Introduction to Integrated Co-Occurring Disorders Treatment for Severe Mental Illness and Substance Use Disorders

October 11, 2013
Collaboration

WESTBRIDGE
Family-centered treatment for mental illness & substance use disorders

NAADAC
THE ASSOCIATION FOR ADDICTION PROFESSIONALS
www.naadac.org

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Chief Executive Officer
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when the door OPENED

Stories of recovery from co-occurring mental illness & substance use disorders

MARY RYAN WOODS, RNC
and KATHERINE ARMSTRONG

FOREWORD BY ROBERT E. DRAKE, MD, PhD
Treating the Whole Person

A person is more than their diagnosis or their symptoms.
Everyone has strengths and gifts.

• Why are we concerned about dual disorders?
• Is this the next new fad?
• How do we as treatment providers contribute to the success/failure of our clients?
Discussion

• What do you want to learn today?
• What are your experiences in treating people with Dual Disorders?
Co-Occurring Disorders

• Substance use disorders are common in people with severe mental illness
• Mental illness is common in people with substance use disorders
• Dual disorders lead to worse outcomes and higher costs than single disorders

• Dartmouth Center for Evidence Based Practices
“those of us with co-occurring disorders have the challenge of trying to operate “normally” in the world with a chemical imbalance in our brains. We speak an inherently different language-the one that is familiar to us-then to learn the world’s language so that we can communicate with the rest of humanity.”

Steven
Severity of Co-occurring Disorders

The classification of “severe and non-severe” is based on a specific diagnosis and by state criteria for Medicaid qualification but can vary significantly based on severity of the disability and the duration of the disorder.
Defining Co-Occurring Disorders

Addiction Treatment Provider Estimates by Psychiatric Disorder

- Mood Disorders
- Anxiety Disorders
- Post-Traumatic Stress Disorders
- Antisocial Personality Disorders
- Borderline Personality Disorders
- Severe Mental Illness

[Bar chart showing percentage estimates for each disorder]
Prevalence of mental illness in alcohol disorders

- In community, 24.4% have mental illness
- In institutions, 55% have mental illness
- In substance abuse treatment, 65% have mental illness

Dartmouth Center for Evidence Based Practices
Co-Occurring Disorders

- Mental Illness and Substance Use Disorders are brain diseases are:
  - Chronic in nature
  - Biological, Psychological, Spiritual
  - Effect all members of the family
  - Responsive to treatment
  - Source of stigma and discrimination
Brain Diseases

• Gambling
• Eating Disorders
• Polysubstance Abuse
• Sex addiction
• Alcoholism
• Fetal Alcohol Spectrum Disorders
• Traumatic Brain Injury
• Mental Illness
Types of Co-Occurring Disorders

• Three categories
  – Milder mood/anxiety disorder with substance use disorder
  – Personality disorder and substance use disorder
  – Severe mental illness and substance use disorder

  – Dartmouth Center for Evidence Based Practices
Co-occurring Disorders Interactions

- Substance use disorders can cause psychiatric symptoms and mimic mental health disorders.
  - An individual who is dependent on methamphetamine might experience periods of psychosis that resemble schizophrenia.
- A substance use disorder can mask psychiatric symptoms and/or mental health disorders.
  - An individual who abuses methamphetamine while experiencing a manic episode related to his or her bipolar disorder could easily attribute the subsequent erratic behavior to the psychoactive substance and not his or her mental health disorder.
- Psychoactive substance use withdrawal can cause psychiatric symptoms and/or mimic mental health disorders.
  - Withdrawal from alcohol can produce hallucinations in an individual who is severely dependent.
Quadrants of Care

- **I**: low substance use severity and low mental health disorder severity
- **II**: low substance use severity and high mental health disorder severity
- **III**: high substance use severity and low mental health disorder severity
- **IV**: high substance use severity and high mental health disorder severity

Substance use severity

Mental health disorder severity
Mood Disorder
Mood Disorders

• Major Depression
• Mania
• Hypomania
• Bipolar I
• Bipolar II
• General Anxiety Disorders
• Panic Disorder
• Obsessive Compulsive Disorders
• PTSD
Major Depression

A.) Five or more symptoms have been present during the same two-week period; criterion one or two must be present.
   - 1.) depressed mood most of the day, nearly everyday
   - 2.) markedly diminished interest or pleasure in all, or almost all, activities
   - 3.) significant weight loss when not dieting, or weight gain or decrease or increase in appetite
   - 4.) insomnia or hypersomnia
   - 5.) psychomotor agitation or retardation
   - 6.) fatigue or loss of energy
   - 7.) feelings of worthlessness or inappropriate guilt
   - 8.) diminished ability to think or concentrate, or indecisiveness
   - 9.) recurrent thoughts of death, suicidal ideation, suicide attempt or specific plan for committing suicide
What Else Could Cause these Symptoms?
Hypomania

• **Hypomanic Episode:**
  
  A.) A distinct period of abnormally and persistently elevated, expansive or irritable mood that lasts at least four days.

  B.) Three or more of the following symptoms during the period described above:

  – 1.) inflated self-esteem or grandiosity
  – 2.) decreased need for sleep
  – 3.) more talkative than usual or pressure to keep talking
  – 4.) flight of ideas or subjective experience that thoughts are racing
  – 5.) distractibility
  – 6.) increase in goal-directed activity or psychomotor agitation
  – 7.) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. sex, shopping, etc.)
Generalized Anxiety Disorder

• Generalized Anxiety Disorder:
• A.) Excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities.
• B.) The client finds it difficult to control the worry.
• C.) The anxiety and worry are associated with at least three of the following:
  – 1.) restlessness or feeling keyed up or on edge
  – 2.) being easily fatigued
  – 3.) difficulty concentrating or mind going blank
  – 4.) irritability
  – 5.) muscle tension
  – 6.) sleep disturbance
What Else Could Cause These Symptoms?
Post Traumatic Stress Disorder

- Posttraumatic Stress Disorder (cont.):

- B.) The traumatic event is persistently re-experienced in at least one of the following ways:
  - 1.) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions
  - 2.) recurrent distressing dreams of the event
  - 3.) acting or feeling as if the traumatic event were recurring
  - 4.) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - 5.) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
PTSD

- Posttraumatic Stress Disorder (cont.):
- C.) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by at least three of the following:
  - 1.) efforts to avoid thoughts, feelings or conversations associated with the trauma
  - 2.) efforts to avoid activities, places or people that arouse recollections of the trauma
  - 3.) inability to recall an important aspect of the trauma
  - 4.) markedly diminished interest or participation in significant activities
  - 5.) feeling of detachment or estrangement from others
  - 6.) restricted range of affect
  - 7.) sense of a foreshortened future
PTSD

• **Posttraumatic Stress Disorder (cont.):**

• D.) Persistent symptoms of increased arousal, as indicated by at least two of the following:
  – 1.) difficulty falling or staying asleep
  – 2.) irritability or outbursts of anger
  – 3.) difficulty concentrating
  – 4.) hyper vigilance
  – 5.) exaggerated startle response

• E.) Duration of the symptoms is more than one month.

• F.) Symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.
Cognitive Disorders
Types of Cognitive Disorders

- Schizoaffective disorder
- Delirium
- Dementia
- Schizophrenia
  - Paranoia
  - Disorganized
- Psychotic Disorder
Symptoms of Cognitive Disorders

• Two or more of the following during one month:
  – Delusions
  – Hallucinations
  – Disorganized speech
  – Grossly disorganized or cationic behavior
  – Negative symptoms (flat affect, alogia or avolition)
    • paranoia
What Else Could Cause these Symptoms?
Stages of Change

• These Stages describe the internal process that individuals experience when making changes.
• Change is driven by motivation
• Motivation is driven by Confidence and Importance
## Stages of Change

<table>
<thead>
<tr>
<th>Stage</th>
<th>Goal</th>
<th>Intervention</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation (Engagement)</td>
<td><em>Shift in Focus</em></td>
<td>Assessment tools, Education Groups, Social Alternatives, Typical Day Exercise</td>
<td>Thought Insight</td>
</tr>
<tr>
<td></td>
<td>Assessment</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Consciousness raising</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Intake Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplation (Persuasion)</td>
<td><em>Shift in Perception</em></td>
<td>Pros &amp; Cons List, Role Playing, Value Clarification, Decision Making, Ambivalence Group, Exercise</td>
<td>Thought Insight</td>
</tr>
<tr>
<td></td>
<td>Increase Ambivalence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insight</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision Making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation (Persuasion)</td>
<td><em>Shift in Behavior</em></td>
<td>Skill development, Image Enhancement, Confidence building, Relapse Group, Social Alternatives, Exercise</td>
<td>Behavior Lifestyle</td>
</tr>
<tr>
<td></td>
<td>Commitment</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Practice New Behavior</td>
<td></td>
<td></td>
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<td></td>
<td>Self-Efficacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action (Active Treatment)</td>
<td><em>Change in Behavior</em></td>
<td>Rewards, Relaxation Techniques, Assertiveness Training, Hobbies, Social Alternatives, Exercise</td>
<td>Behavior Lifestyle</td>
</tr>
<tr>
<td></td>
<td>Modify Lifestyle</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abstinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue Integration and Utilization of New Coping Skills, Abstinence</td>
<td></td>
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</tr>
</tbody>
</table>
Stages of Treatment

• This describes the clinical experience between the individual and the treatment provider.
• This process involves multiple people and can be conceptualized as an external process.
## Stages of Treatment

<table>
<thead>
<tr>
<th>Stage</th>
<th>Definition</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>Client does not have regular contact with program</td>
<td>Establish Working Alliance</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Client has regular contact with program but does not want to reduce substance use</td>
<td>Increase awareness. Develop ambivalence. Increase motivation to change</td>
</tr>
<tr>
<td>Active Treatment</td>
<td>Client reduces Substance use for at least one month but less than 6 months</td>
<td>Further reduce substance use attain abstinence</td>
</tr>
<tr>
<td>Relapse Prevention</td>
<td>Has not experienced problems related to substances or abstinent for 6 months</td>
<td>Identify triggers and coping skills</td>
</tr>
</tbody>
</table>

Course of dual disorders

- Both substance use disorders and severe mental illness are chronic, waxing and waning
- Recovery from mental illness or substance abuse occurs in stages over time
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
    » Prochaska, DiClemente, and Norcross 1992;
    » Miller and Rollnick 1991
How do people obtain remission from dual disorders?

- Stable housing
- Medication (less is more)
- Sober support network/family
- Regular meaningful activity
- Trusting clinical relationship

— Alverson et al, Com MHJ, 2000
Effective Treatment

- Client Factors: 40%
- Therapy Relationship: 30%
- Hope & Expectancy: 15%
- Therapy Model: 15%

Source: Adapted from Miller, Duncan, and Hubble, 1997
MODELS OF TREATMENT
# Traditional Treatment

<table>
<thead>
<tr>
<th>Addiction Treatment</th>
<th>Mental Health Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Counselor Model</td>
<td>Medical/professional model</td>
</tr>
<tr>
<td>Spiritual Recovery</td>
<td>Scientific treatment</td>
</tr>
<tr>
<td>Self-help</td>
<td>Medication</td>
</tr>
<tr>
<td>Confrontation &amp; Expectation</td>
<td>Support &amp; flexibility</td>
</tr>
<tr>
<td>Detachment/Empowerment</td>
<td>Case management/care</td>
</tr>
<tr>
<td>Episodic treatment</td>
<td>Continuous treatment</td>
</tr>
<tr>
<td>Recovery ideology</td>
<td>Deinstitutionalization ideology</td>
</tr>
<tr>
<td>View of psychopathology as secondary to addiction</td>
<td>View of addiction as secondary to psychopathology</td>
</tr>
</tbody>
</table>

Models of Treatment

- **Single model of care** - It was believed that once the “primary disorder" was treated effectively, the client’s substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope.

- **Sequential model of treatment** - acknowledges the presence of co-occurring disorders but treats them one at a time.

- **Parallel model of treatment** - mental health disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.
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 brain diseases that need to be treated simultaneously.
Integrated Model of Treatment

• The integrated model of treatment can best be defined by following 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 an Integrated Model of Care

- Reduced need for coordination
- Reduced frustration for clients
- Shared decision-making responsibilities
- Families and significant others are included
- Transparent practices help everyone involved share responsibility
- Clients are empowered to treat their own illness and manage their own recovery
- The client and his/her family has more choice in treatment, more ability for self-management, and a higher satisfaction with care
Screening and Assessment
“The first treatment center I enrolled in was okay, but they didn’t address my mental illness. They had a standard protocol for addiction, which they fit me into. They kept telling me that depression and anxiety were just normal side effects for people coming out of opiate addiction. I told them about my history of depression and anxiety before being an addict, but they never seemed to know what to do.”

• Frank

• When the door Opened
Screening and Assessment

Complexities of Screening and Assessment

- Intoxication
- Withdrawal
- Substance-induced disorders
- Motivational factors
- Feelings, symptoms, and disorders
Co-occurring Disorders Interactions

- Substances and Negative Emotions

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>NEGATIVE EMOTIONAL STATE</th>
<th>MIMICKED PSYCHIATRIC DISORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Depression; Anxiety</td>
<td>Mood Disorder; Anxiety Disorder</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Depression; Anxiety</td>
<td>Mood Disorder; Anxiety Disorder</td>
</tr>
<tr>
<td>Cocaine/Amphetamine/Methamphetamine</td>
<td>Depression; Anxiety; Mood Swings;</td>
<td>Anxiety Disorder; Bipolar Disorder</td>
</tr>
<tr>
<td></td>
<td>Impulsivity</td>
<td></td>
</tr>
<tr>
<td>Cannabis/Marijuana</td>
<td>Depression; Anxiety</td>
<td>Mood Disorder; Anxiety Disorder</td>
</tr>
<tr>
<td>Opiates/Heroin/Prescription Narcotics</td>
<td>Depression</td>
<td>Mood Disorder</td>
</tr>
<tr>
<td>Polysubstance (Mixed Substance Use)</td>
<td>Depression; Anxiety; Mood Swings;</td>
<td>Mood Disorder; Anxiety Disorder; Bipolar Disorder</td>
</tr>
<tr>
<td></td>
<td>Impulsivity</td>
<td></td>
</tr>
</tbody>
</table>
Integrated Assessment Process – 12 Steps

1. Engage the Client
2. Identify and Contact Collaterals
3. Screen for and Detect Co-occurring Disorders
4. Determine Quadrant and Locus of Responsibility
5. Determine Level of Care
6. Determine Diagnosis
SCREENING AND ASSESSMENT

Integrated Assessment Process – 12 Steps

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
Effective Treatment Interventions
Treatment

• Integrated

• Comprehensive
  – Medical
  – Vocational
  – Spiritual
  – Wellness

• Continuous Assessment

• Monitoring
Evidence-Based Practices

The following EBP’s have been proven to work with people with co-occurring disorders.

- motivational enhancement therapy (MET)
- cognitive-behavioral therapy (CBT)
- twelve step facilitation (TSF)
- Integrated Treatment for Dual Disorders (IDDT)
- Behavioral Family Therapy (FES)
- Supported Employment
- Illness Management and Recovery
- Contingency Management
- Medication Assisted Treatment
- Consensus based interventions
Clinical Tips for Treating Mental Health Disorders

• When treating clients with personality disorders, addiction professionals should apply the following principles:
  
  ▪ Build a therapeutic alliance with the client.
  
  ▪ Avoid power struggles.
  
  ▪ Do not personalize the client’s behavior.
  
  ▪ Clinicians should take a more active approach in treatment.
  
  ▪ Set agreed upon goals with the client.
  
  ▪ Do not be afraid to assess personal feelings/reaction and teach appropriate affective expressions.
Clinical Tips for Treating Mental Health Disorders

- Assist the client in developing skills, such as deep breathing, meditation and cognitive restructuring, to manage negative memories and emotions.

- Understand that denial may be present and be willing and patient to work through it with the client.

- Use blood/urine screens to verify abstinence claims, when appropriate.

- Use referral information from external sources as leverage when setting goals and moving through treatment.

- Do not allow the client to divide staff members against each other.

- Anticipate that these clients will most likely progress slowly and unevenly,
Clinical Tips for Treating Mental Health Disorders

- Assess the risk of self-harm continually.

- Set clear boundaries and expectations regarding limits and requirements in roles and behaviors.

- Maintain a positive but neutral professional relationship, avoid over involvement in the client’s perceptions and monitor the counseling process frequently with supervisors and colleagues.

- Anticipate “crisis” events, such as the need for immediate attention, flattery or manipulation.

- Anticipate separation issues and increased anxiety around termination.
Clinical Tips for Treating Mental Health Disorders

• When treating clients with psychotic disorders, addiction professionals should apply the following principles:
  
  ▪ Work closely with a psychiatrist or mental health professional if not trained/educated appropriately to treat severe mental health disorders.

  ▪ Teach the client skills for detecting early signs of relapse for both mental illness and substance abuse.

  ▪ Expect crises associated with the mental health disorder and have available resources to facilitate stabilization.
Clinical Tips for Treating Mental Health Disorders

- Assist the client in obtaining entitlements and other social services.

- Monitor medication and promote medication adherence.

- Provide frequent breaks and shorter sessions or meetings.

- Present material in simple, concrete terms with examples, using multimedia methods, if available.

- Encourage participation in social clubs with recreational activities.
Medication Assisted Treatment
History of Medication Treatment in Addiction

• **1879** Dr. Leslie E. Keeley found the first Keeley Institute using his “Double Chloride of Gold Remedies.” Chloral hydrate was used to treat alcoholism.

• **1882** Paraldehyde began to be used to treat withdrawal.

• **1888** Dr. J.R. Black began suggesting addicting incurable alcoholics to morphine because morphine addiction was seen as a cleaner, cheaper, and less devastating than alcohol addiction.
1899-1937

• 1899  A search was begun for an alcoholism vaccine.

• 1902  Dr. T.D. Crothers advocated the use of emetics to induce nausea, early aversion therapy

• 1912  Opening of first morphine maintenance clinics.

• 1937  Methadone developed in Germany
1939-1948

• 1939  Dr. Wilfred Bloomburg began using amphetamines to treat hangovers and alcoholism.

• 1947  Erik Jacobson and Jens Hald discovered that disulfram induced alcohol related toxicity.

• 1948  Lithium began to be used to treat alcoholism.
1959-1973

- **1959** Librium began being used to treat alcohol withdrawal.
- **1963** Drs. Marie Nyswander and Vincent Dole began experimenting with methadone as a treatment for heroin addiction.
- **1965** Dr. Jerome Jaffe began working on clinical trials of LAAM.
- **1973** The clinical trials for naltrexone as a treatment for heroin addiction began.
1984-2004

• 1984  FDA approved naltrexone in a 50mg dose as a treatment for heroin addiction
• 1980s  Suboxone developed as an analgesic
• 1993  First reported use of Naltrexone for use of alcohol craving.
• 2002  Suboxone approved for opiate dependence
• 2004  Campral approved for treatment of alcoholism
2006-2010

• 2006 **Vivitrol** approved for treatment of alcohol dependence.

• 2010 **Vivitrol** approved for the treatment of opioid dependence
Current Pharmacotherapy
Common Pharmacotherapy

Pharmacotherapy for co-occurring disorders are divided into 6 major classes:

- antidepressants
- anxiolytics
- hypnotics
- mood stabilizers
- antipsychotics
- substance use disorder medications
Common Pharmacotherapies

- 2.) Anxiolytics are medications used to reduce anxiety and symptoms of anxiety disorders.
  - Benzodiazepines – can be addictive and have a high potential for abuse*
  - Barbiturates – can be addictive and have a high potential for abuse*
  - Anticonvulsants
  - Antihistamines

- Some anxiolytics can take days to weeks to have a full effect, while others can produce immediate effects, making them useful on an as needed basis.
3.) Hypnotics are medications used to induce and maintain sleep. These medications are often prescribed to clients with co-occurring disorders because of the common occurrence of sleep disturbances.

- Melatonin and melatonin receptor agonists
- Non-benzodiazepines that act only on the benzodiazepine 1 receptors
- Benzodiazepines – can be addictive and have a high potential for abuse*
- Trazodone – Desyrel®
- Antihistamines
Common Pharmacotherapies

• 4.) Mood stabilizers are used in the treatment of bipolar disorder and to prevent future episodes of acute mania and depression. Many clients with bipolar disorder tend to use psychoactive substances when in a manic episode, so pharmacotherapy with a mood stabilizer can help clients with co-occurring disorders prevent relapse and stay engaged in treatment.
  ▪ Antipsychotics
  ▪ Lithium
  ▪ Valproic acid and divalproex products
  ▪ Anticonvulsants

• Unfortunately, all of the mood stabilizers are known for unpleasant and sometimes dangerous side effects that require regular monitoring.
Collaboration with the prescriber

Even though the prescriber is ultimately responsible for ensuring safety and effectiveness of pharmacotherapies, addiction professionals can also help in this effort.

Since addiction professionals tend to see the client more often, they are well-positioned to:

- recognize danger signs (including recent psychoactive substance use)
- recognize abnormal side effects
- monitor and support medication compliance
Opiate Replacement

• Does it help or hurt?
• Is it safe or dangerous?
• How long should someone be on it?
• Is someone sober if taking it?
• Is it about the “addict” or the prescriber?
Opiate Replacement Therapy

- Criteria for use
- Accurate assessment
- Substance Abuse Treatment
- Contract for use
- Vigilant Monitoring
- Connect prescription to participation in treatment
- Mutual Help groups
## WestBridge B/N Treatment Risk Level Calculator Worksheet

**Based on most recent assessment, pick one**

<table>
<thead>
<tr>
<th>Level 1: Low-risk:</th>
<th>Level 2: Moderate Risk</th>
<th>Level 3: High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. O  No h/o psychosis/thought disorder</td>
<td>O  History of thought disorder</td>
<td>O  Severe thought disorder episode</td>
</tr>
<tr>
<td>2. O  Able to follow instructions</td>
<td>O  Difficulty following instructions</td>
<td>O  Severe cognitive impairment</td>
</tr>
<tr>
<td>3. O  Willing/Able to take medication daily</td>
<td>O  Unwillingness to take meds daily</td>
<td>O  Inability to organize/adhere meds daily</td>
</tr>
<tr>
<td>4. O  Low impulsivity</td>
<td>O  Moderate impulsivity</td>
<td>O  Marked impulsivity</td>
</tr>
<tr>
<td>5. O  No current BZD misuse &gt;1 mo</td>
<td>O  Intermittent low-dose BZD misuse</td>
<td>O  BZD prescription</td>
</tr>
<tr>
<td>6. O  No manic symptoms</td>
<td>O  Hypomanic episode</td>
<td>O  Currently manic</td>
</tr>
<tr>
<td>7. O  No substance abuse (neg urine &gt;1mo)</td>
<td>O  Cocaine use/ Marijuana use</td>
<td>O  Doses of Suboxone &gt; 32mg/day</td>
</tr>
<tr>
<td>8. O  Abstinence from alcohol &gt;1mo</td>
<td>O  Intermittent alcohol use (&lt;3 drinks)</td>
<td>O  Regular alcohol use/ episodes &gt; 3 drinks</td>
</tr>
<tr>
<td>9. O  No suicidal ideation</td>
<td>O  Chronic SI/no intent plan</td>
<td>O  New onset of SI, or + intent or plan</td>
</tr>
<tr>
<td>10. O  Stable drug-free housing</td>
<td>O  Stable housing/not drug-free environ</td>
<td>O  Homeless/unstable or unsafe environ</td>
</tr>
<tr>
<td>11. O  No opiate misuse (neg urine &gt;1mo)</td>
<td>O  At least 1 opiate pos urine in past mo</td>
<td>O  2 consecutive wks of opiate pos urine</td>
</tr>
</tbody>
</table>

**Risk Level Assignment:** Choose the highest level with any criteria checked.

Signature: __________________________________________________ Date: __________________
Medication Compliance

• Treatment approach techniques for increasing adherence to a medication regimen:
  ▪ Make the medication regimen as simple as possible.
  ▪ Develop strategies for incorporating the dosing regimen into the client’s daily routine.
  ▪ Outline the benefits of taking medications as prescribed.
  ▪ Dispel inaccurate beliefs about the medication.
  ▪ Review the side effects of prescribed medication and discuss options for managing those.
  ▪ Identify the client’s personal goals and explore how taking his or her medication as prescribed will help achieve them.
  ▪ Evaluate the level of support the client is receiving from family and peer groups concerning taking prescribed medication.
Family Treatment
Cultural Considerations

• These special considerations may affect the treatment approach that should be implemented and how it will progress and can vary depending on culture, race, ethnicity, age, sex, gender, sexual orientation, religion, socioeconomic status and housing status, to name a few.

• Addiction professionals must be aware of the individualized needs of a client and be prepared to respond to each diverse client appropriately.

• To be most effective, professionals must be able to recognize the social, political, economic and cultural context within which addiction and mental health disorders exist, including risk and resiliency factors that characterize individuals and groups and their living environments.
How we perceive Families

• Demanding   Fearful
• Entitled    Looking for a responsive
• Codependent  Interdependent
• Enabling    Doing the best they can with what they know
• The PROBLEM   The SOLUTION
Different Stages

• It is very common for individuals and families to be at different stages of change.

• Different stages
  – can create dissatisfaction with treatment
  – Staff distress
  – Shift focus off of effective treatment
Involving families in treatment

- It is a myth that people with co-occurring disorders are disconnected from their families.

- Research has shown that outcomes for substance use and mental health disorders are improved, including fewer relapses, when families are actively engaged in the treatment process.

- Unfortunately, family members of a client who has co-occurring disorders often experience considerable stress, heartbreak, and confusion.
Involving families in treatment

- Encourage family member involvement and develop a collaborative relationship as early as possible in the treatment process

- Use an evidence-based practice for family treatment

- Encourage families to attend self-help groups such as Al-Anon and NAMI
ENGAGING THE FAMILY

- Be respectful, non-judgmental, empathic
- Explain you want to help family members become “members of the treatment team”
- Describe goals of family program as education, reducing hospitalizations, and helping client independence
- Allow relatives to vent and “tell their story”
Family Assessment Domains

• Background Information
• Coping Skills
• Personal substance use
• Knowledge of Mental Illness & Substance Abuse
• Goal Setting
• Leisure and Social Activities
• Medical History
ASSESSMENT OF THE FAMILY

• For Each Family Member
  What do they understand about the disorders?
  What are their short-term goals?
  What are their long-term goals?
  What interferes with obtaining their goals?

• For the Family as a Unit
  What are their strengths?
  What problems do they have in communication?
  How do they solve problems together?
Family Treatment & Support

• Weekly updates
• Check in with family members
• Behavioral Family Therapy
• NAMI Family to Family
• Family Treatment
• Alanon
• Bibliotherapy
• “My family’s experience with Family Education and Support was very positive. As long as a staff member was in the room, I felt comfortable talking with my family about everything that I was feeling, and my family definitely benefitted from that experience. I did the legwork, and my family had the opportunity to observe how I reclaimed my independence. I started to regain their respect. I could be Jacob again without using the drugs and alcohol and with proper medication. “

• Jacob

When the door Opened
Behavioral Family Therapy (FES)
CORE INGREDIENTS OF FAMILY WORK

• Develop a collaborative relationship with the family
• Don’t push the substance abuse issue before family is engaged
• Educate families about mental illness, treatment principles, and substance abuse
CORE INGREDIENTS (continued)

• Improve communication and problem solving in the family
• Decrease substance abuse and its effects on the family
• Encourage the development of all family members
• Hang in there for the long haul
  – Recovery is a Marathon not a Sprint
FORMAT OF BFT

- Individual family sessions
- Everyone is included
- “Open door” policy for reluctant participants
- One hour sessions
- Sessions conducted on a “declining contact basis”
- Treatment is long-term, not short-term
- Focus is on learning new information and skills, not fostering insight
GOALS OF FAMILY INTERVENTION

• Educate family members about mental illness, substance abuse, and their treatment
• Increase coping skills for all family members
• Increase social support
• Decrease burden of care on family members
• Decrease stress on individuals
• Decrease substance use
• Improve individual functioning
• Decrease hospitalization and homelessness
Comfort Agreement

- It may be helpful to set some ground rules to follow during our Family Education and Support meetings. These rules should be discussed and agreed upon by all members, and may be as general or specific as is helpful. General topics to consider may include starting on time, not interrupting, setting a standard for taking breaks if necessary, ‘sharing the time’, etc. Many people find it helpful to review these guidelines at the beginning of each meeting, and edit them when needed. This is a living, breathing document; that is, it may be amended in the future with the approval of all members.

- 1.
- 2.
- 3.
- 4.
EXAMPLES OF CLINICAL STRATEGIES

• Modify stressful communication styles that may contribute to substance abuse

• Teach problem solving skills to help the person:
  – Refuse offers to use substances
  – Avoid high risk situations
  – Develop alternative leisure activities
  – Cope with persistent symptoms
  – Structure daily time

• Teach family how to set limits
Role Play

• Volunteers to participate in family role play!
Traumatic Brain Injury
Traumatic Brain Injury

• Brain injuries can occur when the head strikes an object such as a windshield or the ground at a fast rate of speed, or when a flying or falling object strikes the head. Injury to the brain also can occur without a direct blow to the head, for example in cases of severe "whiplash."

http://www.cemm.org
Mild Traumatic Brain Injury

– Loss of consciousness, if any, lasting for less than 30 minutes
– Memory loss after the traumatic event, called post-traumatic amnesia or PTA, that lasts for less than 24 hours, and A Glasgow Coma Score of 13 – 15.

This score measures a person’s eye opening abilities, verbal responses and motor responses. It is rarely used in diagnosing mild traumatic brain injury but is more commonly used in moderate to severe cases.

In most mild TBI cases, the patient will recover completely. In a small number of cases, the symptoms can last a long time and cause permanent changes to the patient’s life, for example in areas such as personality and memory.

http://www.cemm.org/
Moderate

• A loss of consciousness that lasts for more than 30 minutes but less than 24 hours
• Memory loss after the traumatic event, called post-traumatic amnesia or PTA, lasting for 24 hours to 7 days
• A Glasgow Coma Score of 9 – 12

http://www.cemm.org/
Severe Traumatic Brain Injury

- A loss of consciousness that lasts for more than 24 hours
- PTA lasting for 7 days or longer
- A Glasgow Coma Score of 8 or less, which indicates that the patient is in a coma
Level of Recovery

- Hinges on how severe the injury
- How fast and how well the body recovers
- The brain functions affected by the injury
- The areas of brain function that are not affected by the injury
- The age of the patient at the time of injury
- Other injuries to the body from the same traumatic event

http://www.cemm.org
Fetal Alcohol Effects Syndrome

Diagram showing features of Fetal Alcohol Syndrome:
- Small head
- Low nasal bridge
- Epicanthal folds
- Small eye openings
- Flat midface
- Short nose
- Smooth philtrum
- Thin upper lip
- Underdeveloped jaw
Fetal Alcohol Spectrum Disorders
Co-Occuring Disorder

For Individuals with FASD
- Attention-Deficit/Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Reactive Attachment Disorder
- Schizophrenia
- Depression
- Bipolar Disorder
- Substance use disorders
- Posttraumatic Stress Disorder
Past Month Alcohol Use, Pregnant Women

- 9.6%  African American Women
- 11.0%  Hispanic Women
- 11.8%  White, Non Hispanic Women

SAMHSA
Cost of FASD

• Based on estimated rates of FASD per live births, FASD affects nearly 40,000 newborns each year.

• The cost to the nation of FAS alone may be up to $6 billion each year.2 • For one individual with FAS, the lifetime cost is at least 2 million
Women and Alcohol

• 1 in 9 pregnant women binge drinks in the first trimester.
• 1 in 30 pregnant women drinks at levels shown to increase the risk of FASD.
• More than 1 in 5 pregnant women report alcohol use in the first trimester, 1 in 14 in the second trimester, and 1 in 20 in the third trimester.
Effects of Maternal Alcohol Use

- Of individuals with ARND between the ages of 12 and 51,
  - 95% will have mental health problems;
  - 68% will have "disrupted school experience";
  - 68% will experience trouble with the law;
  - 55% will be confined in prison, drug or alcohol treatment centre or mental institution;
  - 52% will exhibit inappropriate sexual behavior
Effects of Maternal Alcohol Use

• Of individuals with ARND between 21 and 51:

  – More than 50% of males and 70% of females will have alcohol and drug problems; 82% will not be able to live independently;
  – 70% will have problems with employment
Key Facts on Fetal Alcohol Spectrum Disorder

• No amount of alcohol and no time in pregnancy have been established as safe for the fetus.

• Fetal Alcohol Spectrum Disorders are the biggest single cause of mental disabilities in most industrialized countries, and could be totally prevented if all women abstained from alcohol in pregnancy.

• Less obvious and seemingly milder fetal alcohol damage is sometimes called Fetal Alcohol Effects (FAE). Alcohol-Related Neurodevelopmental Disorder (ARND), Partial Fetal Alcohol Syndrome (pFAS) or Static Encephalopathy. These conditions can be equally damaging to babies but are rarely diagnosed. (To keep this simple, we're going to call it all FASD.)
Some experts estimate that about 1% of North Americans suffer from a fetal alcohol disorder - about four times as many people as those with AIDS/HIV.

There are three to five times as many people with ARND as FAS.
FASD

- Individuals with ARND may look normal and have seemingly normal intelligence, but their damaged brains can result in learning disabilities, impulsivity, lying, stealing, tantrums, violence and aggression, inability to predict consequences or learn from experience, lack of conscience, and being highly addictive.
FASD

• Most people with ARND look perfectly normal and are never diagnosed. Research indicates that a high percentage of homeless people, and at least 25% of juvenile and adult offenders suffer from undiagnosed FASD
Recovery
Recovery

• Physical
  – Exercise, sleep, nutrition,

• Mental

• Spiritual

• “be all you can be”

• Individually defined
Guiding Principles of Recovery

- There are many pathways to recovery.
- Recovery is self-directed and empowering, involving personal recognition of the need for change and transformation.
- Recovery exists on a continuum of improved health and wellness.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies, and involves joining and rebuilding a life in the community.
- Recovery is a reality.

(from CSAT’s Regional Recovery Meetings, May 2008)
Recovery in Co-occurring Disorders

• “Recovery is a full-time job, like having a child. It is the need for change, in order to progress with wisdom.”

• “I guess I define recovery as the ability to live a healthy, happy and productive life.”
Recovery in Co-occurring Disorders

• “I would define recovery as a slow but very rewarding process. It’s amazing to be sitting where I am today and to have achieved some of the things that I have achieved.”

• “I do know that it has been important for me to take it easy and to take it slow. It’s not so much that I actively think about or analyze the person that I’m becoming. I just notice that I’m different. Other people in my life notice it. I’m relearning how to live.”

• When the door Opened
Recovery & Illness

• People often experience episodes of illness with lengthening periods of recovery.

• Relapses in either substance abuse or mental illness are opportunities to develop insight and learn new skills.
Nutrition
Mutual Help Groups
Spirituality
Exercise
Sleep
Art
Thank you for Participating!