CO-OCCURRING DISORDERS
THE CASE FOR INTEGRATED CARE

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Working with communities to address the opioid crisis.

- SAMHSA's State Targeted Response Technical Assistance (STR-TA) and State Opioid Response Technical Assistance (SOR-TA) grants created the *Opioid Response Network* to assist states, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis .
- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

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Working with communities to address the opioid crisis.

- The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.
- The ORN accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

PEOPLE FIRST.

The ATTC Network uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.

WORDS HAVE POWER.

Virtual Platform Logistics

- Chat box
- Raise your hand
- Muting and unmuting

Goal

Participants will understand high rates of co-morbid substance use among individuals with mental health disorders, and how to effectively intervene to address substance use for persons with mental health disorders.

Objectives

Define substance use, misuse, and co-occurring disorders

Prevalence of substance use and mental health disorders

Review evidence-based based screening and assessment practices with client with co-occurring disorders

DEFINITIONS & TERMS

Substance Use Terms

- **Substance Use** (SU) refers to the consumption of psychoactive substances
- **At-risk Substance Use** refers to consuming at levels resulting in harmful or hazardous consequences
- **Substance Use Disorder** (SUD) meets a diagnostic criteria

Co-occurring Disorder is when a person meets the criteria for a substance use disorder and is diagnosed with one or more additional mental health disorders, this is called having co-occurring psychiatric conditions or a dual diagnosis.

Comorbidity also means that interactions between two (or more) disorders that can worsen the course of each.

It is difficult to distinguish between overlapping symptoms, making diagnosis and treatment complex.

NIDA, National Institute on Drug Abuse, Research Report Series, August 2018, Comorbidity: Addiction and Other Mental Illnesses, https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

Criteria for Substance Use Disorder Diagnosis

- Taking the substance in larger amounts or for longer than you're meant to.
- Wanting to cut down or stop using the substance but not managing to.
- Spending a lot of time getting, using, or recovering from use of the substance.
- Cravings and urges to use the substance.
- Not managing to do what you should at work, home, or school because of substance use.
- Continuing to use, even when it causes problems in relationships.
- Giving up important social, occupational, or recreational activities because of substance use.
- Using substances again and again, even when it puts you in danger.
- Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
- Needing more of the substance to get the effect you want (tolerance).
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

DSM 5: APA

Severity of Substance Use Disorder

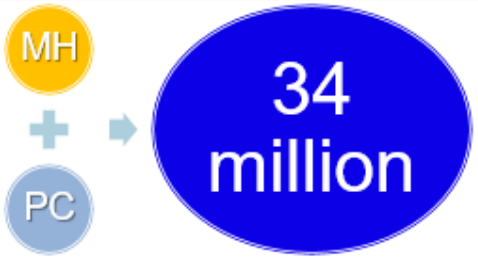
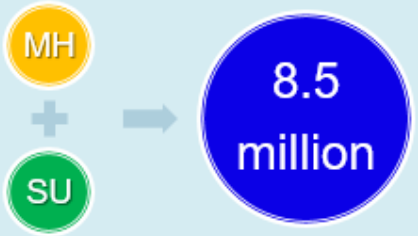
The DSM 5 allows clinicians to specify how severe or how much of a problem the substance use disorder is, depending on the number of symptoms that have been identified.

- **Mild**: Two or three symptoms
- **Moderate**: four or five symptoms
- **Severe**: six or more symptoms

Clinicians can also add "in early remission," "in sustained remission," "on maintenance therapy" for certain substances, and "in a controlled environment."

DSM 5: American Psychological Association

CO-OCCURRING DISORDERS ARE COMMON

➢ 34 million American adults had both a mental and physical health disorder in past 12-months[1].	
➢ In 2017, about 8.5 million people had both a mental health and SUD[2] (ages 12+).	
➢ In 2017, about 3.1 million people had serious mental illness and SUD[2] (ages 18+).	

1 Druss, B.G., and Walker, E.R. (2011).
2 SAMHSA, NSUDH (2018)

Why so common?

- Developmental Factors (i.e. one causes the other):
  - Substance abuse usually **starts during adolescence** when the brain is undergoing significant developmental changes.
  - **Early exposure to drug misuse can change the brain** in ways that increase the risk for mental illness, and early symptoms of a mental disorder may increase vulnerability to drug abuse (Volkow 2004; Bolanso et al. 2003; Carlezon et al. 2003, NIDA Topics in Brief: Comorbid Drug Abuse and Mental Illness)
- Shared Risk Factors: For example, shared genetic vulnerability or environmental stressors--stressful life events, trauma (Pettinati 2004; Kendler et al. 2003; Schuckit 1986; Tambs et al. 1997)
- Indirect risk factor: 'Self medicating' one psychiatric disorder transitions into a substance use disorder (Gross et al. 2013)

Clinical Relevance: Why does this matter?

- Co-occurring psychiatric illness and SUD have:
  - **Worse prognosis**: worse treatment outcomes, higher risk of return to use and hospitalizations (Mangrum 2009; Bradizza 2006; Urbanoski 2018)
  - **Poorer quality of life** (Wittenberg 2021)
  - **Increased risk of suicide**, particularly with bipolar disorder (Schaffer 2015)
- Effective treatment of co-occurring psychiatric disorders, such as bipolar disorder or major depression generally improves the outcome of the substance use disorder (Tolliver 2015)

Clinical Relevance: Diagnostic and Treatment Implications

- When evaluating someone with both substance use disorder and psychiatric symptoms, careful diagnosis, evaluating for substance-induced disorders is important

- A different clinical course may be expected if psychiatric symptoms are substance induced.
  - Substance-induced symptoms should improve rapidly with abstinence (Schuckit 2006).
  - However, other work suggests both primary and substance-induced depression predict future depression, recurrence of SUD symptoms and suicidal ideation, warranting clinical attention and consideration for specific treatment (Nunes et al. 2006; Aharonovich et al., 2002; Hasin et al., 2002)

Clinical Relevance: Diagnostic and Treatment Implications

It is important to note that sometimes even with the most prudent evaluation it can be very difficult to differentiate independent from secondary disorders without reduction/abstinence period

- Reduction/abstinence can be difficult and delaying treatment for psychiatric symptoms can have serious consequences.

For co-occurring independent depressive disorder + SUD

- **Antidepressant treatment improves depression symptoms**
- Improvement in drug/alcohol use is less consistent across studies (Nunes and Levin 2004; Pettinati et al. 2013).

For co-occurring bipolar + SUD

- **Fewer studies** but lithium or mood stabilizers appear to improve both mood and substance use (Nunes and Weiss et al. 2015)

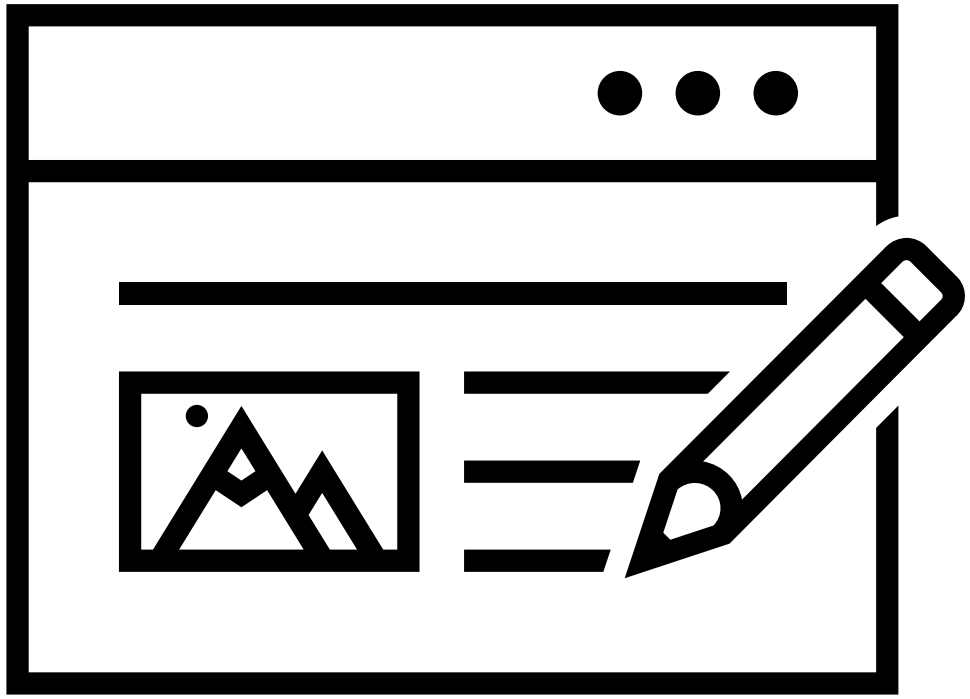
Clinical Relevance: Diagnostic and Treatment Implications

- Reasonable clinical guideline for managing co-occurring substance use disorder + other psychiatric syndromes (Nunes and Weiss et al. 2015)
  - Initiate treatment for the substance use disorder
  - Support the individual to explore abstinence, or reduce substance use, and observe what happens to co-occurring psychiatric symptoms: Do they resolve? Or persist?
  - Differentiating independent from substance-induced disorders may be difficult in practice, especially if the individual is not able to abstain from substance use
    - If psychiatric symptoms are severe, or entail risks (e.g. poor functioning, suicidal ideation) it may be better to initiate treatment for co-occurring psychiatric syndrome right away, rather than delay to await abstinence.

The untreated symptoms of a mental health disorder can cause the individual to be unable to refrain from substance use, and untreated SUD issues can make mental health treatment ineffective

Individuals entering treatment for psychiatric illnesses should also be routinely screened for substance use disorders.

Source: SAMHSA, 2005



EARLY IDENTIFICATION VIA SCREENING

Screening & Assessment
4 Key Principles

1. Because many MH clients have substance use disorders, screen all clients for both types of disorders
2. In addition to clients themselves, gather information from as many sources as possible
3. If information from client doesn't match info from other sources, ask client to help resolve discrepancy in non-threatening, matter-of-fact way
4. It is important to continue the assessment over time

Screening & Assessment
4 Key Principles

- Remember that not all substance use is excessive; even some people with COD are able to drink/use occasionally
- With someone who does, it's a good opportunity to educate on interaction with their MH condition and risks of drinking/using more frequently or heavily

Before Starting

What might you need to consider to create an atmosphere of trust, (culturally appropriate, trauma informed, affirming) and comfortability prior to beginning the screen?

I would like to ask you some questions that I ask all my patients. These questions will help me to provide you with the best care possible. As with all medical information your responses are confidential. Also, we can stop at any time.

GOAL of Screening, Brief Intervention and Referral to Treatment (SBIRT)

The primary goal of SBIRT is to **identify** and **effectively intervene** with those who are at moderate or high risk for psychosocial or health care problems ***related*** to their substance use.

Source: SAMHSA, 2013

Screening: Universal screening for quickly assessing use and severity of alcohol; illicit drugs; and prescription drug use and misuse

Brief Intervention: Brief motivational and awareness-raising intervention given to risky or problematic substance users

Referral to Treatment: Referral for further assessment or specialty care for patients with a potential of a substance use disorder

Source: SAMHSA, 2013

Screening & Assessment

- It is important to understand a client's mental illness and their substance use, *and how they interact with each other*, in order to provide effective treatment

- Once someone screens positive for both types of disorders, proceed with in-depth assessment

What Comes Next?

Positive Screen = Referral for Assessment

SUD SCREENING INSTRUMENTS

CAGE-AID

CAGE-AID (CAGE Questions Adapted to Include Drugs)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Scoring: Item responses on the CAGE-AID are scored 0 for "no" and 1 for "yes" answers. A higher score is an indication of alcohol problems. A total score of 2 or greater is considered clinically significant

Interpretation: One or more "yes" responses is regarded as a positive screening test. It's an indication of possible substance use disorder and need for further evaluation.

Source: SAMHSA, 2014

Drug Abuse Screening Test – DAST

- In the past 12 months:
- 1. Have you used drugs other than those required for medical reasons?
- 2. Have you abused more than one drug at a time?
- 3. Are you always able to stop using drugs when you want to?
- 4. Have you had “blackouts” or “flashbacks” as a result of drug use?
- 5. Do you ever feel bad or guilty about your drug use?
- 6. Does your spouse (or parent) ever complain about your involvement with drugs?
- 7. Have you neglected your family because of your use of drugs?
- 8. Have you engaged in any illegal activities in order to obtain drugs?
- 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
- 10. Have you had any medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc…)?

DAST Zones and Scores

Score	Risk Level	Intervention
0	Zone 1: **No risk**	Simple advice: Congratulations this means you are abstaining from excessive use of prescribed or over-the-counter medications, illegal or non-medical drugs.
1-2	Zone 2: At Risk Use - "low level" of problem drug use	Brief Intervention (BI). You are at risk. Even though you may not be currently suffering or causing harm to yourself or others, you are at risk of chronic health or behavior problems because of using drugs or medications in excess; and continued monitoring
3-5	Zone 3: "intermediate level"	Extended BI (EBI) and RT – your score indicates you are at an "intermediate level" of problem drug use. Talk with a professional and find out what services are available to help you to decide what approach is best to help you to effectively change this pattern of behavior.
6-10	Zone 4: Very High Risk, Probable Substance Use Disorder	EBI/RT- considered to be at a "substantial to severe level" of problem drug use. Refer to specialist for diagnostic evaluation and treatment.

Should be comprehensive; addressing a wide range of domains including routine exploration of substance use

Should document a SUD diagnosis (or rule out)

Can address clinical perceptions of the interactive features of the client's substance use and mental disorders

Should inform treatment planning (i.e. service provision)

Source: SAMHSA, 2020

The Chicken or the Egg: Which Comes First?

Does it really matter?

Regardless of how they develop, substance use and mental disorders become "functionally intertwined" in the maintenance of the co-occurring disorders such that each perpetuates the other

Source: McCarthy, 2009

Substance use can create and mimic mental health symptoms like paranoia, delusions or depression.

Examples:

- Risk of psychosis increases in some marijuana users.
- Depression is a common effect of certain drugs like crystal meth and alcohol as they begin to wear off, and it's a symptom that can deepen into a disorder over time.

If we have similar or overlapping symptoms, then what are the implications to clinical assessments and diagnosis?

Source: SAMHSA, 2005

DIFFERENTIAL DIAGNOSIS

Diagnostic Challenges

- Are symptoms substance-induced or part of an underlying MH disorder?
  - If symptoms go away after period of sustained abstinence, they were likely substance-induced
  - If they persist, it is likely they have an underlying MH disorder
- Vital to get accurate history

Diagnostic Challenges

- There is limited research data on how much time must pass to consider a symptoms as having been substance-induced. For instance:
  - Cocaine-induced hallucinations or depression may linger even after abstinence has been established
  - Alcohol-induced depression may last 6 months or longer if someone has been drinking heavily for many years
  - Meth-induced psychosis or depression may last for several months or longer

Diagnostic Challenges

- Recommendation:
  - At intake/program admission, treat the presenting symptoms
  - May not know etiology yet
  - Example: prescription meds to reduce cravings and treat hallucinations or depression symptoms
  - Discuss diagnostic challenge with treatment team
  - Explain the diagnostic challenge to the client/patient and enlist their help

Mental Health Symptoms Often Caused by Substance Use

Substance	Associated Depressive Symptoms		
	Intoxication	Withdrawal	Chronic Use
Alcohol		Depressed mood, anxiety, poor appetite, poor concentration, insomnia, restlessness, paranoia and psychosis	Depressed mood and other depressive symptoms
Opioids	Low energy, low appetite, poor concentration	Depressed mood, fatigue, low appetite, irritability, anxiety, insomnia, poor concentration	Depressed mood and other depressive symptoms
Cocaine and stimulants	Anxiety, low appetite, insomnia, paranoia and psychosis	Depressed mood, increased sleep, increased appetite, anhedonia, loss of interest, poor concentration, suicidal thoughts	Depressed mood and other depressive symptoms
Cannabis	Anxiety, apathy, increased appetite	Anxiety, irritability	Low motivation, apathy
Sedative-hypnotics	Fatigue, increased sleep, apathy	Anxiety, low mood, restlessness, paranoia and psychosis	Depressed mood, poor memory

Source: SAMHSA, 2008

Symptom	Intoxication	Withdrawal
Depressed Mood	Opioids, alcohol, benzos	Stimulants, hallucinogens, cannabis, caffeine, tobacco
Anhedonia (lack of pleasure)	N/A	Feature of withdrawal from numerous substances; powerful relapse trigger
Hypersomnia	Opioids, alcohol, benzos	Stimulants, caffeine
Insomnia	Stimulants, caffeine	Opioids, alcohol, cannabis, tobacco
Significant weight loss	Stimulants (long-term)	Opioids/benzos (nausea/vomiting), cannabis
Significant weight gain	Cannabis (increased appetite)	Stimulants

Symptom	Intoxication	Withdrawal
Psychomotor Agitation	Alcohol, caffeine, stimulants	Cannabis, benzos, stimulants
Psychomotor Retardation	Inhalants, Opioids	Stimulants
Fatigue/loss of energy	N/A	Caffeine, stimulants
Worthlessness or excessive guilt	Not in diagnostic criteria	Not in diagnostic criteria but frequent in withdrawal from numerous substances
Impaired focus, concentration, and/or memory	Alcohol, cannabis, opioids, benzos	Caffeine, stimulants in individuals with ADHD

Diagnostic Challenges

- As client proceeds in treatment, the etiology of their symptoms should become clearer
- The longer they are abstinent or using minimally and symptoms persist, the more likely that they have a non-substance induced MH disorder
- There will be diagnostic uncertainties, so be prepared to revise your diagnoses and treatment plans over time
  - How is your tolerance of ambiguity?

CO-OCCURING CASE STUDY THE POWER OF ASSESSMENT

Case Study: Post Traumatic Stress Disorder (PTSD)

- Ms. M is a 28-year-old woman who comes to you requesting buprenorphine for treatment of opioid use disorder.
- Ms. M reports that she was first prescribed oxycodone 2 years ago after a fall in which she fractured her arm requiring surgical intervention. She reports about 1 month later she fractured her jaw, again after a fall, receiving another prescription for oxycodone. She tells you that since this time she has had a number of other injuries, and "aches and pains," for which she was taking oxycodone.
- She reports initially the "oxys" were "magic pills" not only treating her physical pain, but helped her "stay numb and emotionally checked out."

Case Study: PTSD History-continued

- However, she tells you that over time she began to need increasing doses of oxycodone to achieve the same effect (tolerance). She describes using more than she planned, trying to cut back but being unable to, describes symptoms of opioid withdrawal when she has tried to stop, cravings that are
- "impossible to resist," and reports that financially she is "in trouble," as she is spending all of her money on oxycodone; she was recently fired from a job due to repeated absences, "I was out getting high." She is using about 150mg orally per day.

- She reports the desire to stop using oxys, stating "they've ruined my life," and has heard that you can prescribe buprenorphine/naloxone (e.g. Suboxone, Zubsolv).

Case PTSD

- You diagnose Ms. M with opioid use disorder and believe that Suboxone is a reasonable treatment option.
- However, you begin to wonder about her "aches and pains," and the many fractures she has reported, particularly given she is only 28 years old.
- You ask Ms. M a bit more about the circumstances leading to her injuries.
- Ms. M opens up to you and reveals that she had been experiencing intimate partner violence in her relationship for 4 years; she tells you her injuries are the result of the physical abuse she suffered.
- Ms. M says that with the help of friends she was able to leave the relationship and is currently living with a friend in a "safe environment."
- You begin to wonder if Ms. M might have post traumatic stress disorder (PTSD).

Case PTSD

- You now wonder how to treat Ms. M.
- Question 1: How is PTSD treated?
- Question 2: Should I treat her OUD first?
- Question 3: Will treating her PTSD worsen her OUD?

- Because the focus has traditionally been on establishing which disorder is primary, the most common strategy in treatment of co-occurring disorders has been to treat them **sequentially.**
  - E.g., requiring substance abstinence before initiating mental health treatment.

BUT, Integrated approaches are evidence-based and more effective; most important is that a clinician understands the interactive features of a client's co-occurring substance use and mental disorders and then develops a treatment plan that incorporates a focus on both disorders.

FEEDBACK AND QUESTIONS

Your Feedback is Important

Contact the Opioid Response Network

- To ask questions or submit a request for technical assistance:
  - Visit www.OpioidResponseNetwork.org
  - Email
    - Emely.Santiago@nyspi.Columbia.edu
    - Katherine.Cunningham@nyspi.Columbia.edu
  - Call 401-270-5900

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