Co-Occurring Disorders

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Understanding Co-Occurring Disorders

- What is a co-occurring disorders (COD)?
- What are the rates of (COD)?
- What are some common COD's?
- What are some treatment and suggestions for working with COD?

What is a Co-occurring Disorder?

- Co-occurring disorder is when an individual has 2 simultaneous disorders.
- Often when we hear this we translate that to a patient has both a substance use history and a mental health disorder (though this can include a medical disorder and a MH or SUD disorder)
- Often this is referred to as “dual diagnosis”

What came first?

- Either disorder can develop first.
- Mental health issues can cause people to use alcohol and/or drugs as a form of self medication.
- Substance use can make an underlying mental health condition worse (i.e. someone that has depression who drinks becomes suicidal)
- Substance use can cause an onset of symptoms that may or may not continue after substance use stops (i.e. psychosis after marijuana, amphetamine or spice use)

How many adults in the US have a co-occurring disorder?

2014 National survey on drug use and health indicates of American adults over the age of 18:

- Estimated 43.6 Million (18.1%) experience a Mental illness
- 20.2 Million (8.4%) have substance use disorder
- Highest rates of COD occurs during ages 18-25 (confirmed by studies done by Hazelden and SAMHSA)
- 7.9 million adults have co-occurring disorders

Co-occurring disorder rates

We know that there is a high level of comorbidity but did you know:

- Women in substance use treatment, 55%-99% report trauma history.
- Men in substance use treatment, 11-38% have PTSD
- Approximately 7% of adult population in the US have major depressive disorder
- 19% of adults in the US suffer from at least one anxiety disorder in any given year
- .5 to 1.5% of adult population (worldwide) have Schizophrenia Equal rates in men and women.

Co-occurring rates continued

- COD rates are highest with bipolar disorder and any substance use. (Depression and alcohol are next).
- Approximately 37% of all individuals with alcohol dependence also will have 1 or more mental health disorders.
- National surveys of comorbidity (1996, 2001 and 2003) have found that individuals diagnosed with any MH disorder are 2.4x more likely to also have alcohol/drug disorder.

Co-occurring disorder rates

The National Comorbidity Study (1996) found that 41-65% of participants with any lifetime substance use disorder also had a lifetime history of at least one MH disorder

36.8% Receive treatment for one condition

7.4% Receive Co-Occurring treatment

55.8% Receive no treatment at all
Why is this?

55.8% receive no treatment at all. WHY IS THIS?

<u>Possible reasons:</u>

No formal diagnosis

People are not well informed re: symptoms/warning signs

Untrained staff or Lack of professional help available

People don't know how to help

People with MH problems often won't seek help

Lack of screening

Overlap of symptoms

Overlap of other health issues

Complex symptom presentation (is it diagnosis a, or b?)

Barriers to treatment success

- *Treatment resistance*
- *Patients with COD will have poorer treatment courses and outcomes than those with a single disorder*
- *Contradictory treatment practices for each type of disorder*
- *Controversy between MH meds and recovery programs*
- *SUD patients don't want to divulge MH symptoms (stigmas, additional requirements/recommendtaions)*
- *MH patients don't want to divulge SUD symptoms/use (stigmas, additional requirements/recommendations).*

COD and active use

- Less likely to follow through with services (studies are showing that MH treatment is more effective in those who are not actively using)
- Less likely to adhere to medications
- Receive less adequate medical care
- Can have severe medical complications (even early death)
- At increased risk of impulsive, even potentially violent acts

Signs of Co-Occurring Disorders Are Unique

- Individuals who are living with co-occurring disorders find functioning on a day-to-day basis to be significantly difficult – if not impossible

Increased difficulties with:

- Maintaining employment
- Maintaining functional relationships
- Maintaining housing or finding housing if homeless
- Legal problems
- Financial issues
- Extreme mood swings or an inability to control their emotions
- Difficult to find adequate help

Common warning signs

- Sudden changes in behavior, work/school performance
- Withdrawal from friends, friends, social activities, things that they once enjoyed
- Extreme or prolonged mood changes. Feeling excessively sad or low, uncontrollable highs, strong feelings of irritability or anger.
- Excessive worry or fear
- Engaging in risky behaviors
- Confused thinking, problems with concentrating and learning
- Difficulties understanding or relating to people
- Changes in energy level and sleep habits (nightmares)
- Changes in eating habits
- Multiple physical ailments without obvious cause (headaches, stomach aches, vague and ongoing aches and pains)
- Thinking about suicide
- Inability to carry out daily activities

Common Co-occurring disorders

Bipolar disorder and substance use

- Alcohol is the most commonly abused substance among individuals with bipolar disorder.
- Patients with bipolar do are significantly more likely to develop an addiction. Symptoms (anxiety, pain, depression, sleeplessness) of bipolar disorder can trigger self medicating and self medicating can trigger more symptoms of depression or mania creating a vicious cycle.

- **<u>According to a study by the American Journal of Managed Care</u>**:

Approx *56%* of individuals with bipolar who participated in a national study had experienced drug or alcohol addiction during their lifetime.

Approx 46% of that group had abused alcohol or were addicted to alcohol.

Approx 41% had abused drugs or were addicted to drugs.

Common Co-occurring Disorders

Alcoholism and Mental health disorders

- Alcohol abuse is associated with a number of mental health concerns, including:
  - Depression (Drinking dampens the brain, and can mimic depression, which can lead to increase in suicidal thoughts.
  - Mania
  - Dementia
  - Schizophrenia

Common Co-occurring Disorders

Marijuana Addiction and Schizophrenia

- Large doses of marijuana may induce acute psychosis
- Longer lasting psychotic disorders have been associated with the use of marijuana.
- The use of marijuana as a teenager can produce changes in the brain that resemble features of schizophrenia.

- Spice/K2 (synthetic version of marijuana). Reports indicate it's more harmful than weed because of the chemicals that are added to it. Long term effects include psychotic episodes, hallucinations, depression, brain and kidney damage.

Common Co-occurring Disorders

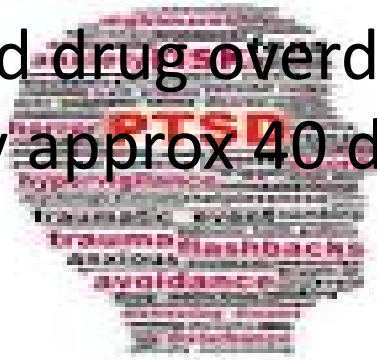
Cocaine Addiction and Anxiety Disorders

- Cocaine can result in: euphoric high, rush of energy, aggression, paranoia and anxiety.
- It can make pre-existing anxiety worse, and those that use for a long period of time may develop anxiety.
- Anxiety can also be a symptom of withdrawals from cocaine.

Common Co-occurring Disorders

Opioid Addiction and PTSD

- Post-traumatic stress disorder (PTSD) is a mental illness that takes hold in the aftermath of a very serious episode in which the person was either facing death or watching someone else die. Often, people who survive these episodes emerge with very serious physical injuries, and often, those injuries are treated with prescription painkillers.
- Prescription opiod drug overdoses increased 300% in 3 years. Currently approx 40 deaths per day.



Common Co-occurring Disorders

Heroin Addiction and Depression

- More than 90% of people that use heroin also use at least one other drug.
- While heroin can make users feel remarkably pleasant in the short term, long-time users can burn out the portions of the brain responsible for producing signals of pleasure
- In time, they may have a form of brain damage that leads to depression

Mental Illness and Violence

Individuals with a mental illness are NOT more or less violent than anyone else

Substance use in combination with a mental illness is often the culprit when it comes to violence. Mentally ill individuals are more sensitive to the effects of drugs. This increases their risk of violence.

Psychosis, Violence and Substance Use

- Voices and delusions appear irrational to us but they are experienced as real to the individual
- If a person fears personal harm or feels threatened by others, interpersonal violence becomes more likely
- When internal controls that might otherwise block the experience of violence break down (ie: substance use leading to disinhibition), violence becomes more likely

Incarceration/Supervision

- Be aware that incarceration and supervision are an additional stressor to the individual
  - Incarceration may add guilt and shame. Many can't tolerate the boredom and restriction that is experienced. Sleep while incarceration can be difficult. Leading to someone who is even more distressed
  - It's anxiety producing to not know what is going to happen
  - Can be traumatic to be arrested or incarcerated
  - All of these can lead to the decompensation of mental health

Suggestions

- **Be empathetic that clients can't always control their symptoms and can't just "get up and do something."**
- **Be mindful about scheduling**
- **Offer phone appointments/support; in the community appointments if the client has difficulties coming to you**
- **Be mindful that coming to court or probation appointments may heighten anxiety. Some may experience flashbacks or have previous negative experiences and will be on edge to begin with. Using calm and non threatening approaches.**
- **Write things down.**

Suggestions continued

- **Keep appointments short and focused on 1-2 things.**
- **Have harm reduction techniques available when appropriate**
- **Talk about things that have helped in the past for them to be successful and are they doing them now.**
- **Explore medical supports**
- **With hallucinations/delusions- understand that this is very real for the client and often challenging the hallucination/delusion will lead to further conflict.**

Treatment related

- Ways to increase awareness and detection:
  - Routine screenings at:
    - SBIRT (Screening, Brief Intervention, and Referral to Treatment)
    - Entry points to criminal justice settings
    - Primary care provider appointments
    - Within schools
    - At assessment (providing MH screenings at SUD assessment; and vice versa).
  - Using standardized screening tools (training staff to administer screening tools)

Treatment related

- Patient driven care: patient has choices, shared decision-making
- Patient/family education, support and resources
- Patient is provided one consistent message about treatment and recovery
- Integrated treatment specialists when possible. Patients that have the same clinician treating COD have a better outcome than 2 providers treating 1 disorder.

Treatment Related

- Individual treatment
  - Cognitive Behavioral Therapy
  - Motivational interviewing
  - Stages of Change
  - Dialectical Behavioral Therapy

- Therapeutic courts: Substance Abuse Court, Drug Court, Mental Health Court, Family Treatment Court, Juvenile Recovery Court, Veteran's Court, Domestic Violence Court

- Programs that include client accountability

- Group therapy: Relapse prevention, MRT, Integrated groups (Seeking Safety, Living in balance)

Treatment Related

- Case Management
- Peer Support
- Self help groups (AA, NA, DDR, NAMI, Celebrate Recovery, SMART)
- Medication management including medications that help with substance use (i.e. antabuse, suboxone, subutex, methadone, buprenorphine, naloxone)
- Assertive Outreach Case management (can be known also as PACT teams)
- Overall it has been found that comprehensive longer-term approach, addressing motivational, individual, and family issues maintained clients in treatment and produced better outcomes than other programs
- Early detection and treatment can increase treatment outcomes

Treatment Example
Lifeline Connections

- **Sobering Services-** a place for intoxicated people to come for basic needs. A hot meal, shower, sleep. Treatment providers start talking about options and provide assessments as appropriate.
- **Withdrawal Management (detox)**- the first major challenge is to stop using. Inpatient withdrawal management programs are more effective for initial sobriety and safety.
- **Inpatient** (residential) program- a 24/7 facility where a patient can receive substance disorder and mental health treatment. Offer groups, individual therapy, family therapy, medication management, and begin case management.
- **Outpatient program-** utilizing individual psychotherapy, medications, group therapy, family therapy, peer support, case management.
- **Supportive housing** (family style recovery home)- they provide support and accountability. *In Clark County there are very few supportive housing programs that have therapy support, they are often peer led/run homes.

Questions

Thank you

For additional information:

- Hazelden; www.Hazelden.org
- Substance Abuse and Mental Health Services Administration; www.samhsa.gov and www.samhsa.gov/sbirt/about
- National Alliance Mental Illness; www.nami.org
- Management of aggressive behaviors; www.moabtraining.com
- Mental health America; www.mentalhealthamerica.net
- Seeking Safety; www.seekingsafety.org
- DBT Skills lessons; www.dbtselfhelp.com
- Motivational Interviewing; www.motiviationalinterview.org
- Mental health First aid; www.mentalhealthfirstaid.org
- Dual Diagnosis; www.DualDiagnosis.org
- The National Council for Behavioral health: www.thenationalcouncil.org
- The American Journal of Managed care: www.ajmc.com