Co-occurring Substance Use and Mental Disorders: Clinical Issues in Diagnosis, Treatment and Pharmacotherapy

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Terminology

Co-occurring Mental and Substance-Related Disorders

In "A Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders," SAMHSA defines people with co-occurring disorders as "individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person… at least one disorder of each type can be diagnosed independently of the other." The report also states, "Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). There are no specific combinations of… disorders that are defined uniquely as co-occurring disorders."
(https://www.ncmhjj.com/wp-content/uploads/2014/10/Behavioral_Health-Primary_CoOccurringRTC.pdf)

- "Co-occurring Disorders refer to substance use disorders and mental disorders."

- "Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques."
  (Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005, page 27, 29)

- "The key to effective treatment for clients with dual disorders is the seamless integration of psychiatric and substance abuse interventions in order to form a cohesive, unitary system of care."

- "The integration of services represents the organizational dimension of treatment: Services for both mental illness and substance abuse need to be provided simultaneously by the same clinicians within the same organization, in order to avoid gaps in service deliver and to ensure that both types of disorders are treated effectively."
  (Mueser KT, Noordsy DL, Drake RE, Fox L (2003): "Integrated Treatment for Dual Disorders – A Guide to Effective Practice" The Guilford Press, NY. page xvi, 19)

- "Integrated treatment is the interaction between the mental health and/or substance abuse clinician(s) and the individual, which addresses the substance and mental health needs of the individual."
  (From page vi in "A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders" 2002, from the Substance Abuse and Mental Health Services Administration (SAMHSA). Resource: (https://www.ncmhjj.com/wp-content/uploads/2014/10/Behavioral_Health-Primary_CoOccurringRTC.pdf)

- One Team, One Plan for One Person

Cultural Clashes in the Behavioral Health Field

Polarized Perspectives About Presenting Problems

3 Ds	*3 Ps*
1 Deadly Disease Consider addiction in differential diagnosis, ask questions to screen, diagnose	**1 Psychiatric Disorders** Not all mental health problems are symptoms of addiction and withdrawal
2 Denial Conscious lying, amnesia of blackouts, unconscious survival mechanism	**2 Psychopharmacology** Medications often necessary, can prevent psychiatric and addiction relapse
3 Detachment Healthy distance, don't pin your professional self-esteem to client's success	**3 Process** Often no quick, easy answer to decide addiction versus psychiatric versus COD

Different Theoretical Perspectives, Different Treatment Methodologies

- **Addiction System versus Mental Health System**
  - **3 Ds and 3 Ps** - implications for medication, staff credentials, attitudes towards physicians, role of staff and team, programs

- **Integrated Treatment versus Parallel or Sequential Treatment**
  - **Hybrid programs** - staffing difficulties, numbers of patients and variability, but one-stop treatment
  - **Parallel programs** - use of existing programs and staff, but more difficult to manage cases

Care versus Confrontation

- **Mental health** - care, support, understanding, passivity
- **Addiction** - accountability, behavior change

Abstinence-oriented versus Abstinence-mandated

- Treatment as a process, not an event
- Respective roles in both approaches

Deinstitutionalization versus Recovery and Rehabilitation

- Role of "least restrictive" setting
- Role for individualized treatment with continuum of care

Why Diagnostic Confusion?

Diagnostic Confusion Due to:

- Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity)
- Prolonged alcohol/drug use can cause short or long-term psychiatric illness
- Alcohol/drug use can escalate in episodes of psychiatric illness
- Psychiatric symptoms and alcohol/drug use can occur in other psychiatric disorders
- Independent addiction and psychiatric illnesses (co-occurring disorders)
  (Marc A. Schuckit: Am. J. Psychiatry, 143:2, 1986. p.141 - modified)

Decision Tree for "Addiction versus Psychiatric Diagnoses: Either or Both?"

Take a good history.

A definitive psychiatric diagnosis by history requires the psychiatric symptoms to have occurred during drug-free periods of time.

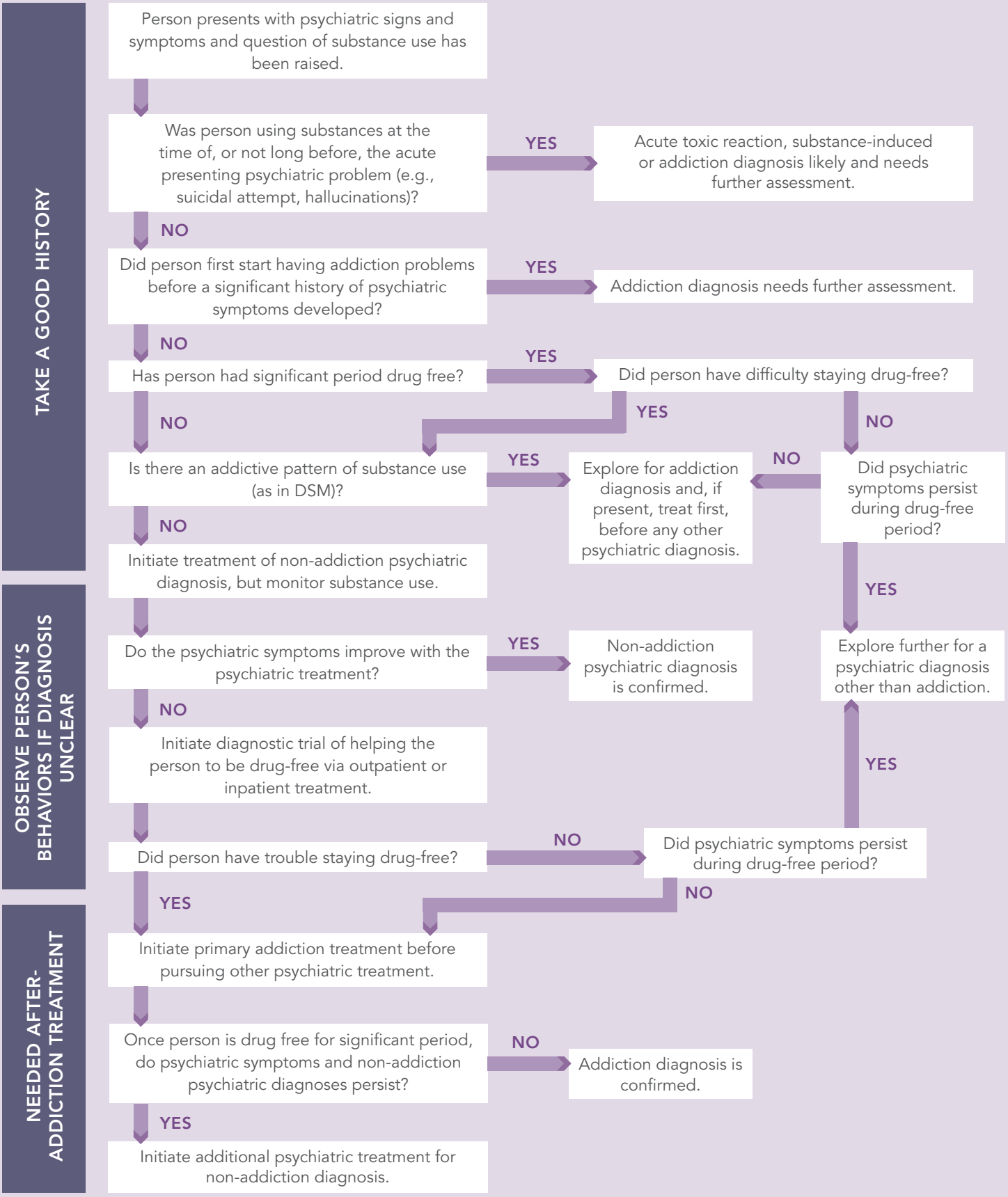
Observe the client for a sufficient time drug-free.

- Shorter time for objective, psychotic symptoms
- Longer for subjective, affective symptoms
- Non-drug ways of coping

Addiction is a biopsychosocial disorder, so encourage active involvement in a recovery program. Incorporate meetings, tools, techniques and a wide variety of non-drug coping responses to help client deal with the stresses of everyday living. Diagnosis is a process, not an event.

DECISION TREE

for Addiction vs. Other Psychiatric Diagnoses: Either or Both?



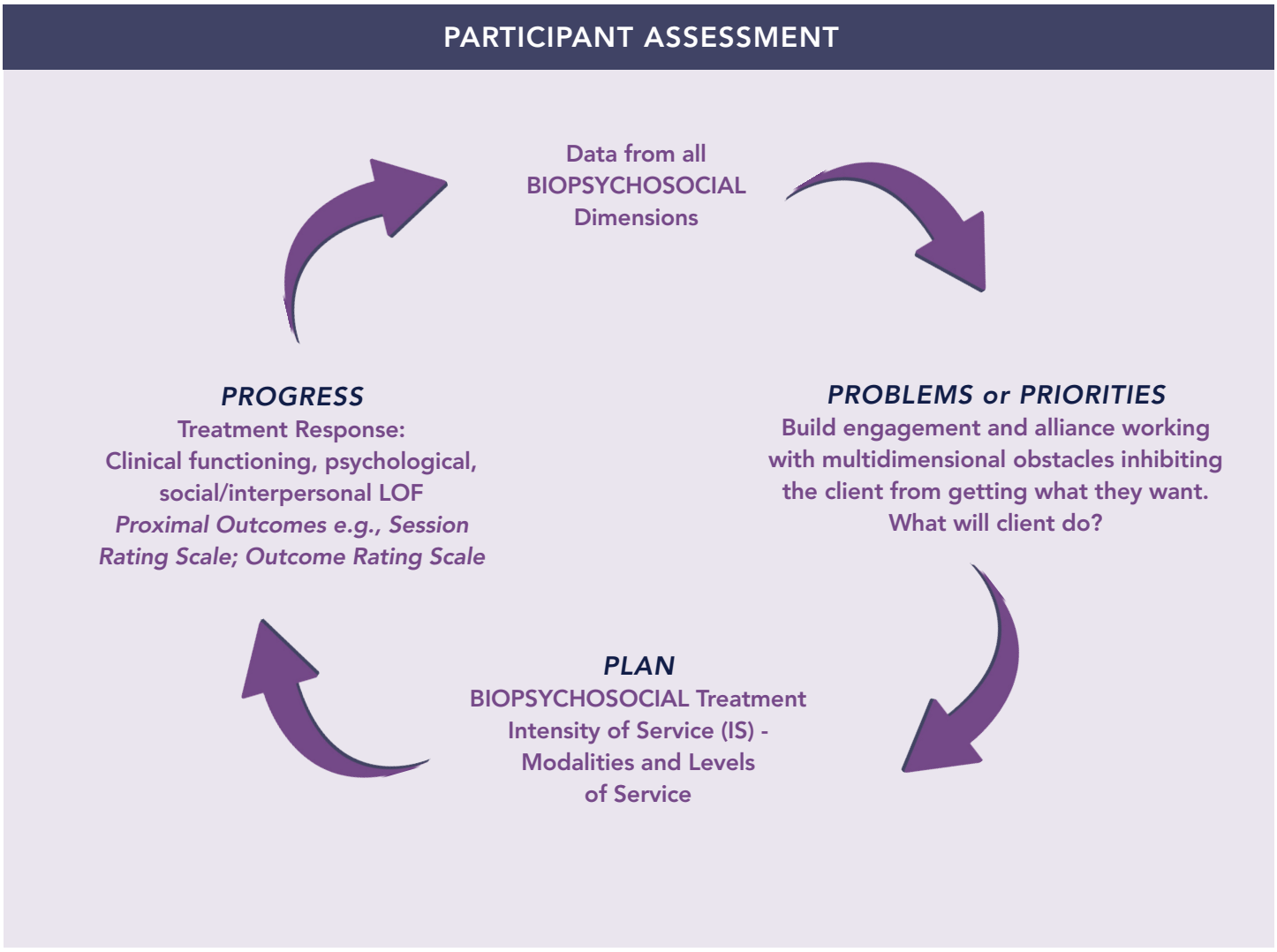
Integrated Treatment Approach: Person-centered Assessment and Treatment

Biopsychosocial Perspective of Addiction and Mental Disorders

A common view allows a common language of assessment and treatment for all involved. Addiction illness and many psychiatric disorders are chronic, potentially relapsing illnesses, often needing an ongoing process of treatment, rehabilitation and recovery, with brief episodes of acute care and stabilization.

Feedback Informed Treatment - Measurement-based Practice

A diagnosis is a necessary but not sufficient determinant of treatment. A client is matched to services based on multidimensional needs and the focus of treatment, not placed in a set program based only on having met diagnostic criteria.



Multidimensional Assessment - ASAM Assessment Dimensions

(The ASAM Criteria 2013, pp 43-53)

- The common language of the six assessment dimensions can be used to determine multidimensional assessment of obstacles, needs and strengths

1. **Acute intoxication and/or withdrawal potential**
2. **Biomedical conditions and complications**
3. **Emotional/behavioral/cognitive conditions and complications**
4. **Readiness to change**
5. **Relapse/continued use/continued problem potential**
6. **Recovery environment**

- **Biopsychosocial Treatment - Overview: 5 Ms**

5 M's

1

Motivate

Dual diagnosis clients can have ambivalence about and lack of interest in changing their addiction and mental health problems. Deal with readiness to change at a pace that keeps the patient engaged in treatment. Family and healthcare workers may also need "motivating" to deal with both addiction and psychiatric issues equally (Dimension 4).

2

Manage

Because co-occurring disordered clients easily present to both addiction and mental health programs, treatment requires more case management across the addiction and mental health treatment systems, social welfare, legal, family systems and significant others than individual therapy. Case management is especially important for high risk, multiproblem and chronic relapsing clients. Take a total systems approach. To improve outcomes, alternative services may be necessary (e.g., educational or vocational services, child care and parenting training, financial counseling, coping with feelings and dual relapse groups, daily living skills, tutoring or mentoring services, transportation) (Dimensions 1 - 6).

3

Medication

For a diagnosed co-morbid psychiatric disorder (but only after sufficient assessment strategies exclude addiction mimicking). also for withdrawal management if necessary, educate clients about their medication and interaction with alcohol/drugs. Prepare them on how to deal with conflicts about medication at AA/NA meetings. Anti-addiction medication (MAT): naltrexone (Vivitrol), acamprosate (Campral); disulfiram (Antabuse); methadone; buprenorphine; opioid antagonists (Dimensions 1, 2, 3, 5).

4

Meetings

Mainstream into AA and NA as much as possible, but prepare clients on how to not alienate themselves (e.g., too readily discussing medication and mental health issues unless with an understanding member or group). Help clients deal with their "dual identity." Help identify appropriate meetings in the area and locate or develop special support groups for those unable to be "mainstreamed." Other self/mutual help groups include SMART Recovery, Dual Diagnosis Anonymous, Emotions Anonymous, Double Trouble in Recovery, Schizophrenia Anonymous (Dimensions 3, 4, 5, 6).

5

Monitor

To ensure continuity of care, be alert to missed appointments, hospitalizations and professionals unfamiliar with dual diagnosis and the treatment goals (e.g., drug-free diagnostic trial). Promote accountability for an ongoing treatment plan rather than fragmented responses to crises. Recognize treatment as a process, not an event (Dimensions 1 - 6).

Treatment Levels of Service - ASAM Levels of Care/Service to Match Severity of Problems

- **Outpatient Services**
- **Intensive Outpatient/Partial Hospitalization Services**
- **Residential/Inpatient Services**
- **Medically-managed Intensive Inpatient Services**

(The ASAM Criteria 2013, pp 106-107)

Medication Treatment Adherence Problems: Differential Diagnosis and What to Do About It

It is important to diagnose why the person does not adhere to medication. Otherwise, the strategy may be counterproductive:

Cognitive

- Client had a bad side effect or felt meds have not worked before and so won't take medication anymore. Treat the fear of side effects and/or the lack of confidence in medication.
- Readiness to change issues: client not ready to accept medication as necessary for an illness which they may accept or be ambivalent about (motivational enhancement, stages of change work)
- Wants to use natural substances rather than psychotropic medication.

Cultural

- Believes the medication is dangerous from a cultural perspective (get a bi-cultural outreach worker)

Unconsciously non-adherent

- Somatic complaint
- Sick role, characterological
- The more the therapist is involved, the more it shows they care and the more the sick role pays off (Assertive Community Treatment (ACT) for example, because the more you go to their home to count pills, the more they are non-compliant to keep you coming back)

Drug addicted person

- Overusing pills due to addiction

Psychotic

- Delusional
- Maintain the relationship and don't struggle over the diagnosis (ACT is appropriate in such situations)

Malingering

- External incentives for the behavior (e.g., keep getting workers compensation)

Recovery environment problems

- Insufficient funds to pay for medication and/or transportation and/or childcare to keep appointments for medication monitoring

Literature References and Resources

Center for Substance Abuse Treatment. "Substance Abuse Treatment for Persons With Co-Occurring Disorders" Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005

(TIP 42 available online at Health Services/Technology Assessment Text (HSTAT) section of National Library of Medicine Web site at https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

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Resources from SAMHSA

1. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) presented "A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders". It provides a summary of practices for preventing substance use disorders among individuals who have mental illness and also a summary of evidence-based practices for treating co-occurring disorders. Resource: https://www.ncmhjj.com/wp-content/uploads/2014/10/Behavioral_Health-Primary_CoOccurringRTC.pdf

2. Substance Abuse and Mental Health Services Administration. Integrated Treatment for Co-Occurring Disorders: The Evidence. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. https://store.samhsa.gov/system/files/theevidence-itc.pdf

3. Center for Substance Abuse Treatment. "Substance Abuse Treatment for Persons With Co-Occurring Disorders" Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005 (TIP 42 is available online at the Health Services/Technology Assessment Text (HSTAT) section of the National Library of Medicine Web site at the following: https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

Notes:

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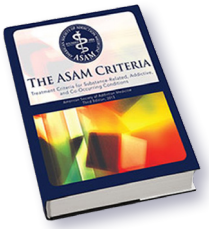
ASAM eLearning Modules

The ASAM eLearning modules introduce *The ASAM Criteria* and provides opportunities to practice multidimensional assessment, service planning and level of care placement.

Module 1: Multidimensional Assessment
Module 2: From Assessment to Service Planning and Level of Care
Module 3: Introduction to *The ASAM Criteria*
www.changecompanies.net/etraining/

The ASAM Criteria

The ASAM Criteria, Third Edition, is the most comprehensive set of guidelines for assessment, service planning, placement, continued stay and transfer/discharge of individuals with addiction and co-occurring conditions.
www.changecompanies.net/asam



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