuse field, MH was minimized if not totally ignored. MH symptoms would prevent admission to treatment. Meds were not allowed and just seen as "using drugs to treat drugs" which was forbidden. AA shunned any use of medication

    - Time passed, at it became evident that some people had serious mental illness but they still needed substance abuse treatment. MICA programs began, however they usually only catered to people with serious, obvious MH issues.

    - More recently, it has become evident that there is a large portion of people needing substance abuse treatment that still need MH treatment that are too high functioning for MICA programs, however there was a divide with regard to how to treat them. The MH field focused on treating the MH, with the idea that the addiction will get better if the MH improves, however the SA field believed treat the SA and the MH will get better.

    - Next came the concurrent services approach (Parallel Treatment) MH providers referring out to SA specialists for SA issues and SA providers referring out to MH specialists for MH issues.

    - Finally – **The Integrated Treatment Model** – Treating both MH and SA issues simultaneously at the same facility. What is needed?
        - Psychiatrists who understand addiction on staff
        - Dual trained clinicians and supervisors (both MH and SA)
        - Acceptance of psychotropic meds in treatment
        - Dual focused group curriculum
        - Recovery oriented treatment – Client-centered treatment seen as an ongoing process (as opposed to rapid discharges for "noncompliant" clients)

    - Issue – Which came first the chicken or the egg? Is the SA causing the MH issue or is an underlying MH issue causing SELF MEDICATION – (Using alcohol and/or unprescribed drugs as a means to cope with problems such as depression, anxiety, feelings, etc.)

    - Time is needed to resolve chicken/egg issue. For example a person may come to treatment depressed and abusing drugs. If over time, the person stops using and the depression is lifted, then likely the SA was causing the depression.

Why COD's are challenging to diagnose and treat: Many symptoms can be related to by EITHER MH or SA issues.

What are some examples of symptoms that can be present as part of both MH and SA disorders:

- Mood swings
- Anger issues
- Depressed mood or sadness
- Isolation
- Feelings of worthlessness
- Feelings of helplessness
- Low self esteem
- Racing thoughts
- Paranoia
- Delusions
- Poor concentration
- Decrease in motivation
- Insomnia or hypersomnia
- Poor appetite
- Weight loss
- Decline in work or school performance
- Difficulty focusing
- Family arguments
- Social problems and relationship problems (fights)
- Irritability
- Unmanageability
- Impulsivity
- Poor judgment, Reckless behavior and poor decisions
- Anti-social or oppositional-defiant behavior/attitude
- Etc.…

➢ Overview of a few common MH disorders that may often co-occur with SA disorders:

- Depressive Disorders – Characterized by depressed mood, poor motivation, sleep and appetite problems, decreased motivation, suicidal thoughts, hopelessness or worthlessness
- Bipolar – Characterized by severe mood swings, impulsivity, out of control pleasure seeking
- Anxiety Disorders – Racing thoughts, excessive worry, poor concentration, restlessness – Specific types: Generalized, OCD, Social Phobia, Panic Disorder
- ADHD – poor attention, difficulty focusing, distractibility, restlessness
- Schizophrenia, schizoaffective

Addiction? - Some factors to consider in identifying substance use disorders in MH setting

1. People often get hung up on the term "addiction". Addiction can often be incorrectly looked at as a "black and white issue"

2. Medically, addiction is viewed as disease like cancer or diabetes due to some of the following similarities:
   - Diagnosable Signs and Symptoms
   - Progressive in Nature
   - Genetic Factors

3. A better analogy than comparing addiction to diseases like diabetes or cancer, is to view addiction more like a cold: As opposed to cancer or diabetes which you either have or don't have, a cold is more commonly viewed along a spectrum: from "the sniffles" as far as pneumonia.

4. What makes substance abuse so much more difficult to assess and treat is that many people we meet in MH setting are in the earlier stages (especially young people) or they are in later stages but minimizing use or not telling the whole story.

5. Important to note is that the majority of people who use drugs are not and will not become addicted. The problem with substance abuse is that it can be difficult to discern between the early stage "addict" and the person who is just going through a "phase" - Avoid labeling

6. What matters much more than amount and frequency of substances used, is the consequences and how the user reacts to them. Things to look for:

   - How does the person react to consequences? – Do they keep using or try to stop?
   - Family/relationship complaints – These are a big red flag
   - Loss of control of amount or frequency used – Does the person end up using more than they planned or more often than intended? Blackouts?
   - Repeated consequences – Do problems keep on happening related to substance use?
   - Efforts to control use – If the person keeps trying to set "rules" for use (like only using on the weekends) that can indicate a potential lack of ability to control it (especially if they don't stick to their rules)
   - Acknowledgement of past problem (for example if someone went to rehab in the past, even many years ago, that is a red flag if there are problems coming up again with substance use today – even if in the past it was for a different substance)
   - "Addictive Personality" – Some individuals, by nature tend to be more compulsive with their behavior

7. Some other basic risk factors to consider and things to look for – Don't be afraid to ask ***(Respectfully Suspicious)***
   - Family History of substance abuse
   - Early onset of use
   - Current support system/environment/peer group
   - Preoccupation – Talking about substance use all the time and/or loss of interest in activities not related to substance use
   - Once again – "Self-Medication" – How and why does a person use? (Managing stress, anger, depression or anxiety?)
   - Appearance – Does the person look high? Do they look "strung out"? Don't ignore it

- Attitude - Does the person glorify use? Are they "street smart" - .Do they know the terminology and the lifestyle?
- Legal – past DUI's or other legal problems related to substance use
- "Tip of the iceberg" phenomenon – if you or others are seeing something, it often may be much, much more going on.
- Drug testing – If reasonable suspicion of a substance abuse issue why not give it a shot. Even if the person refuses the conversation can tell you a lot.
- Family – ask parents/SO's about what they are seeing

Addressing Substance Abuse in a Mental Health Setting

There are a few key principles to remember when dealing with substance abuse issues in a mental health setting:

1. Avoid the "Head in the Sand" mentality – Simply avoiding asking about substance abuse issues does not make them go away. It does not mean they don't exist. It is a clinician's responsibility to inquire about the role that substance use/abuse plays in the recovery from mental health issues.

    - Fear of lacking the skills or qualifications should not prevent basic substance abuse assessment in MH treatment. SA is way too prevalent and way to relevant an issue to ignore
    - Clients often enter substance abuse treatment after months or even years of ineffective MH treatment due to a clinician's failure to inquire about substance use/abuse

2. There are some basic red flags that should alert MH clinicians to inquire about substance use/abuse:
    - Previous substance abuse history or SA Tx Hx
    - Family and/or friends/significant other using substances
    - Evidence of pre-occupation (Client stories regularly revolve around substance use)
    - Consequences related to SA (DUI, arrests, missed work, strange injuries)
    - SA related environment
    - Evidence of blackouts
    - Evidence of self-medication

3. One does not need to be a substance abuse "expert" in order to make a basic assessment of substance abuse. Some basic questions that are appropriate:
    - Amount and frequency of use
    - Date of last use
    - Family HX of substance abuse problems
    - Family/friends perception of their use (Complaints/concerns)
    - Efforts to control or limit substance use

4. There are three main sources of information to utilize when determining a substance abuse level of care referral:
    - Client self-report
    - Reliable Collateral Report
    - Urine Alcohol/Drug Screen

5. Fear of client refusal to submit to urine testing should not prevent clinician from asking for test. The refusal in itself provides valuable information.

6. Seek consultation when unsure how to proceed

7. Once a substance abuse issue is identified use DSM, then use ASAM criteria to determine appropriate level of care referral.

DSM 5 Criteria for Substance Use Disorder

Opioid Use Disorder Criteria:

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (APA, 2013). Opioid Use Disorder is specified instead of Substance Use Disorder, if opioids are the drug of abuse. Note: A printable checklist version is linked below

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Introduction to ASAM Patient Placement Criteria

- **Dimension 1:** Acute Intoxication and/or Withdrawal Potential
- **Dimension 2:** Biomedical Conditions and Complications
- **Dimension 3:** Emotional, Behavioral, or Cognitive Conditions or Complications
- **Dimension 4:** Readiness to Change (Treatment Acceptance/Resistance)
- **Dimension 5:** Relapse/Continued Use Potential
- **Dimension 6:** Recovery Environment

Basic Scoring Guidelines: (These are guidelines only!)

Consider a rating of LOW, MODERATE, or HIGH on each dimension:

Level I Outpatient Treatment: At least 4 to 6 Dimensions are LOW, with none HIGH (**GAF 60-70)**

Level II Intensive Outpatient Program (IOP) and Partial Care: At least one or more of Dimensions 1-6 is MODERATE and no HIGH in Dimensions 1-3 **(GAF 50-60)**

Level III – Inpatient/Residential Treatment: At least one or more Dimension is HIGH **(GAF< 50)**

Level IV –Medically Managed Inpatient – Dimension I is HIGH: Withdrawal symptoms reported or observed OR client is using physically addictive substances in such a way that withdrawal potential is HIGH

Theoretical vs. Actual Client Level of Care Placement Issues

We live in the real world and unfortunately, client's circumstances do not allow for a simple assessment and referral using ASAM criteria alone.

Many other factors come into play and must be considered in addition to ASAM criteria, when using a CLIENT-CENTERED approach, such as:

- Client's willingness (or unwillingness) to follow through with ASAM level of care recommendations
- Family members refusal to agree to ASAM LOC recommendation
- Financial issues
- Insurance/funding issues
- Availability of desired treatment level
- Transportation issues
- Mandates by referral sources (such as probation, parole, EAP, etc.)
- Childcare issues
- Etc. (Other unexpected concerns)

When it is not clear what level of care is appropriate due to these special circumstances, consider:

The wrong level of treatment is often better than no treatment at all. One way to address this is through **contracting** (verbal or written):

For example: Client meets criteria for IOP but is refusing to attend. Clinician has no leverage to get client into IOP. A common strategy would be to let client know recommendation is IOP, however lower level care will be attempted on TRIAL BASIS (provided there are no identified safety concerns or other emergent risk factors)

Contract then made between clinician, client, and family (if available) that lower level of care to be attempted and will remain, provided client demonstrate a level of compliance and progress. If client non-compliant or fails to make progress, higher level of care referral to be reconsidered

Always keep risk factors and safety in mind

Example: Assess theoretical ASAM level of care vs. Actual level of care referral

1. John is 32 and has been attending outpatient mental health treatment for mild depression and anxiety for about 3 months and he has been relatively compliant but making minimal progress. John recently tells you he received a DUI over the weekend and he believes he may have a drinking problem as he has been drinking to medicate his social anxiety. He has no prior substance abuse treatment Hx. John tells you he is drinking about 3-4 times per week, anywhere from as few as 5 to as many as 12 beers per night. John has never had withdrawal symptoms and he has no medical problems. This is his first arrest and he denies any other consequences of alcohol use other than his wife complaining about drinking recently. There are no SI/HI or other active risk factors reported. John tells you at first that he will do whatever you recommend except that under no circumstances will he attend group because he is too anxious in social situations. John lives with his wife and 2 children and his wife and immediate family members do not drink regularly or problematically to the best of your knowledge.

   How would your recommendation change if at the next session, his urine drug screen was returned positive for opiates and marijuana despite him not mentioning these issues?

   How would your recommendation change if John's wife called you and reported that the last few times John got drunk he was violent with her?

   How would your recommendation change if John told you he wants to go away to residential treatment but his insurance is refusing to pay?

   What if John later revealed to you that he was having some pretty serious suicidal thoughts since his DUI, but only when he is drinking?

DRUGS OF ABUSE

Drug	Physical Effects	Mental/Emotional	Potential Consequences
Stimulants: Cocaine, Crack amphetamine, methamphetamine	*increased heart rate, blood pressure, metabolism;* reduced appetite, weight loss, dryness of mucous membranes Binge use **EYES** – Dilated – Popping out	*feelings of exhilaration, energy, increased mental alertness*/nervousness, insomnia, restlessness, loss of appetite, mood swings	rapid or irregular heart beat heart failure panic, paranoia, paranoid delusions, impulsive behavior, aggressiveness, tolerance, addiction, psychosis strokes, seizures
Depressants: Alcohol, Benzodiazepines Barbiturates GHB	*slowed pulse and breathing; lowered blood pressure; sedation, drowsiness* *slurred speech* *staggered gait* **EYES** – Spasmodic eye movements, bloodshot	*reduced anxiety; feeling of well-being; lowered inhibitions;* fatigue, *poor concentration*/; confusion,	; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death withdrawal with seizure potential (possibly fatal)
Opioids and Morphine Derivatives: Heroin Morphine Oxycodone Hydrocodone Codeine Fentanyl and analogs	*pain relief, drowsiness*/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, "nodding" physical addiction, withdrawal-(nausea, sweating, chills, cramps, diarrhea, insomnia) **EYES** – Constricted pupils (pinholes)	*euphoria, feeling of well being*	unconsciousness, coma, death physical withdrawal "dope sick" High overdose rates, Associated with diseases due to needle (HIV, Hep C) Abscesses
Hallucinogens and "Club Drugs" MDMA LSD Psilocybin Mescaline PCP Ketamine	*increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness,* ataxia - lacking motor coordination **EYES –** Glassy, Blank stare, Dilated pupils	*altered states of perception and feeling* *;Hallucinogenic effects*	*persistent mental disorders* persisting perception disorder (flashbacks) impaired memory and learning, hyperthermia, Toxic to nervous system MDMA: cardiac toxicity, renal failure, liver toxicity, hyperthermia
OTC: DXM Inhalants	*stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination;*	*Sedation, euphoria, Drowsiness*	Unconsciousness, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death (inhalants)
Cannabinoids Marijuana Hashish	cough, odor of marijuana, "Cottonmouth" **EYES** – Bloodshot, glassy	*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*/ Impaired time and distance perception "Burnt"	*Amotivational Syndrome* *Tolerance, anxiety, impaired memory,* *psychological dependence* cough, frequent respiratory infections; Chronically "Burnt"
Anabolic Steroids	Rapid increase in muscle growth and athletic performance development of beard and other masculine characteristics acne Hair loss	*no intoxication effects* *Mood Swings- Poor anger control,* hostility and aggression, *"Roid Rage"*	hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities,