Dual Disorders:
An Overview

Presented by:
Lindsay Cure-Hendrickson, BA, BS, LADC Supervisor
Miranda Skinner, MPS, LADC

Northern Pines Chemical Health Training, March 24th, 2017

About us

Miranda Skinner, MPS from The University of Minnesota, Integrated Behavioral Health program.
*Current LADC and Licensure Candidate providing mental health services at NPMH.

Lindsay Cure-Hendrickson, BA and BS from St. Cloud State University, LADC
*Current chemical health division supervisor.
*Current graduate student in Hazelden Betty Ford Graduate School of Addiction: Integrated Recovery for Co-Occurring Disorders program.

Overview of presentation

You are about to learn….

A brief overview of addiction, co-occurring disorders, complications in diagnosing these disorders, best practices, treatment models, and recovery.

What is addiction?

ASAM's "Short" Definition of Addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

For the "long" definition, refer to ASAM's website: http://www.asam.org/quality-practice/definition-of-addiction

Co-occurring/Dual Disorder Overview

Dual Disorder: a term for when someone experiences a mental illness and a substance abuse problem simultaneously. (NAMI definition)

Chicken or the egg?

How do dual disorders start?

- Self medication theory: using substances to medicate MI.
- Causality theory: Substance use may lead to or cause MI.
- Multiple risk factor theory: Multiple environmental vulnerabilities.
- The supersensitivity theory: People with SPMI may be more vulnerable and sensitive to

Diagnosing Co-Occurring Disorders

General guidelines:

Every individual presents and experiences their illnesses differently.

Mental illness OR withdrawal/intoxication? (6 months - 1 year of sobriety)

Assessment is ongoing and treatment plans are modified accordingly.

Basic awareness of similar mental health and substance intoxication/withdrawal symptoms.

Useful screens: GAD-7, PHQ-9, PCL-5, Rule 25-D3, and CAGE-AID, etc

McGovern, M. (2009). *Co-occurring Addiction and Mental Health Disorders: A handbook for recovery.* Center City, Minnesota: Hazelden Foundation.

Example:

MI Symptoms: Anxiety	**Intoxication/Withdrawal Symptoms: Meth**
Physical symptoms: heart rate, breathing, etc.	Increased heart rate, breathing, etc.
Sleep Disturbance	Sleeping too little or too much
Weight change	Weight loss/weight gain
Restlessness	Restless, fidgety, paranoid
Difficulty concentrating	Poor concentration
Irritability	Irritable, short fuse
Excessive worry that’s difficult to control	Anxiety/worry/paranoia

Example:

MI Symptoms: Schizophrenia	**Intoxication/Withdrawal Symptoms: Synthetic Cannabis**
Delusions	Delusions/hallucinations
Hallucinations	Paranoia
Disorganized speech	Psychosis
Catatonic behaviors	Sudden and extreme behavior changes
Difficulty concentrating	Elevated heart rate/blood pressure
Negative symptoms	Hyperactivity
	Panic attacks

Stats

National Statistics from SAMHSA's 2014 Behavioral Health Trends- (this is the most recent report)

- 43.6 million adults had mental illness (9.8 million of those are considered SMI)
- 20.2 million adults had a substance use disorder
- 7.9 million of those adults had both

NPMH most common disorders (from Procentive)

Of ALL clients admitted to chemical health programs, our most common mental health disorders:

35%- Depressive/Mood disorders

15%- Anxiety disorders (including PTSD)

10%- Conduct disorders

10%- Adjustment Disorders

8%- Bipolar disorder

5%- ADHD/ADD

4%- Schizophrenia/ Schizoaffective

2%- Personality disorders- most commonly borderline personality disorder

11%- no mental health diagnosis, outliers- diagnosis from another provider not in procentive

Substance Use Disorders (from DAANES)

Of clients in all NP chemical health programs, most common substance use disorders:

Alcohol use disorder: 41%

Cannabis: 31%

Stimulant: 20% (1% are cocaine)

Opioid: 7%

Sedative/Hypnotic/ Anxiolytic: 0.4%

Other: 0.4%

Other: 0.4%

Tool: Cognitive Behavioral Therapy (CBT)

Definition: “A structured, short-term, present-oriented psychotherapy for depression, directed towards solving current problems and modifying dysfunctional (inaccurate and /or unhelpful) thinking and behavior.”

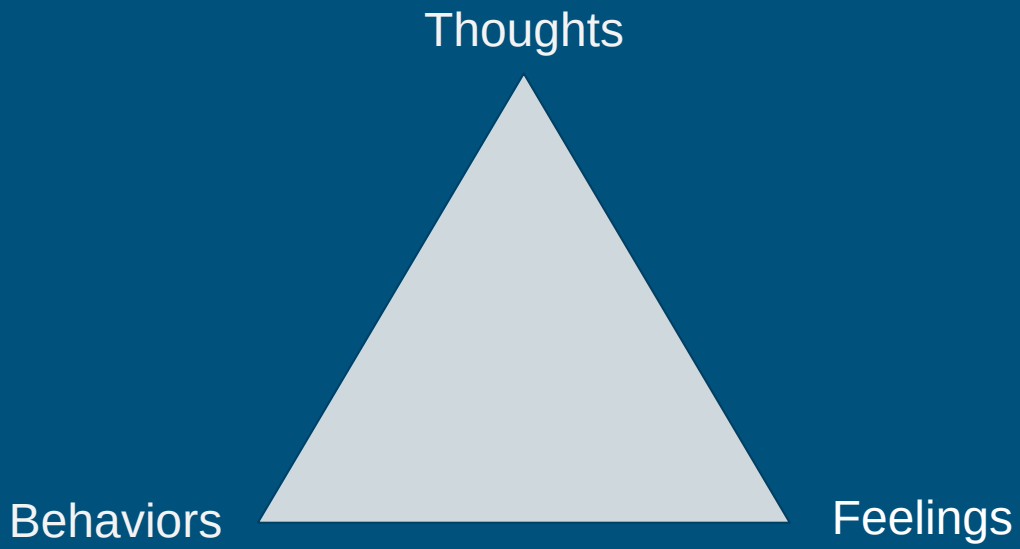
CBT focuses on patients basic beliefs about themselves, their world, and other people.

Since it originated in the 1960’s, CBT has been adapted to multiple populations and disorders. (DBT, PE, CPT, problem solving therapy, etc.)

CBT has been studied extensively and over 500 studies have proven its efficacy on a wide range of psychological and medical problems.

Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and beyond*. New York, NY: The Guilford Press.

Tool: Cognitive Behavioral Therapy (CBT)



Tool: Dialectical Behavior Therapy (DBT)

Cognitive behavioral treatment developed for chronically suicidal individuals, diagnosed with Borderline Personality Disorder.

Even though DBT was developed for individuals diagnosed with BPD, it has been proven effective for a variety of other disorders.

Key components of DBT: individual psychotherapy, group skills training, telephone coaching, and a therapist consultation team.

Skills: Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance

These skills are helpful for individuals struggling with impulse control, interpersonal relationships, self-image, and emotion regulation.

Linehan, M. M. (2015). *DBT Skills Training Manual: Second Edition.* New York, NY: The Guilford Press.

Tool: Motivational Interviewing (MI)

Integrated treatment involves working with BOTH the stages of CHANGE and stages of TREATMENT.

The fundamental basis of MI is meeting clients where they are at and using interventions appropriate for the stage of change they are in.

Stages of Change: Precontemplation, Contemplation, Planning/Preparation, Action, Maintenance.

For most there is a back and forth between stages, most often between Action and Maintenance.

Stages of Change

Precontemplation: *Problem, what problem?*

The client is unaware there's a problem, so of course they are unwilling to change at this time.

Contemplation: *Hmmm… maybe they're right, maybe I do have a problem. Is it really a problem? Do I want to do anything about it? Do I even really care?*

The client is ambivalent, uncertain about change, but the wheels are starting to turn in their mind.

Preparation/ Planning: *Oh no, I think I want to change some stuff, but I don't know how! Who do I call, what do I do, its so overwhelming!*

Client asks questions, asks for resources, indicate a willingness to start "walking the walk" and put some plans into place.

Stages of Change continued

Action: *I'm totally doing this! I made phone calls! I went to my appointment! I arranged for a ride myself! I went to a support group meeting!*

Client is receptive, following through, sometimes a "pink cloud" effect/ high on life, but client motivation can change quickly and relapse is a possibility.

Maintenance: *Wow, this is working, I better keep doing it! Life will always have challenges but I can do this!*

Clients "keep on keepin' on"-- goals are being met or have been met, they have found what works for them and they are taking their "medicine" (using various healthy tools regularly)

Stages of Treatment

Engagement

Clients and integrated treatment specialists have no relationship. In this stage, clients typically do not consider substance use or mental illness symptoms to be problems. During this stage, your job is to help clients become engaged in integrated treatment for co-occurring disorders.

Persuasion

During the persuasion stage, help clients think about the role of substance use in their lives. Active listening, asking exploratory questions about experiences and goals, and educating clients about substance use and mental illness are common techniques (motivational interviewing).

Stages of Treatment continued..

Active Treatment

Once clients recognize that substance use is a problem and they decide to reduce or stop using altogether, they are in the active treatment stage. Provide them with additional skills and supports, and strive for abstinence at this stage.

Relapse Prevention/ Maintenance (long term)

When clients are abstinent for 6 months or more, they are in the relapse prevention stage. The task is to avoid relapsing into problematic substance use.

When developing a relapse prevention plan, work with clients to identify their triggers to using substances, such as feelings, people, or situations. In partnership with the client, outline specific ways they can avoid or handle these triggers or cues.

What does recovery look like?

SAMHSA’s working definition of recovery:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Essential areas of recovery include Health, Home, Purpose, and Community

Treatment Options

Historically treatment was sequential or parallel to one another BUT wasn't fully integrated

The future of treatment is moving towards integrated, long-term systems including all aspects of the patient's life such as medical concerns. (Northern Pines will be a CCBHC starting July 1st, which is a federally funded pilot project across the nation. Currently in the policy writing stage with DHS).

"The most successful treatments address all parts of the disorder together, in a single, integrated way--usually in the same setting, with a single professional or group of professionals" (McGovern, 2009).

The following slides entail multiple aspects and options for treatment

McGovern, M. (2009). *Co-occurring Addiction and Mental Health Disorders: A Handbook for Recovery.* Center City, Minnesota: Hazelden Foundation.

Treatment: Client Centered Care

Client-centered care or patient-centered health is rooted in the idea of respect for patients as individual beings and the obligation to care for them on their terms.

At one time the question was posed, is client-centered care at odds with evidence based practices?

It’s now accepted that positive outcomes must be defined by what the individual finds meaningful and valuable.

Epstein, R. M., & Street, R. L. (2011). The Values and Value of Patient-Centered Care. *Annals of Family Medicine, 9* (2), 100-103. doi:10.1370/afm.1239.
DeSanto, P. (2013). *Effective Addiction Treatment: The Minnesota Alternative.* Spring Lake Park, MN: Minnesota Alternatives, LLC.

Treatment: Harm Reduction

Examples of harm reduction: medication assisted therapies (Methadone, Suboxone, Naltrexone), needle exchange, ignition interlock, cannabis, designated driver, wet houses, tapering, narcan, and benzodiazepines.

Harm reduction approaches accept that many people are unlikely to be “cured” due to present circumstances or few readily available resources.

Harm reduction is a way to prevent the spread of illness, decrease crime, and lower the rates of fatal overdoses.

Countries that have implemented needle exchange and opioid substitution programs have seen substantial changes in the prevalence of HIV. However, on a global scale we have yet to achieve international HIV control.

DeSanto, P. (2013). *Effective Addiction Treatment: The Minnesota Alternative.* Spring Lake Park, MN: Minnesota Alternatives, LLC.
Mate, G. (2010). *In the Realm of Hungry Ghosts: Close Encounters with Addiction.* Berkeley, CA: North Atlantic Books.

Treatment: Detox

Medical necessity: Alcohol, Benzodiazepines, Opioids

Local Detox resources:

St. Cloud- Central MN Mental Health Center (320) 252-6654

Nevis- Pine Manor (218) 732-4337

Hastings- Cochran Recovery Services/Dakota County Receiving - (651) 437-4209

Treatment: Residential and Outpatient

Residential Treatment: Facility that requires patients to live at the treatment center.

Outpatient with Lodging/ Sober House: Some “residential” programs are actually outpatient with lodging. Go to a different place for room and board.

Halfway House: Typically a 90 day combined treatment and sober house after completing residential treatment.

Sober House: for funding, is a group home for its residents that attend outpatient treatment as a stipulation for living there.

Outpatient Treatment: Patients attend treatment but return to their own residence. Step down.

Some changes coming our way in treatment

Integrated teams, co-occurring add-on certification (optional at this time)

CCBHC (6 agencies within the state)- what is this?

Difference between being allowed to bill co-occurring and being certified.

Behavioral health homes - what does that mean? Who is on the team?

Focus will shift from treatment “episodes” to long term care- no more focus on days, hours, etc.

Will be more person centered and promote long term maintenance

***these are new issues DHS is currently considering

Treatment: Medications

Four major classes of drugs: antipsychotics, antidepressants, mood stabilizers, and antianxiety medication/sleeping pills.

Medications can be a useful addition to therapy

Therapist/counselors are great advocates for their clients and generally know them better than prescribers.

Communication and collaboration with medication providers is important throughout the duration of treatment.

Diamond, R. J. (2009). Instant Psychopharmacology: Third Edition. New York, NY: W. W. Norton & Company, Inc.

Treatment: Therapy

1. Getting an assessment: diagnostic assessment, typically completed within the first two sessions in order to best understand the issues at hand.
2. Finding the ideal treatment: factors to consider include: diagnosis, age, sex, cultural background, demographics, and religious beliefs.
3. Choosing and working with a therapist: important to consider the above factors along with the therapist's areas of specialty.
4. The courage to change: the outcome of therapy is dependent on changes made by the client outside of therapy.

McGovern, M. (2009). *Co-occurring Addiction and Mental Health Disorders: A Handbook for Recovery.* Center City, Minnesota: Hazelden Foundation.

Treatment: Therapy cont.

"For the great majority of people with co-occurring disorders, on-to-one talk therapy (or psychotherapy) is an important part of recovery" (McGovern, 2009).

Key aspects of therapy:

- Building rapport and having a positive therapeutic relationship
- Recovery or maintenance of diagnosis using various treatment models
- Team contribution (therapist and client) of time, effort, and careful attention towards a common goal of improving the client's life

McGovern, M. (2009). *Co-occurring Addiction and Mental Health Disorders: A Handbook for Recovery.* Center City, Minnesota: Hazelden Foundation.

Treatment: Support and Resources

Support groups: AA, NA, CMA, OA, Al-non

Self Care- Sleep, Nutrition, Exercise

Healthy friends and family members

Drop in centers

Treatment

Housing

Jobs

Q & A

Sources

McGovern, M. (2009). *Co-occurring Addiction and Mental Health Disorders: A Handbook for Recovery.* Center City, Minnesota: Hazelden Foundation.

Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond*. New York, NY: The Guilford Press.

DeSanto, P. (2013). *Effective Addiction Treatment: The Minnesota Alternative.* Spring Lake Park, MN: Minnesota Alternatives, LLC.

Epstein, R. M., & Street, R. L. (2011). The Values and Value of Patient-Centered Care. *Annals of Family Medicine, 9* (2), 100-103. doi:10.1370/afm.1239.

Linehan, M. M. (2015). *DBT Skills Training Manual: Second Edition.* New York, NY: The Guilford Press.

Diamond, R. J. (2009). Instant Psychopharmacology: Third Edition. New York, NY: W. W. Norton & Company, Inc.

Mate, G. (2010). *In the Realm of Hungry Ghosts: Close Encounters with Addiction.* Berkeley, CA: North Atlantic Books.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition. Arlington, VA: American Psychiatric Association.

www.nami.org

www.samhsa.gov