

Addressing the Needs of Clients with Co-Occurring Disorders

Joan E. Zweben, Ph.D.

Executive Director: EBCRP
www.ebcprp.org
Clinical Professor of Psychiatry, UCSF

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Overview

- Guiding principles of programming
- How untreated psychiatric conditions affect recovery and quality of life
- Basic counselor competencies
- Distinguishing between substance-induced symptoms and independent disorders
- Psychosocial issues
- Medication
- Collaboration with physicians

Influences Promoting the Paradigm Shift (1990's)

- Epidemiological data: ECA and NCS
- Collaboration of federal agencies
- Merging of local mental health and substance abuse agencies
- Intense interest in cross-training events in local communities
- Revised Patient Placement Criteria

Terminology: Common Confusions

- Dual vs multiple disorders
- Medical comorbidities
- AOD and any coexisting psychiatric disorder
- AOD and severe and persistent mental illness
- What is funded in your community, and how?

Untreated Psychiatric Disorders

- low self esteem
- low mood
- distorted relationships & family functioning
- impaired judgment
- lower productivity
- less favorable outcome for alcohol and drug treatment

Programming: Guiding Principles

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to tx
4. Address specific real-life problems early in tx
5. Plan for the clients' cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness

(TIP 42, 2005)

"No Wrong Door"

1. Assessment, referral and tx planning must be consistent with this principle
2. Use creative outreach to promote engagement
3. Programs and staff may need to change expectations and requirements to engage reluctant clients
4. Tx plans based on client's changing needs
5. Seamless system of care to provide continuity; interagency cooperation

(TIP 42, 2005)

Integrated Treatment for COD'S

- Treatment at a single site, by cross-trained clinicians
- Medications OK and monitored when possible
Must be at least DDC (dual diagnosis capable)
- Appropriate adaptations for SMI: emphasis on reduction of harm, lowering anxiety, appropriate pacing, self help offered but not mandated

(TIP 42, 2005)

Basic Counselor Competencies

- Screen for COD; ability to refer for formal diagnostic assessment
- Form preliminary diagnostic impression to be verified by trained professional
- Preliminary screening of danger to self or others
- De-escalate client who is agitated, anxious, angry or otherwise vulnerable

(TIP 42, 2005)

Counselor Competencies, cont

- Manage crisis, including threat of harm to self or others
- Refer to mental health facility if appropriate and follow up to assure that services were received
- Coordinate care with mental health counselor; coordinate treatment plans

(TIP 42, 2005)

Addictive Behavior and Co-existing Psychopathology

Substance-Induced Disorders

- cognitive dysfunction/disorder: delerium, persisting dementia, amnestic disorder
- psychotic disorder
- mood symptoms/disorder
- sexual dysfunction
- sleep disorder

See DSM-IV-TR, pages 193, 748-749

Substance-Induced Symptoms

AOD USE CAN PRODUCE SYMPTOMS CHARACTERISTIC OF OTHER DISORDERS:

- Alcohol: impulse control problems (violence, suicide, unsafe sex, other high risk behavior); anxiety, depression, psychosis, dementia
- Stimulants: impulse control problems, mania, panic disorder, depression, anxiety, psychosis
- Opioids: mood disturbances, sexual dysfunction

Psychotic Symptoms

Hallucinations, paranoia:

- alcohol intoxication, withdrawal, overdose
- stimulant intoxication, overdose
- depressant intoxication, overdose
- hallucinogen intoxication, overdose
- phencyclidine intoxication, overdose

Common Psychiatric Disorders

- Mood disorders
- Anxiety disorders, especially PTSD
- Eating disorders
- Pathological gambling
- Antisocial personality disorder
- Severe mental illness (usually presents in the mental health system)

Coexisting Disorders: Clinical Course

- usually more difficult to establish abstinence
- greater frequency of relapse
- treatment response worse unless both are addressed
- symptoms can emerge as a consequence of chronic intoxication: post stimulant psychotic sx/disorder; panic disorder

Screening & Assessment Issues

Screening & Assessment

Screening is a process for evaluating the possible presence of a particular problem

Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing that problem

(COD TIP, 2005)

Steps in the Assessment Process

1. Engage the client
2. Identify and collaterals to gather additional information
3. Screen to detect COD's
4. Determine quadrant and locus of responsibility
5. Determine level of care
6. Determine diagnosis

(COD TIP, 2005)

Steps in the Assessment Process (2)

7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify problem domains
11. Determine stage of change
12. Plan treatment

(TIP 42, 2005)

Distinguishing Substance Abuse from Other Mental Disorders

- Wait until withdrawal phenomena have subsided (usually by 4 weeks)
- Physical exam, toxicology screens
- History from significant others
- Longitudinal observations over time
- Construct time lines: inquire about quality of life during drug free periods

Self-Medication Theory

Two versions:

- etiological - psychiatric disorder "causes" the person to develop substance abuse
- coping method - substances are used to cope with the psychiatric disorder

VS:

- many factors initiate AOD use; those and others perpetuate it

Treatment Issues


General Treatment Considerations

- Need for realistic expectations
- Offer appropriate forms of hope to counteract despair
- Accept chronicity of the disorder without viewing self as a failure or using this as an excuse
- Educate about other mental disorders as well as AOD use




Prioritizing Treatment Tasks

- Safety
- Stabilization
- Development/growth
- Maintenance of gains; relapse prevention




Additional Psychosocial Treatment Issues (COD)

- client attitudes/feelings about medication
- client attitude about having an illness
- other clients' reactions: misinformation, negative attitudes
- staff attitudes
- medication compliance
- control issues: whose client/patient?




Reasons to Resist an Abstinence Commitment

- fear of failure
- addiction pattern in family of origin
- self medication
- trauma history
- survivor guilt



Confrontation


- Many practices are believed helpful because we don't follow our dropouts
- Firm feedback needed in supportive atmosphere
- More disturbed clients are highly vulnerable to aggressive exchanges and become disorganized; they do better with low levels of expressed emotion



Suicidality

- AOD use is a major risk factor, especially for young people
- Alcohol: associated with 25%-50%
- Alcohol + depression = increased risk
- Intoxication is associated with increased violence, towards self and others
- High risk when relapse occurs after substantial period of sobriety, especially if it leads to financial or psychosocial loss

(TIP 42, 2005)



Suicidality

- Suicide does not imply depression; may be anxiety and/or despair
- Addiction: higher probability of completed suicide
- There is no data that supports the view that antidepressants prevent suicide (but, studies are only 3 months long)
- Lithium and clozaril reduce suicide attempts

Rick Ries, MD CSAM 2004

Suicidality: Counselor Recommendations

- Treat all threats with seriousness
- Assess risk of self harm: Why now? Past attempts, present plans, serious mental illness, protective factors
- Develop safety and risk management process
- Avoid heavy reliance on “no suicide” contracts
- 24 hour contact available until psychiatric help can be obtained

Note: must have agency protocols in place
(TIP 42, 2005)

Preparing Psychiatric Patients for 12-Step Meetings

- Medication is compatible with recovery, but meetings are best selected carefully
- Some meetings are more tolerant than others of medication or eccentric behavior
- People with thought disorders benefit from coaching on how to behave in meetings
- 12-step structure often beneficial; non-intrusive and stable

Issues in the Collaboration between Counselors, Physicians and Other Professionals

Barriers to Accessing Offsite Psychiatric Services

- Distance, travel limitations
- Obstacle of enrolling in another agency
- Stigma of mental illness
- Cost
- Fragmentation of clinical services
- Becoming accustomed to new staff

(TIP 42, 2005)

Prescribing Psychiatrist Onsite

- Brings diagnostic, behavioral and medication services to the clients
- Psychiatrist learns about substance abuse
- Case conferences, supervision allow counselors to learn more about dx and tx
- Better retention and outcomes

(TIP 42, 2005)

Some Common Issues

- Defining the roles of team members
- Communication pathways
- Communication breakdowns
- Struggles for control
- Integrating the physician into the team
- Educating physicians about addiction

Role of the Physician

- Establish good screening and assessment protocols
- Establish protocols for managing crises
- Training plan to upgrade staff skills
- Medication evaluation and management
- Commit to increasing knowledge about addiction if appropriate

Role of the Counselor

- Screening for COD
- Clear evaluation request for MD – specific observations and questions
- Explore charged issues
 - Client resistance to getting an evaluation
 - Client resistances to medication
 - Family history of problems
- Periodic inquiry
- Support medication adherence
- Keep physician informed

Educate Clients about Psychiatric Conditions

- The nature of common disorders; usual course; prognosis
- Important factors: genetics, traumatic and other stressors, environment
- Recognizing warning signs
- Maximizing recovery potential
- Misunderstandings about medication
- Teamwork with your physician

Reasons to Avoid Medications

- Don't believe they ever needed it; never were mentally ill or had a real disorder
- Don't believe they need it anymore; cured
- Don't like the side effects
- Fear the medication will harm them
- Struggle with objections or ridicule by friends and family members
- Feel that taking meds means they are not personally in control

Attitudes and Feelings about Medication

- shame
- feeling damaged
- needing a crutch; not strong enough
- "I'm not clean"
- anxiety about taking a pill to feel better
- "I must be crazy"
- medication is poison
- expecting instant results

Preparing Clients to See Physician about Meds

- Explore fears and hopes
- Encourage client to be a good observer and reporter; written notes are good
- Discourage client from insisting on a particular medication
- Encourage client to write out questions
- Encourage client to make notes about what the doc recommends
- Getting the right medication is often a process requiring ongoing teamwork

Medications: Counselor's Queries (1)

- Adherence
 - "sometimes people forget their medications...how often does this happen to you? (% not taking)"
- Effectiveness
 - "how well do you think the meds are working?"
 - "What do you notice?"
 - Here is what I notice

Medications: Counselor's Queries (2)

- Side Effects
 - "Are you having any side effects to the medication?"
 - "What are they?"
 - "Have you told the physician?"
 - Do you need help talking with the doc?"

(Richard K. Ries, MD CSAM 2004)

When Clients Admit to Choosing Not to Take Their Meds

- Acknowledge they have a right to make this choice;
- Stress that they owe it to themselves to make a good decision; this choice should be thought out and not impulsive;
- Explore their reasons; probe beyond initial statements like "I just don't like pills."

Resources

- Addiction Technology Transfer Centers: www.nattc.org
- NIDA Blending Initiative – partnership with SAMHSA to disseminate research findings: www.nida.nih.gov/Blending/
- NIDA Dissemination Library: <http://ctndisseminationlibrary.org/>
- Download slides from: www.ebcrp.org

Treatment Improvement Protocols (TIPS)

- Substance Abuse Treatment for People with Co-Occurring Disorders (TIP 42)
- Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery (TIP 48)
- Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (TIP 50)

<http://kap.samhsa.gov/products/manuals/tips/index.htm>