Chapter 4

Substance Misuse With A Co-Occurring Disorder Or Disability
Co-Occurring Disorders

• Double whammy—substance dependence and mental disorder.
  – Treatment facilities fight over which is “primary”
    • Turf issues
    • Funding streams
  – MI think once underlying issues resolve SA will abate
  – SA think of MI as a symptom of use and feel it would fall away
  – Present for SA treatment refused because of MI meds.
  – Present for MI treatment refused because “using”

• Parallel and sequential services
  • When treated by two agencies or departments
  • Miss the cyclical and interactive nature of both disorders
  • Right hand not know what the left hand is doing
Co-occurring

• “We all treat dual diagnosis clients but few provide dual diagnosis treatment.” (Shulman, 1995, p. 33)

• Fewer adjust for cognitive impairments
  – High rate of TBI
    • Vehicle accidents
    • Falling down due to drunkenness
    • War trauma
Dual Diagnosis

• Integrated Approach—there is no primary or secondary
  – Harm reduction
  – Motivational interviewing
  – Abstinence viewed as a long term goal
  – Funding stream available

• What’s in a name?
  – Co-occurring
  – Co-existing disorders
  – Dual diagnosis
  – MISA (Mentally Ill and Substance Abuse)
    • Coined in Illinois – Tinley Park
Prevalence and Characteristics

- Four quadrants
  1) Less severe mental disorder / less severe substance disorder
  2) More severe mental disorder / less severe substance disorder
  3) Less severe mental disorder / more severe substance disorder
  4) More severe mental disorder / more severe substance disorder

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<thead>
<tr>
<th>Lowest Risk</th>
<th>Highest Risk</th>
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<tbody>
<tr>
<td>Less MI</td>
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<td>Less SA</td>
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Prevalence and Characteristics

• Sample of people with schizophrenia (2003)
  – 79% alcohol
  – 46% cocaine
  – 32% marijuana
  – 8% opiates

• Why
  – Loneliness
  – Anxiety
  – Boredom
  – Insomnia
  – Mania
  – Depression
Dual Diagnosis

• Vulnerable
  – Frequent hospitalizations
  – Relapse depression suicide
  – Housing issues - homeless
  – Financial problems
  – Homelessness
  – Sexually transmitted disease
  – Violence
  – Incarceration
  – Legal problems

• Dual Diagnosis clients less likely to
• Meds may be less effective
• “Higher Risk”
  – Poor
  – Urban
  – No parallel or sequential treatment (viewed not acceptable for both)
Perils of Differential Diagnosis

• Is Mental Illness dependent or independent of Substance Abuse?
  – Monitor symptoms over time
  – If dependant - symptoms should fall away

• Anxiety symptoms can abate within a few days or weeks
  – Worry
  – Apprehensive expectations
  – Tension
  – Sweating
  – hyper arousal
  – Insomnia
  – Irritability
  – Poor concentration

• Things that may never disappear
Perils of Differential Diagnosis

• Psychotic symptoms (see & hear things; paranoia, delusions)
  – From heavy and long-term amphetamine abuse

• Dementia (Memory problems, Concentration, Problem solving)
  – Alcohol
  – Inhalants
  – Amphetamines
Perils of Differential Diagnosis

• If only a perfect world
  – Each has a unique time frame for symptoms
  – Months to see if symptoms are dependent or independent
    • May never really know
  – Look at other issues
    • Stressors (home, school, work)
    • Living arrangement
    • Trauma
    • No motivation to stop SA
    • Unable to get reliable collaborative
    • Substance use increase or hide MI symptoms
      – NOS Dx or Substance induced Dx
  – Look at previous mental health hospitalizations
  – Psychotropic medications can be addictive
  – Some medical problems can mimic MI symptoms
Disorders That Often Co-exist with Substance Abuse:

- Anxiety*
- PTSD
- Compulsive gambling
- Mood disorders*
  - Depression
  - Bipolar
- Eating disorders
- Personality disorders
- Psychosis
Anxiety

• Symptoms – response to danger – real or perceived
  – Cold, clammy hands
  – Tremulous voice
  – Shakes
  – Panic
  – Shortness of breath
  – Increased heart rate
  – Restlessness

• Diagnoses
  – Panic attacks
  – Agoraphobia
  – Phobia
  – OCD
  – Generalized anxiety disorder

• High risk of suicide when accompanied by depression
  – Symptoms persist following 30 days abstinence refer for MI
Post Traumatic Stress Disorder (PTSD)

• 1980 Vietnam War Veterans
• Women sexually assaulted

• Symptoms
  – Traumatic event experienced or witnessed
  – Increases arousal
  – Sleep disturbance
  – Irritability
  – Hyper-vigilance
  – Difficulty concentration
  – Numbing
  – Avoid stimuli associated w/ trauma
PTSD & Substance Use

- PTSD leading to SA
  - 25 – 30 % exposed to severe trauma
  - 5 - 10% exposed to moderate trauma
  - Worst treatment outcomes
    - 60 in women’s prison study
    - Over half with PTSD -
      - early sexual assault and/or later domestic violence
    - High rate SA relapse
- Abstain from SA may increase MI symptoms (Anxiety).
  - Flood of memories
PTSD & Combat

• 30% Vietnam veterans
  – Flashbacks
• 6,200 Iraq soldiers
  – 1 in 6 - PTSD and depression or anxiety
  – 12% - PTSD alone
  – Feel under reported, before major combat
  – Risk of trauma rose based on # of instances of combat
  – Women seeking help for rape trauma,
    • sometimes by fellow soldiers
• Homelessness
  – 76% alcohol & other drug issues as well as MI
  – 1/3 reported alcohol or other drug misuse
PTSD and Substance Use

- Dulling the senses
  - Alcohol
  - Tranquilizers
  - Following 911 –
    - those on psychotropic coped better than those not
- VA reports 36% increase since 2003 seeking help
  - Box 9.2 page 464

- “Post Traumatic Stress Injury”
Poster Girl
POSTER GIRL

• Robynn Murray was an all-American high-school cheerleader.

• In returning from Iraq, she has fought an insidious foe: Post-Traumatic Stress Disorder

• Documentary follows Robynn for two years as she embarks on a journey of self-discovery & redemption through art and poetry.
Natural Disasters

• Hurricane “Katrina” and “Rita”
  – Expect 30% of Louisianans to develop PTSD & need SA treatment
• Behavior change
  • Marshal Law
  • Looting
  • Free for all
  • Close quarters in encampments
  • Who to monitor
    – Increased violence
    – Rape
    – Domestic violence
• “Post traumatic growth”
  – Increased spirituality
  – Trauma helped gain inner strengths
SA Life Itself can be Traumatic

- Stress
- Homelessness
- Dangerous and illegal activity
- Physical assaults
- Acute illness
- Extreme isolation from friends and family
Mood Disorders

- Major depression
- Dysthymia
- Mania
- Hypomania
- Bipolar disorder
- Cyclothymia

- Mood disorders and Anxiety = most common with SA
Mood Disorders

• Those Dual Dx at higher risk for depression
  – Women
  – Native Americans
  – Patients with HIV
  – Patients on methadone
  – Elderly

• Depressive symptoms can be induced by
  – Chronic drug use
  – Withdrawal

• Manic symptoms can be induced by
  – Stimulants
  – Steroids
  – Hallucinogens
  – Withdrawal from alcohol
Mood Disorders - Bipolar

- Bipolar
  - Formerly Manic – Depressive
  - Episodes of mania and depression
- Mania – imitate drug use
  - Talkative / Active
  - Flight of ideas
  - Racing thoughts
  - Engaging in activates that are highly pleasurable
    - Sex
    - Spending spree
  - Impulsive
- Depression
  - Suicide
- 90% bipolar = SA (prison study)
  - Cocaine to lengthen euphoria
  - Alcohol to subdue mania
Psychotic Disorders

• Symptoms
  – Periods unable distinguish between information from the outside world and information from the inner world of the mind
  – Delusions –
  – Hallucinations –

• Psychotic Disorders
  – Schizophrenia
  – Schizoaffective disorder
  – Delusional disorder
  – Part of mania in mood disorders
Schizophrenia

- Schizophrenia
  - 1% develop disorder in lifetime
  - Onset 16-30
    - Early for boys
    - Later for girls
    - Use of hallucinogens – wake the sleeping tiger

- Paranoid Schizophrenia
  - Sub type
  - Feeling others are “after them” to do them harm
  - John Nash, A Beautiful Mind

- Difficulty in concentration; relating to or tolerating others

- 48% have substance-related problems
Schizophrenia

• Negative symptoms (those **not** present)
  – Flat affect
  – Apathy
  – Low motivation
  – Loss of pleasure
  – Limited content of speech

• Positive Symptoms (those present)
  – Disorganized speech
  – Grossly disorganized or catatonic behavior
  – Delusion
  – Hallucinations
Case Management: Homeless Persons w/ Dual dx

- Homelessness
  - Erratic behavior
  - Evicted by landlord or family
  - 175,000 admitted to SA treatment were homeless in 2004
    - Alcohol primary drug
      - Stress
      - Availability

- Case management
  - Housing
  - Budgeting
  - Medications

- Harm reduction, the goal
Integrated & No Wrong Door

• Healthcare delivery system –
  
  – “Responsibility to address the range of client needs wherever & whenever a client presents for care”

  – Holistic

• Integrated treatment Vs. parallel or sequential

• No wrong door
4 Levels of Integrated Services

1. **Basic** –
   - Treat 1; screen and refer for other

2. **Intermediate** –
   - Treat 1; address some of other

3. **Advanced** –
   - Services for both disorders

4. **Fully integrated** –
   - Actively combine services by one clinician
   - Collaboration w/ physicians, probation, self help sponsors
Integrated

• Redefine aspects of SA & MI
  – Enabling
    • MI – good to help someone with housing
    • SA – bad = enabling
• Increased treatment success in long term
  – To be expected as dual more issues
• Need for screening tools
• Ongoing assessment and education of SA and MI
• ID client’s insight of the pros & cons of both MISA
• Use – type, frequency, amount, pattern & expectancies
  – How this overlays with MI symptom patterns
• Information about medications
Summary Substance Abuse & Psychosis

- No clear pattern of drug choice w/ schizophrenia
- Understand the role of SA in psychosis
- What looks like resistance / denial = neg. symptoms
- Psychosis = higher risk of self destructive & violence
- Vulnerable to:
  - homelessness
  - housing instability
  - victimization
  - poor nutrition
  - inadequate financial resources

As Well As........
Summary Substance Abuse & Psychosis

• Both SA and psychotic disorders:
  – chronic disorders w/ multiple relapse & remission
  – need for long-term treatment

• Program should be multidisciplinary w/ cross trained staff
  – Comprehensive & integrated services for SA & MI
  – Long term focus on bio-psycho-social issues
Case Management

• Offer services

• Refer to services
  – Budgeting
  – Job skills
  – Housing
  – DV / SV
  – Parenting classes
  – Nutrition
  – Transportation

• Help coordinate services

• Different agencies have different models
Strength Based Interventions

• 2 important assumptions

1) Persons with Dual Dx are capable of making decisions & taking actions that will help them achieve their goals

2) Motivation for abstinence must reside *in the patient*, not the clinician or family
Medication Issues

• Interaction problems
• MI medications can be addictive
• SA change efficacy of MI meds
• Psychoactive
  – Opioids
  – Stimulants
  – Benzodiazepines
  – Barbiturates
  – Sedative-hypnotics
• Non-psychoactive
  – Lithium
  – Antipsychotics
  – Beta blocker
  – Anti-depressants
  – Anti-convulsants
Medications

• Acute & severe symptoms w/ these require immediate meds
  – Mania
  – Psychotic depression
  – Schizophrenia

• If symptoms are not acute, use a “stepwise” approach of:
  – Try no medication for less severe problems;
    • anxiety or mild depression
  – Add non-psychoactive medications if the symptoms do not lessen after detox and psychosocial approaches
  – Add meds if the symptoms do not abate or worsen
Physical and Cognitive Issues

• 22.4% of SA: Of these 58% were not mental health issues
  – TBI
  – Learning disability
  – Cognitive

• High risk of
  – Victimization
  – Isolation
  – Substance use

• Persons with head injuries at high risk for substance misuse;
  – 17 – 68% intoxicated when injured
Physical and Cognitive Issues

• High among wounded war veteran
  – Traumatic brain injury from war in Iraq – 60%
    • behavior changes
    • memory issues
    • depression
    • PTSD
  – SA Women with disabilities
Barriers to Treatment for with ADA

- Too fast too abstract
- Complex audiovisual
- Communication issues - Written assignments
- Facility not ADA compliant
Myths that Cause Barriers to Tx

• CSAT
  – People w/ disabilities do not abuse substances.
  – People w/ disabilities should receive exactly the same treatment protocol as everyone else so not singled out as different.
  – A person is noncompliant when her disability prevents her from responding to treatment.
  – A person w/ disabilities will make other clients uncomfortable.
  – People w/ disabilities will sue the program regardless of the services offered.
  – People w/ disabilities deserve pity so they should be allowed more latitude to indulge in substance use.
Issues for Dx Dual Diagnosis

- MI symptoms can mimic SA
- SA symptoms can mimic MI
- MI meds are less effective if SA
- If only treat one the other will worsen
- MI symptoms may not present at Dx