Co-occurring Psychiatric & Substance Use Disorders

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Scope of Practice

An addiction professional’s scope of practice varies with education, training and state requirements

Each practitioner should keep their scope of practice in mind as we conduct this presentation

Personal Experience-Science-Practice

Bottom-line → There is more than one path to recovery, and its important for practitioners to understand how our personal perspectives influence how we talk to patients about their treatment decisions.

Science»»» Practice! With informed caution and humility!

Patient-centered collaborative approach: Scientific Knowledge + Experience + Perspective

Defining CODs

•**Co-morbidity of Substance Use and Psychiatric Disorders**

Among a sample of about 10,000 adults:

- 13.5% had an alcohol use disorder. Of those, 36.6% also had a psychiatric disorder
- 6.1% had a drug use disorder; Of those, 53.1% also had a psychiatric disorder
- 22.5% had a psychiatric disorder Of those, 28.9% also had an alcohol or drug use disorder

	%	ODDS RATIO
Alcohol Use	**13.5**	
Psychiatric Disorder	36.6	2.3
Drug Use	**6.1**	
Psychiatric Disorder	53.1	4.5
Psychiatric Disorder	**22.5**	
Alcohol or Drug Disorder	28.9	2.7

Brickman's Model of Helping & Coping Applied to Addictive Behaviors

Is the person responsible for the development of the addictive behavior?	Is the person responsible for changing the addictive behavior? YES	Is the person responsible for changing the addictive behavior? NO
YES	MORAL MODEL (War on Drugs) Relapse = Crime or Lack of Willpower	SPIRITUAL MODEL (AA & 12-Steps) Relapse = Sin or Loss of Contact with Higher Power
NO	COMPENSATORY MODEL (Cognitive-Behavioral) Relapse = Mistake, Error, or Temporary Setback	DISEASE MODEL (Heredity & Physiology) Relapse = Reactivation of the Progressive Disease

Defining Co-occurring Disorders

Psychiatric Disorders in Addiction Treatment

- Two studies of Prevalence rates in addiction treatment settings had similar findings. Persons with substance use disorders are also like to have mood and anxiety disorders.

DISORDER	CACCIOLA	ROSS
Mood Disorder	10–45%	31.4%
Anxiety Disorder	10–46%	45.4%
Post-traumatic Stress Disorder	15–45%	NA
Antisocial Personality Disorder	25–50%	36.5%
Borderline Personality Disorder	10–30%	NA
Schizophrenia	< 5%	4.3%

Source: Cacciola et al, 2001; Ross, Glaser and Germanson 1988

Defining Co-occurring Disorders (CODs)

- Context of addiction treatment-roughly half of the population with have another psychiatric disorders
- In mental health services, SUDs are the second most common diagnosis in the general population-& the most frequent co-occurring disorder among people with serious psychiatric illness
- Expectation not an exception
- The good news is: effective treatment of substance use can improve the course of CODs
- Which comes first????

Definitions & Concepts

- The combination of 2 disorders is generally more serious than either disorder alone
- When the 2 disorders co-occur, the course of each problem area is worsened
- CODs tend to be more severe and have a greater effect on QOL

Kessler, 1995; Swann, 2010

Why High Comorbidity?

- Secondary psychopathology models
- Secondary substance use disorders model: Self-medication hypothesis; Common factors, & Bidirectionality

Severity of Co-occurring Disorders

- Co-occurring psychiatric disorders are often placed on a continuum of severity.
  - **Non-severe:** early in the continuum and can include mood disorders, anxiety disorders, adjustment disorders and personality disorders.
  - **Severe:** include schizophrenia, bipolar disorder, schizoaffective disorder and major depressive disorder.

Overrepresented Disorders

- Mood disorders
- Anxiety disorders
- Thought disorders
- Personality disorders
- Misdiagnosing??

Research

Practice

Screening & Assessments

Engage the patient

Identify and engage family/CSO

Screen for and detect COD

Determine quadrant and locus of responsibility

Determine level of care/Patient-treatment matching

Determine diagnosis-disability and functional impairment

Determine strengths and support and value system (VC)

Identify cultural needs

Determine readiness for change

Individualize Treatment plan

Approaches to Treating CODs

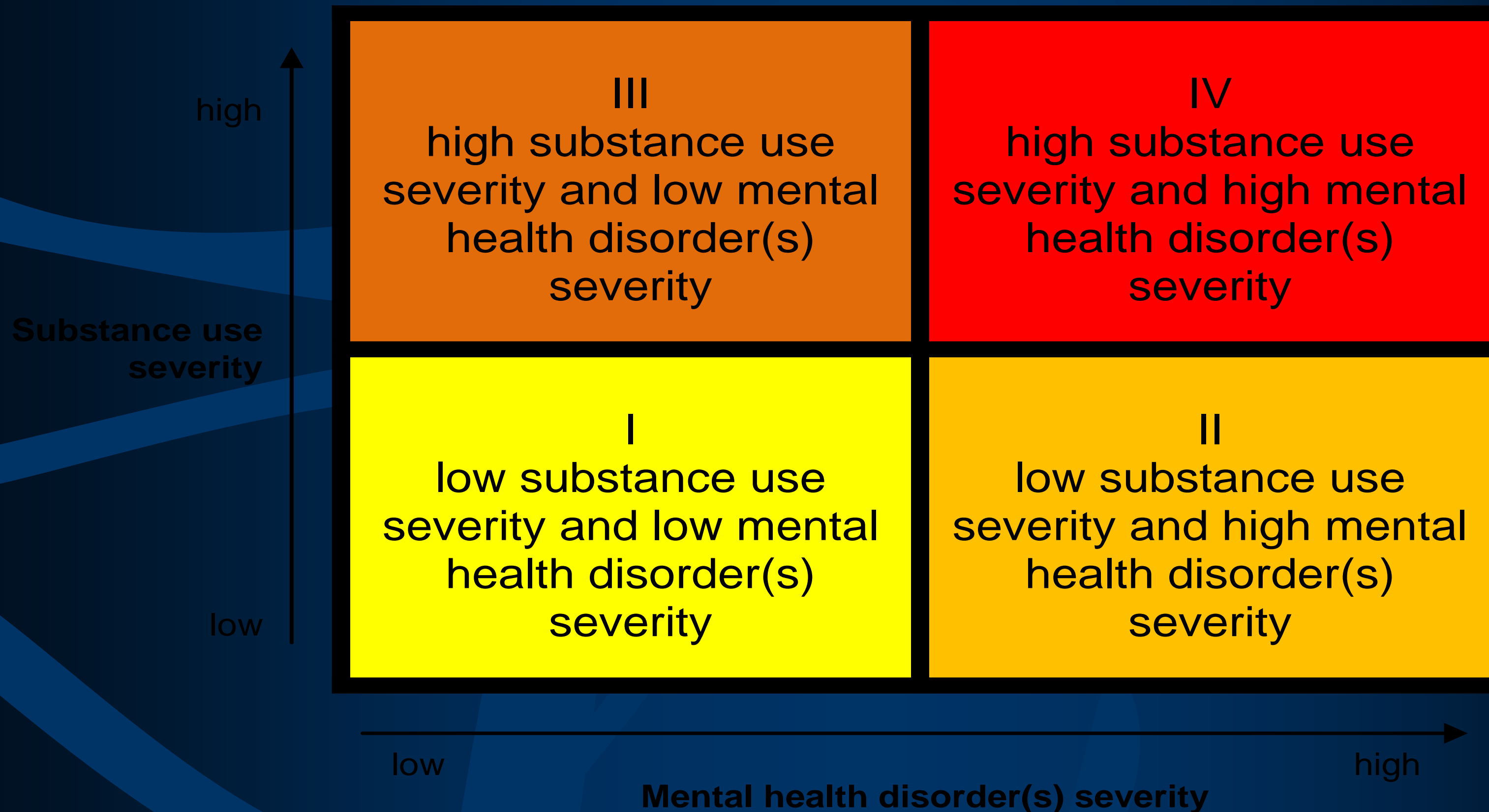
- Quadrant model
- Integrated treatment model

Models of Treatment

Erin, a twenty-eight year-old-woman entered an addiction treatment center where she was assessed as having alcohol use disorder. Six months earlier, Erin had been diagnosed with major depressive disorder and was prescribed medication by her family doctor. At the treatment facility, it was recommended that Erin be re-assessed and treated, if necessary, at a mental health clinic, located nearby in town. ***What model of treatment does this scenario represent?***

- single model of treatment
- sequential model of treatment
- parallel model of treatment
- integrated model of treatment

Quadrants of Care



Why Integrated Treatment?

- A high rate of co-occurrence, or comorbidity, between substance use disorders and psychiatric illness…
- Comorbidity affects the course and prognosis of both the individuals psychiatric illness and substance use…
- Individuals experience poorer outcomes than those with only a psychiatric illness or substance use…
- Higher service utilization and increased service costs…
- Traditional practice of treating co-occurring disorders as separate conditions in a parallel or sequential fashion is largely ineffective…
- We have identified integrated best and evidence-based practices that result in improved outcomes for these individuals… Motivational Interviewing and Relapse prevention, dual recovery counseling are ones of these practices…

Integrated Care; 3-Legged Stool

Abstinence from
Drugs & Alcohol

Engagement in
Treatment, Mutual
Support Groups
& Medical Care

Adherence to
Medications

Integrated Approach

- **Defined by seven components:**

1- Integration

2- Comprehensiveness

3- Assertiveness

4- Reduction of negative consequences

5- Long-term perspective

6- Motivation-based treatment

7- Multiple psychotherapeutic modalities

Benefits of the Integrated Model

- Reduced need for coordination
- Reduced frustration for patients
- Shared decision-making responsibilities
- Families and concerned significant others (CSO) are included
- Transparent practices help everyone involved share responsibility
- Patients are empowered to treat their own illness and manage their own recovery
- The patients and their family/ CSO have more options to choose from in treatment, more ability for self-management, and a higher satisfaction with care

Co-occurring Disorders Interactions

An integrated model of care assumes that:

- One disorder does not necessarily present as “primary.”
- There isn’t necessarily a causal relationship between co-occurring disorders.
- These are co-occurring conditions that need to be treated simultaneously.

Evidence-Based Practices

- In most treatment addiction centers, the primary evidence-based practices used are:
  - Motivational interviewing and adaptations such as motivational enhancement therapy (MET)
  - Cognitive-behavioral therapy (CBT)-Relapse prevention-dual recovery counseling (integrated)
  - Twelve-step facilitation (TSF) and engagement in 12-step programs including DRA
  - Family interventions?
  - Behavioral couple therapy ?
  - Pharmacotherapies and Medication assisted treatment

Recovery

- Think of recovery as something positive beyond the disorders
- Closing note of optimism

(Miller, 2011; Xie et al., 2010)