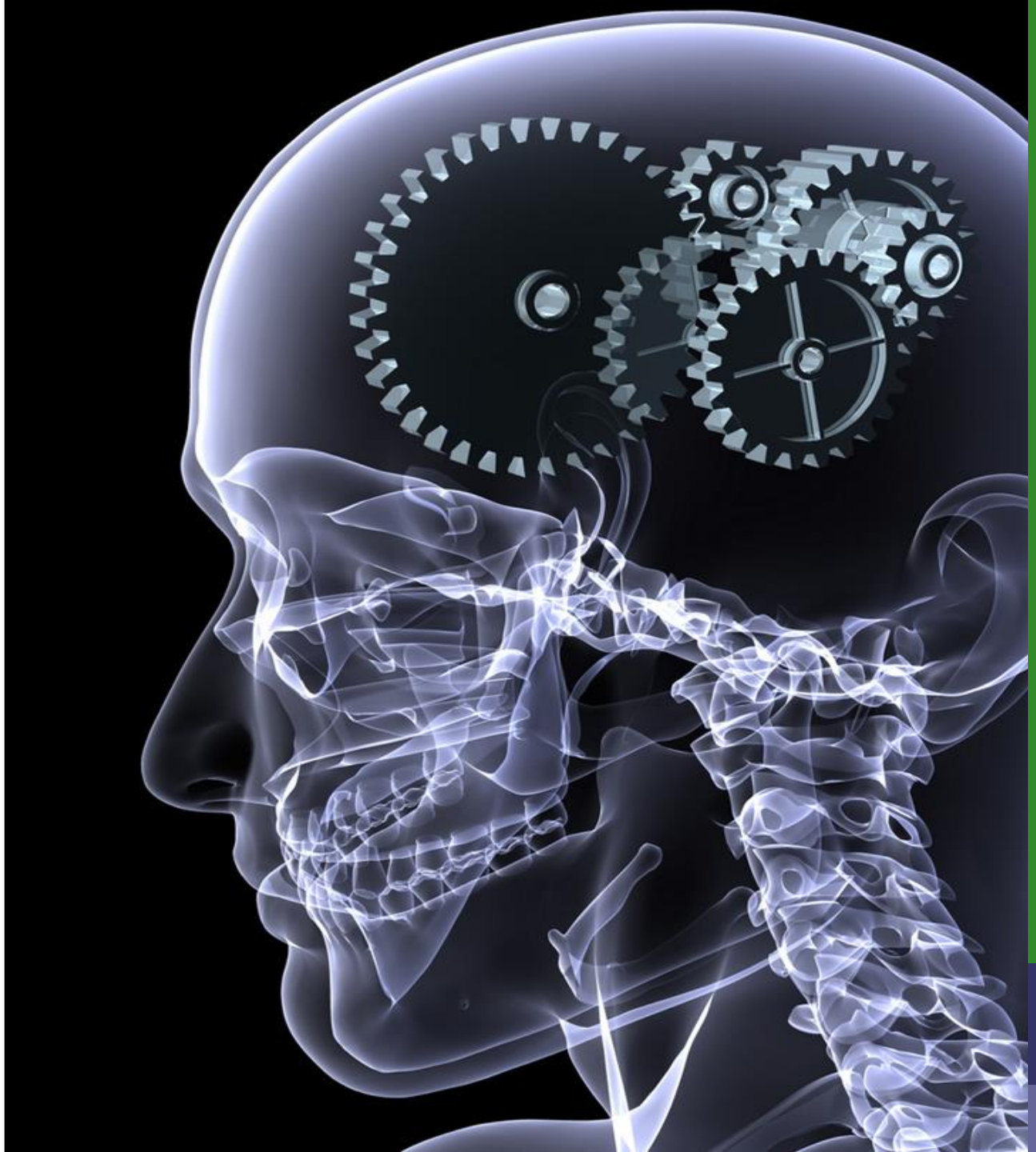


African-American Training and Technical Assistance (AATA)

Pathways to Wellness

Co-Occurring Disorders

INTRODUCTION

The ***SINGULAR OBJECTIVE*** of this presentation is to provide participants with the most current, evidence-based, practice-informed knowledge so that they can confidently address these five co-occurring disorder and other related questions:

And Those Questions Are . . .

1) How do the World Health Organization (WHO) and the Substance Abuse and Mental Health Services Administration (SAMSHA) define COD?

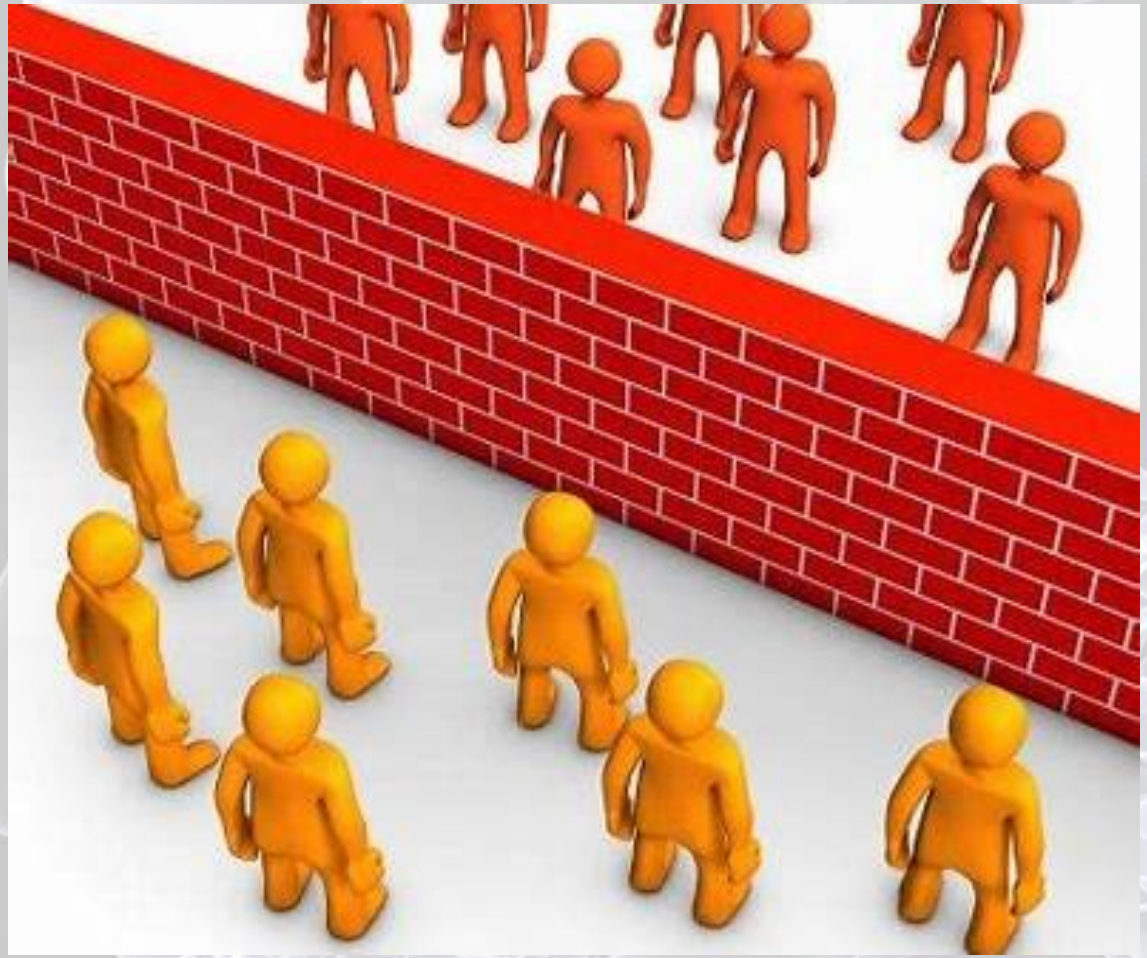
2) How are CODs diagnosed, and what factors complicate the process?

3) Why is the identification of CODs important, and how does that relate to the course of illness and prognosis?

4) Where do race and the diagnosis and treatment of CODs intersect?

5) How do you non-pharmacologically and pharmacologically treat CODs?

The Wall of Health Care

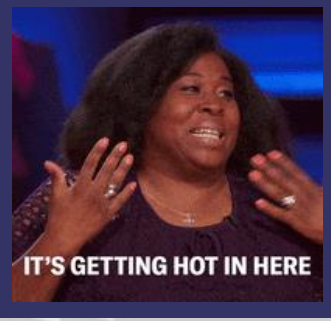


If you don't ***THINK*** about it, you won't ***ASK*** about it, and you don't ask about it, you won't ***DO*** anything about it.

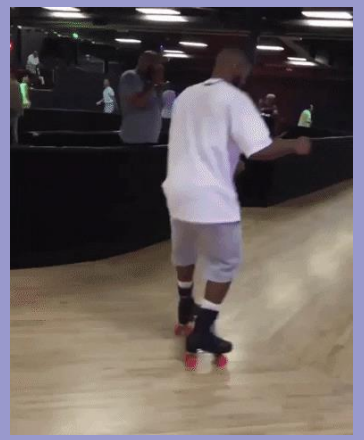
Co-Occurring Disorders

Integrated Thinking

Pregnancy and Anxiety



Roller Skates



Psychiatric Residents and SUD

Co-Occurring Disorders: Big Picture

SUD Quadruples → SMI — 400%

SMI Triples → SUD — 300%

One SUD → Another SUD — 50%

SUD or SMI → Receiving any care — 50%

Race → Tx: SUD or SMI — 33%

Substance use disorders reduce life expectancy by approximately 14 years

The Art and Science of Medicine

- According to the President's New Freedom Commission on Mental Health:

  "State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings."

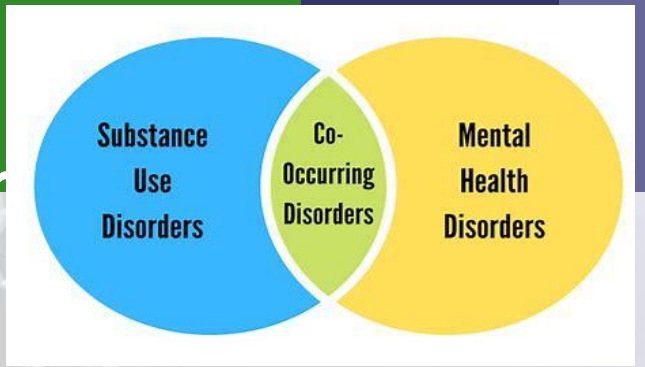
- According to the President's New Freedom Commission on Mental Health:

  "If effective treatments were more efficiently delivered through our mental health services system . . . millions of Americans would be more successful in school, at work, and in their communities."

Co-Occurring Disorders

DEFINITION

Definition of Co-Occurring Disor



SAMHSA defines people with "co-occurring disorders" as individuals who have at least one mental disorder, as well as at least one alcohol or drug use disorder.

While these disorders may interact differently in any one person at least one disorder of each type can be diagnosed **independently** of the other

Co-Occurring Disorders

DIAGNOSIS

Case Example of Co-Occurring Disorders

The Confounding Case of Mr. S . . .

Important questions:

1) Is this a substance-induced psychotic disorder, or is it the onset of a cluster A personality disorder?
2) What is the course and prognosis?
3) Does a psychotic disorder better explain this condition due to another medical (HIV, hepatitis, others)or another DSM-5 Tr condition?

Equality

SUD + Ψ = COD

Inequality

Definition ≠ Diagnosis

SAMHSA DEFINES people with "co-occurring disorders" as individuals who have at least one mental disorder, as well as at least one alcohol or drug use disorder.

Diagnosis/Differential Diagnosis

- Co-Occurring Disorders
- Substance-Induced Psychiatric Disorder
- Psychiatric Disorder Due to Another Medical Condition
- Substance Withdrawl
- Substance Intoxication

Diagnosis/Differential Diagnosis: Substance-Induced Mental Disorders

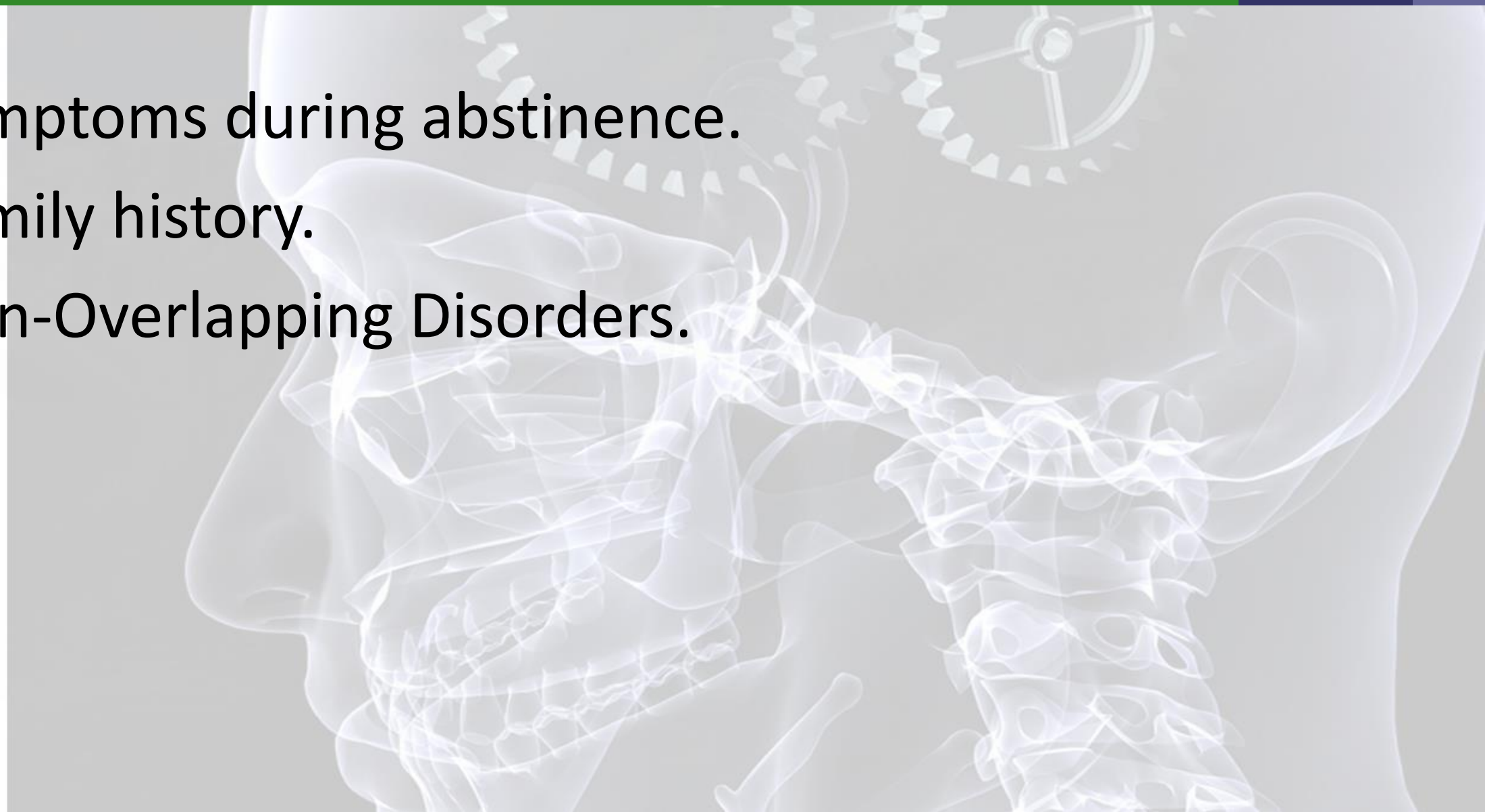
1. Substance/Medication-Induced Delirium
2. Substance/Medication-Induced Major or Mild Neurocognitive Disorder
    a. Non-amnestic-Confabulatory Type
    b. Amnestic-Confabulatory Type
3. Substance/Medication-Induced Persisting Amnestic Disorder
4. Substance/Medication-Induced Psychotic Disorder
5. Substance/Medication-Induced Depressive Disorder
6. Substance/Medication-Induced Bipolar and Related Disorder
7. Substance/Medication-Induced Anxiety Disorder
8. Substance/Medication-Induced Obsessive–Compulsive and Related Disorder
9. Hallucinogen Persisting Perception Disorder
10. Substance/Medication-Induced Sleep Disorder
11. Substance/Medication-Induced Sexual Dysfunction

Addressing the Diagnostic Challenges

- Comprehensive screening.
- Intoxication and withdrawal.
- Metabolic disturbances, head trauma, and personality disorders.
- Timeline/Order.

Diagnostic Challenges

- Symptoms during abstinence.
- Family history.
- Non-Overlapping Disorders.



Prognosis of Co-Occurring Disorders

1. Functioning.
2. Quality of life.
3. Suicide.
4. Medical conditions.
5. Isolation.
6. Housing.

Prognosis of Co-Occurring Disorders

7. Abandon treatment.

8. Return to use.

9. Treatment outcomes.

10. Medication adherence.

11. Cycling.

12. Symptom severity.

Prognosis of Co-Occurring Disorders

13. Severe symptoms on return to use.

14. Finances.

15. ER and hospital.

16. Violence.

17. Criminal justice system.

Worsen Outcomes

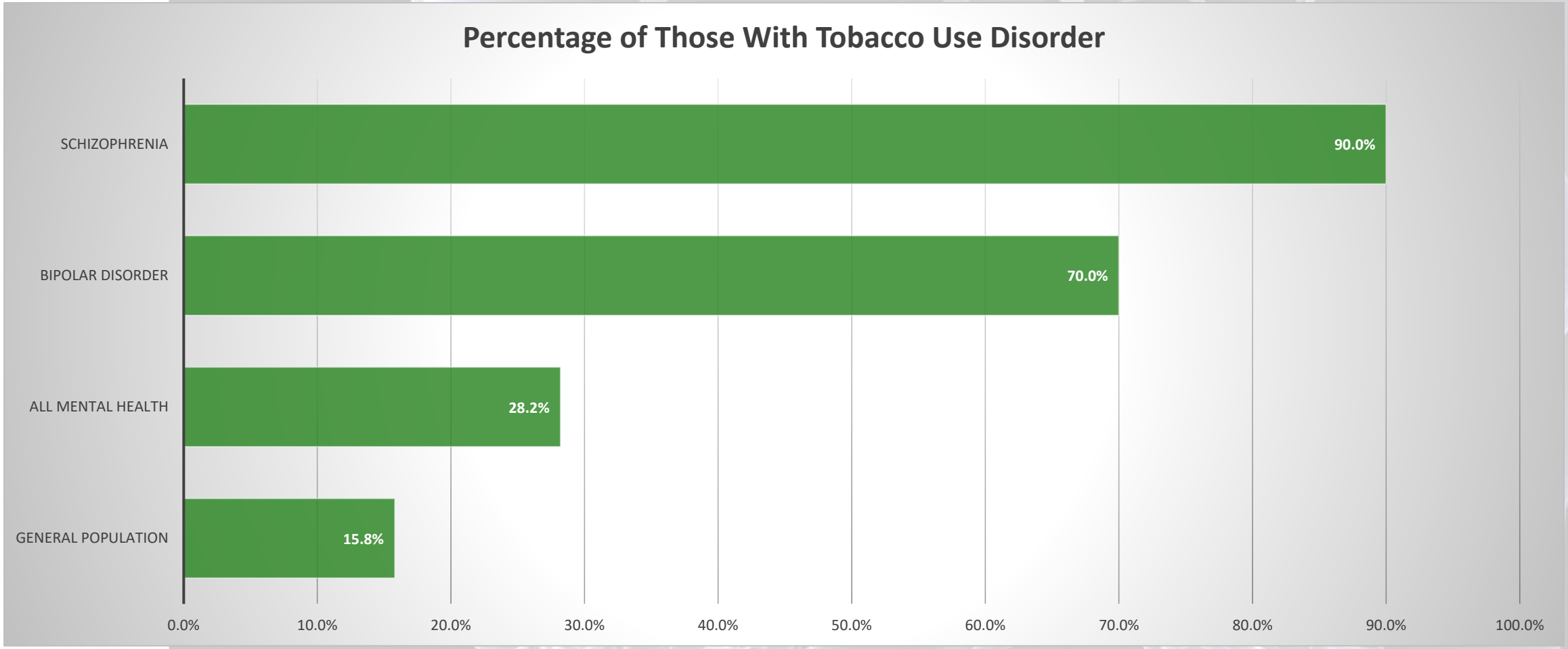
- Co-Occurring disorder patients generally do worse (Ritsher et al 2002; Schaar and Ojehagen 2001).
  - Maybe not for severely and persistently mentally ill (Farris et al 2003; Gonzalez and Rosenheck 2002)
  - Probably not for antisocial personality disorder (Cacciola et al 1995; Kranzler et al 1996)
  - Even subclinical depression worsens alcohol use disorder outcomes (Brown et al 1998; Curran et al 2000).
  - Major Depressive Disorder in remission does not worsen outcomes (Hasin et al 2004).

Big Picture 2022

+

+

Tobacco Use Disorder



Medical Sequalae

Co-Occurring Disorders

(National Institute on Drug Abuse: https://www.drugabuse.gov/; Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/)

Medical Co-Occurring Disorders

Factors to Consider

Medical Complications of Substance Use Disorders

Type of Substance	Medical Complications
Alcohol	Liver disease (e.g., acute alcohol-related hepatitis, alcohol-related fatty liver disease, cirrhosis); cardiovascular disease (e.g., hypertension, cardiomyopathy); gastrointestinal illnesses (e.g., pancreatitis, gastritis, esophagitis); bone marrow suppression; peripheral neuropathy; chronic infectious diseases (e.g., pneumonia); several types of cancer (e.g., of the mouth, esophagus, throat, liver, and breast); associated with psychiatric and behavioral conditions (e.g., depression sleep disturbance); alcohol withdrawal
Cannabis	Chronic bronchitis; cannabis-related hyperemesis; possible association between heavy marijuana use and reduced cognitive function as well as onset of schizophrenia (although controversy remains)
Cocaine	Cardiac ischemia; cerebrovascular and renal disease; chronic rhinitis and perforation of the nasal septum associated with intranasal use; acute and chronic pulmonary complications associated with smoked use (e.g., acute pulmonary toxicity involving diffuse alveolar damage and hemorrhagic alveolitis)
Designer Drugs	Synthetic cannabinoids are associated with seizures, acute renal failure, and myocardial infarction; cathinones or "bath salts" are associated with muscle spasm, bruxism, cardiac arrhythmias, myocarditis, hyponatremia, rhabdomyolysis, and psychiatric effects

Type of Substance	Medical Complications
Injection Drugs	Local infections (e.g., abscesses, cellulitis); blood-borne infections, including bacterial (e.g., endocarditis, pneumonia, osteomyelitis, septic arthritis) and viral (e.g., HIV infection, hepatitis C and B)
Methamphetamine	Cardiotoxicity; acute behavioral effects (e.g., irritability, anger, panic, and psychosis); neurotoxicity and cognitive decline; oral health issues (e.g., tooth decay)
Opioids	Injection-related risks (see above); nausea and constipation; hypothalamic-pituitary-adrenal axis suppression (e.g., amenorrhea, low bone density, loss of libido); opioid-related hyperalgesia; respiratory depression and overdose

Medical Complications: Tobacco

"Cigarette smoking remains the leading preventable cause of death in this country and is responsible for an estimated 438,000 deaths per year, or about one of five deaths. An estimated 38,000 of these deaths are the result of secondhand smoke exposure."

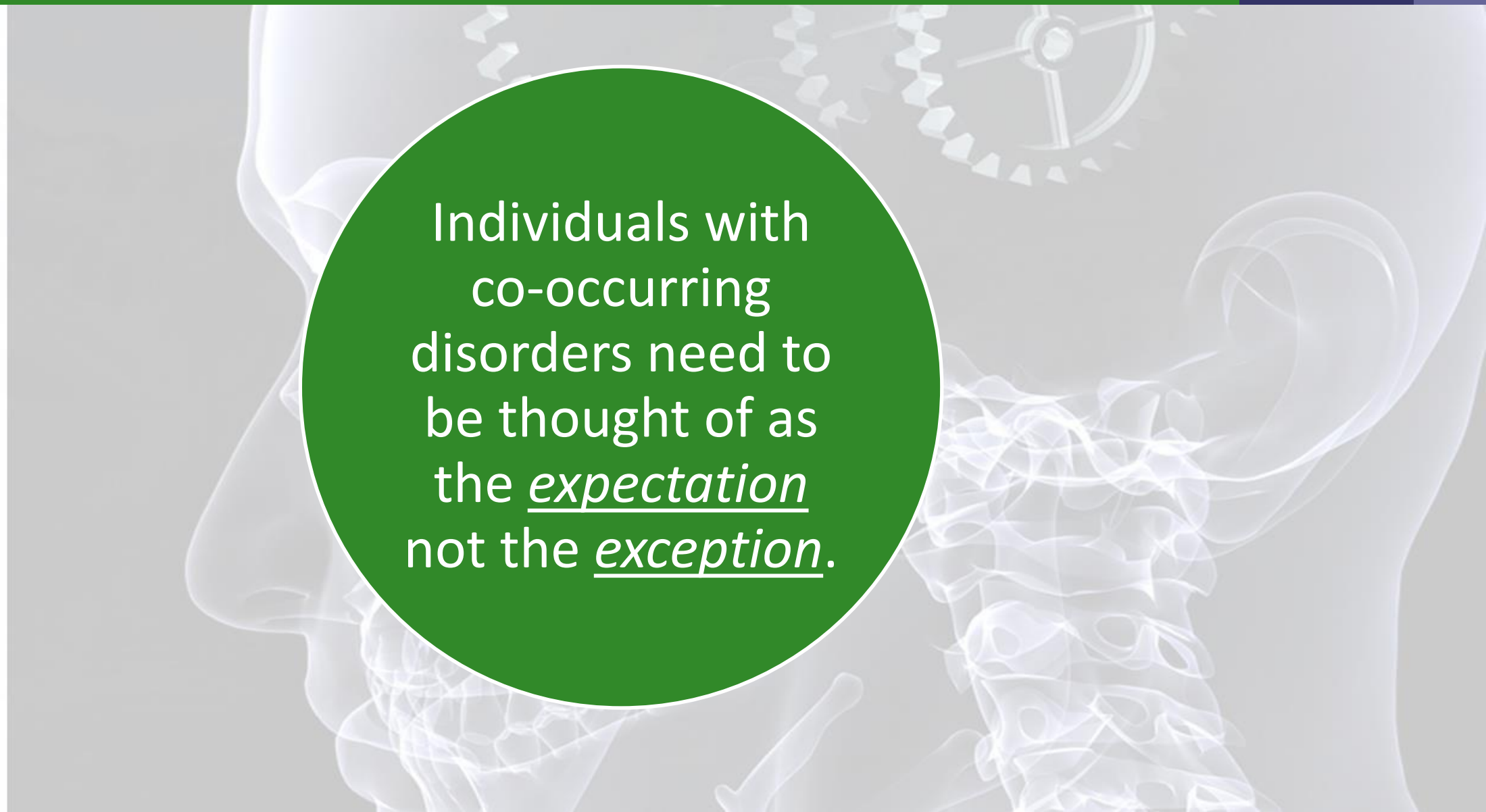
https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm

HCM: My Patient With Bipolar Disorder and Alcohol Use Disorder

Epidemiology of Co-Occurring Disorders

Most comorbidity (co-occurring disorders) is accounted for by Antisocial Personality Disorder and another substance use disorder ~ 85%.

In Summary . . .



Individuals with co-occurring disorders need to be thought of as the *expectation* not the *exception*.

Co-Occurring Disorders

THE ROLE OF RACE AND RACISM

Results from the 2019 National Survey on Drug Use and Health

- 10.4% of adults aged 18 or older had a co-occurring mental illness and substance use disorder.

By race and ethnicity:

- White: 12.6%
- Black or African American: 17.8%
- Hispanic or Latino: 14.5%
- Asian: 7.8%
- Native American or Alaska Native: 15.5%

* National Institute on Drug Abuse: https://www.drugabuse.gov/
* National Institute of Mental Health: https://www.nimh.nih.gov/
* Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/

The Co-Occurring Numbers in 2021

Table B.19B Substance Use Disorder (SUD) and Any Mental Illness (AMI) in the Past Year: Among Adults Aged 18 or Older; by Race/Ethnicity, 2021

Characteristic	SUD or AMI		SUD but No AMI		AMI but No SUD		SUD and AMI	
TOTAL	32.5	(0.40)	9.7	(0.23)	15.1	(0.30)	7.6	(0.19)
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	32.9	(0.42)	9.7	(0.25)	15.5	(0.31)	7.7	(0.22)
White	33.6	(0.51)	9.8	(0.30)	16.0	(0.38)	7.9	(0.24)
Black or African American	32.3	(1.08)	10.9	(0.64)	13.9	(0.81)	7.4	(0.58)
American Indian or Alaska Native	45.3	(4.74)	18.6	(3.05)	16.3	(3.65)	10.4	(2.17)
Native Hawaiian or Other Pacific Islander	*	(*)	9.7	(3.11)	7.9	(2.68)	10.2	(3.50)
Asian	21.4	(1.37)	5.0	(0.73)	12.9	(1.14)	3.5	(0.57)
Multiracial[1]	48.0	(2.47)	13.1	(1.87)	18.6	(1.68)	16.3	(2.05)
Hispanic or Latino[2]	30.3	(0.95)	9.6	(0.61)	13.5	(0.69)	7.2	(0.46)

* Low precision; no estimate reported.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Additional estimates may be found in *Results from the 2021 National Survey on Drug Use and Health: Detailed Tables* at https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables. Measures and terms are defined in Appendix A of the 2021 Detailed Tables.

NOTE: SUD estimates are based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5). Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. These estimates include prescription drug use data from all past year users of prescription drugs. See the *2021 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions* for details on these changes.

NOTE: AMI aligns with criteria from DSM-IV and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. These mental illness estimates are based on a predictive model and are not direct measures of diagnostic status.

[1] Multiracial refers to people not of Hispanic or Latino ethnicity who reported two or more races.

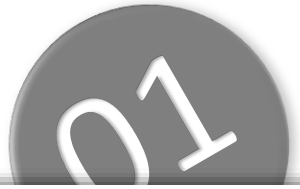
[2] People who reported Hispanic or Latino ethnicity could be of any race.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Race, Racism, SUD, and COD

- Racial Disparities and COD
  - Burden of substance use disorder/COD.
  - Treatment: kind, availability, retention, and outcomes.
- Structural factors:
  - The war on drugs: Treatment versus Punishment
  - Racism and stress.
  - Bias within substance use treatment systems.

Race, Racism, SUD, and COD



Buprenorphine vs. Methadone

Duration of Treatment

Prescribed vs. Non-Prescribed

Overdose Follow Up

Cannabis Consequences

Completion & Discharge

Tobacco Use Disorder Treatment

Lung Cancer Screening

Death Rates

Co-Occurring Disorders

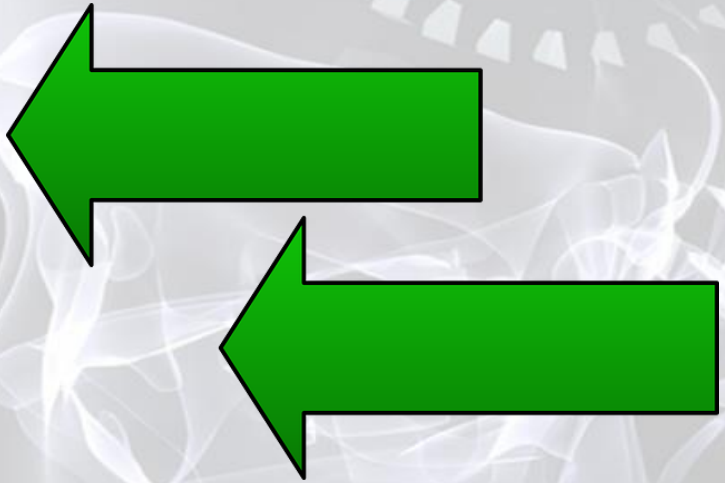
TREATMENT

Treatment

Non-Pharmacological Treatment

Co-Occurring Disorder Treatment Models

Sequential



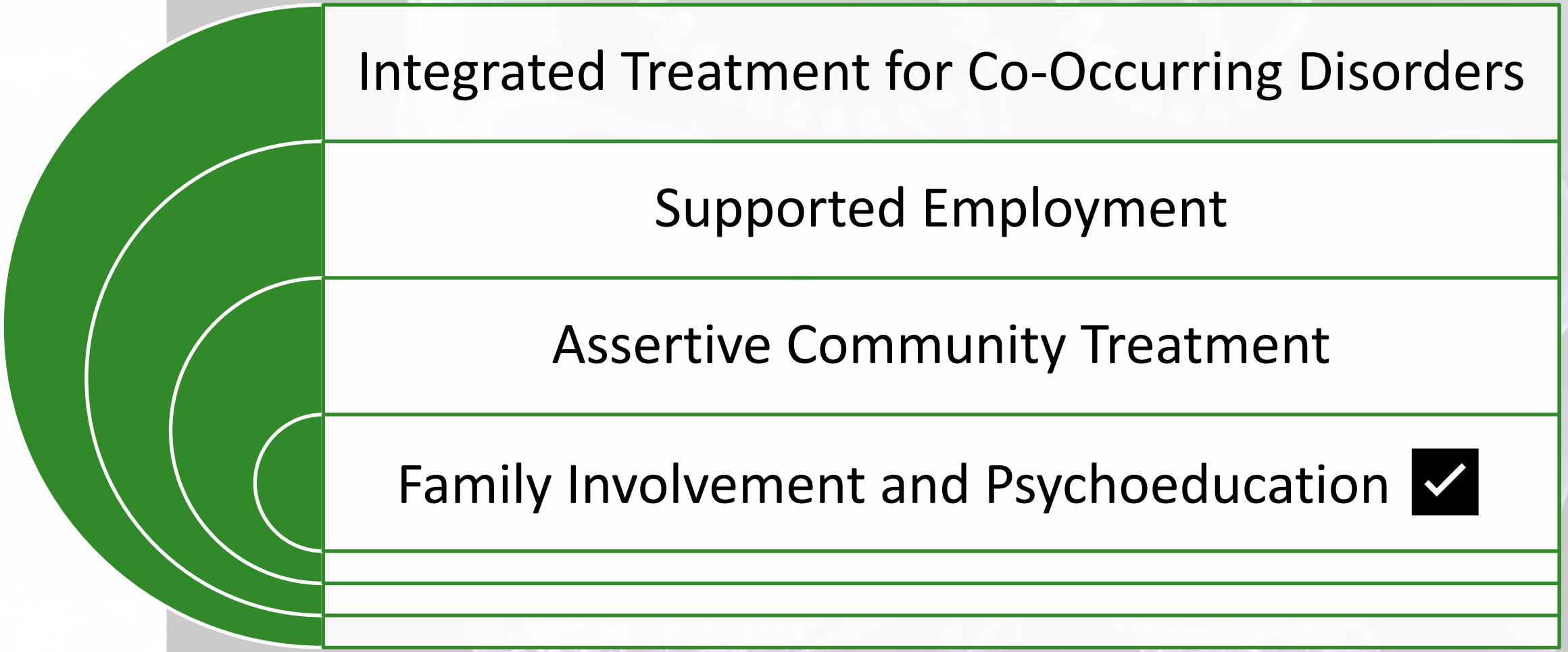
Parallel

Integrated

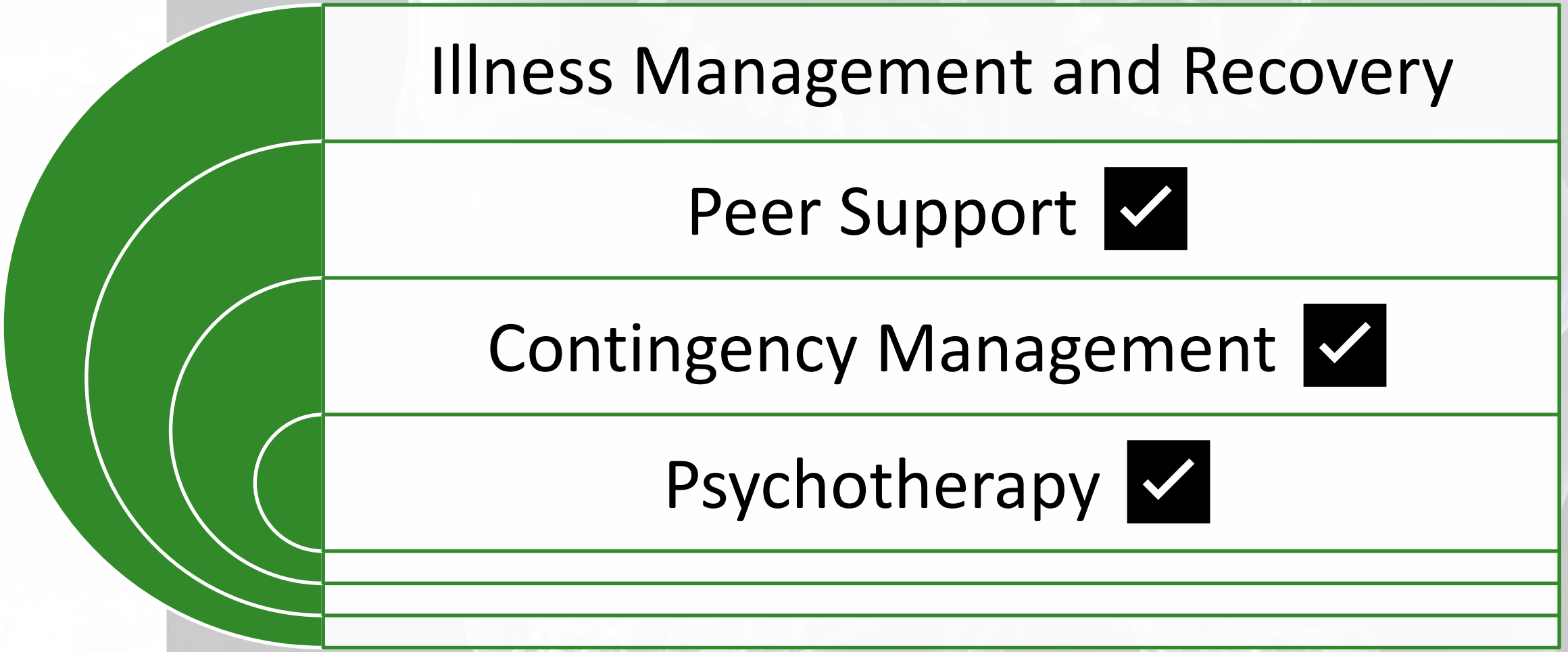
Evidence-Based Integrated Therapy

- "Seeking safety" for PTSD (Najavits et al 1996, 1998).
- Integrated Group Therapy for bipolar disorder (Weiss et al 2000)
- Assertive Community Treatment for bipolar (Drake et al 2004)
- Motivational interviewing for dual diagnosis (Carey et al 2001; Martino et al 2002)
- Family interventions (Mueser and Fox 2002)
- Contingency management improves attendance, but effects on psychiatric outcomes have been mixed.
- Twelve-step facilitation has generally been unimpressive in this population.
- Integrated CBT for anxiety and alcohol use disorder improved outcomes for both disorders {Ciraulo et al 2013).

Examples of Evidence-Based Practices



Examples of Evidence-Based Practices



Single Modal Verses Multimodal

Recovery Capital: Race and Treatment Success

- The breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Cloud & Granfield,1, 2004).

- Employment.
- Education.
- Finances.
- Living situation.
- Social networks.

Treatment of Co-occurring Disorders

One team, one plan, for one person

Treatment

Pharmacological Treatment

New Language for MAT

16

12 APPOINTMENTS

32% INCREASE

Medications for Addiction Treatment

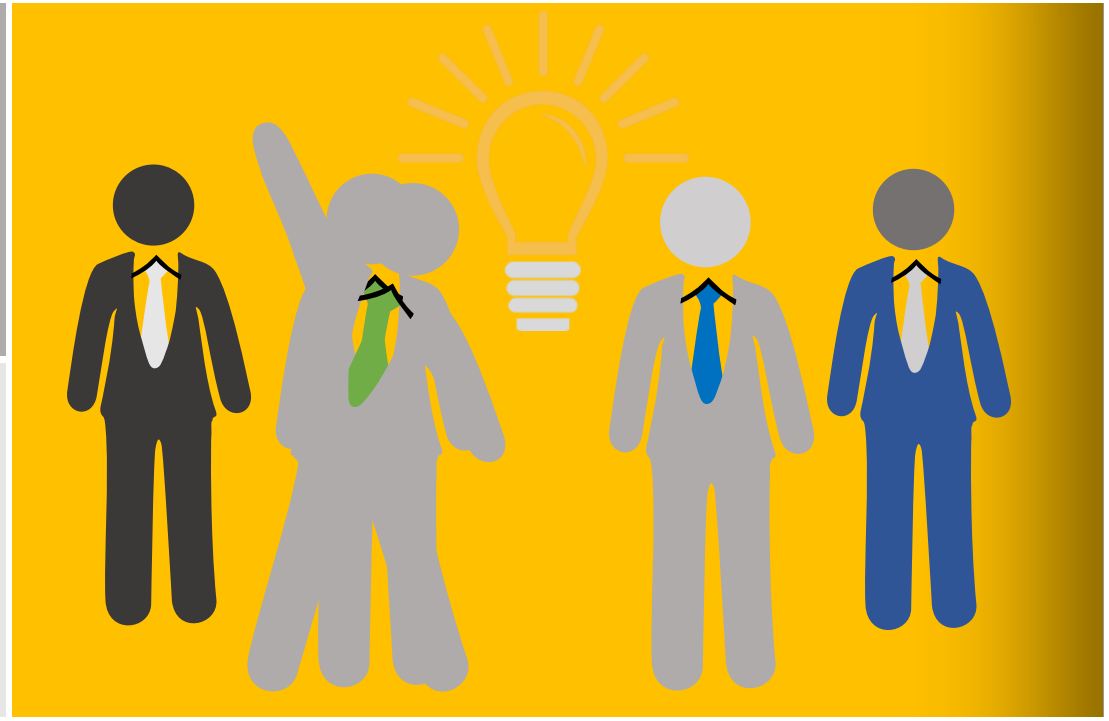
26 March

5 SOLUTIONS

18 OPTIONS

WHY
The NAME
CHANGE?

12
MONTHS



Medication *Assisted Treatment* → → **Medications for Addiction Treatment**

Effectiveness for Addiction Treatment

16

12 Appointments

01 Improve patient survival

02 ↑ Retention in treatment

03 ↓ Criminal system contact & illicit substance use

04 ↑ Gaining & maintaining employment

05 ★ Improve birth outcomes

06 Improved social functioning

07 ↓ HIV, hepatitis B, or C risks

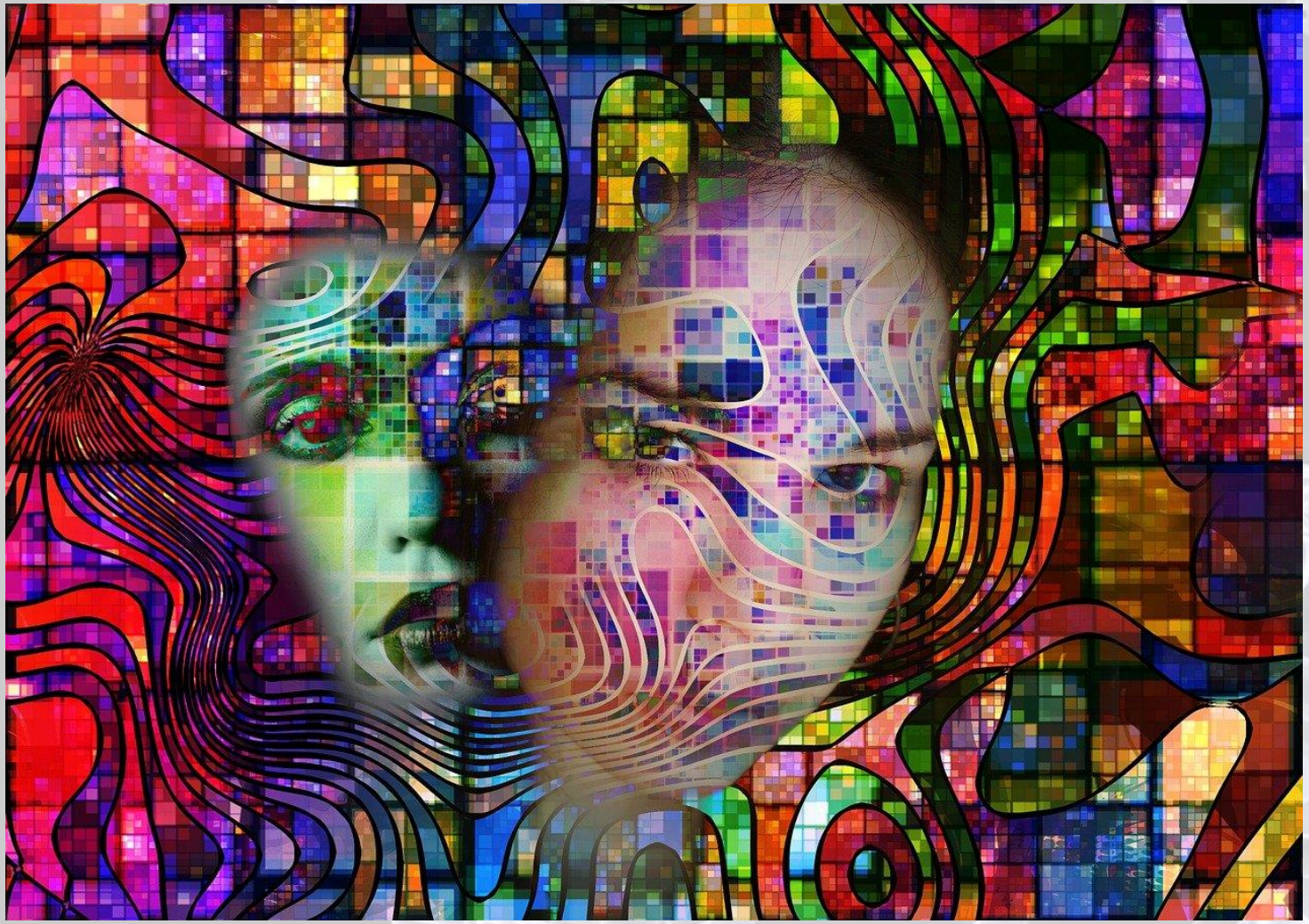
Treatment

Pharmacological Treatment: Condition Specific

C-Occurrent Major Depressive Disorder

Co-Occurrent Bipolar Disorder

Co-Occurrent Schizophrenia Spectrum Disorders



Psychostimulants and Negative Symptoms of Schizophrenia

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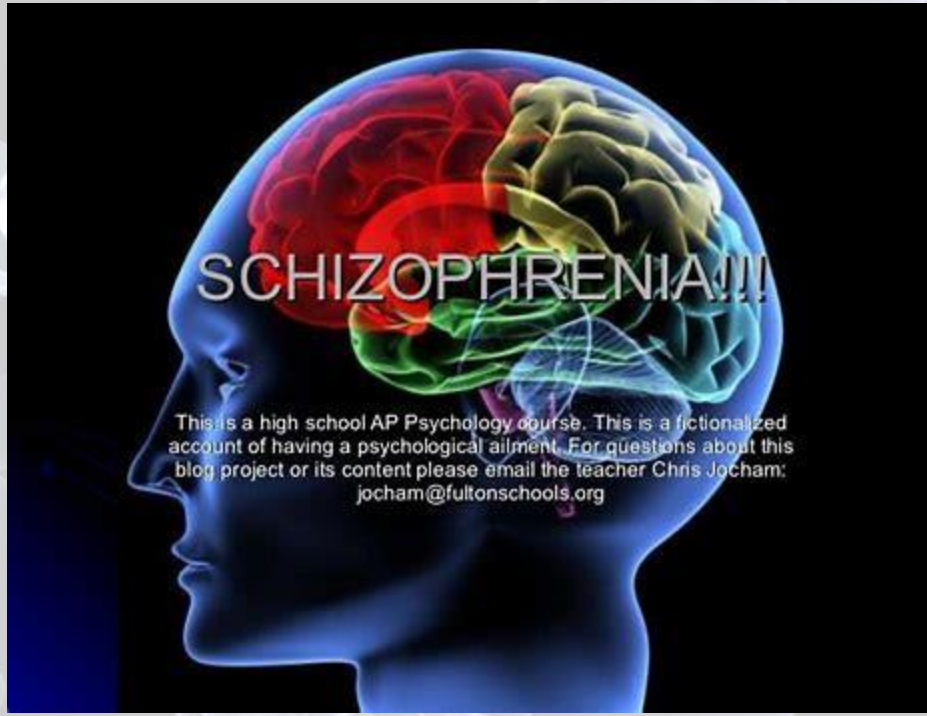
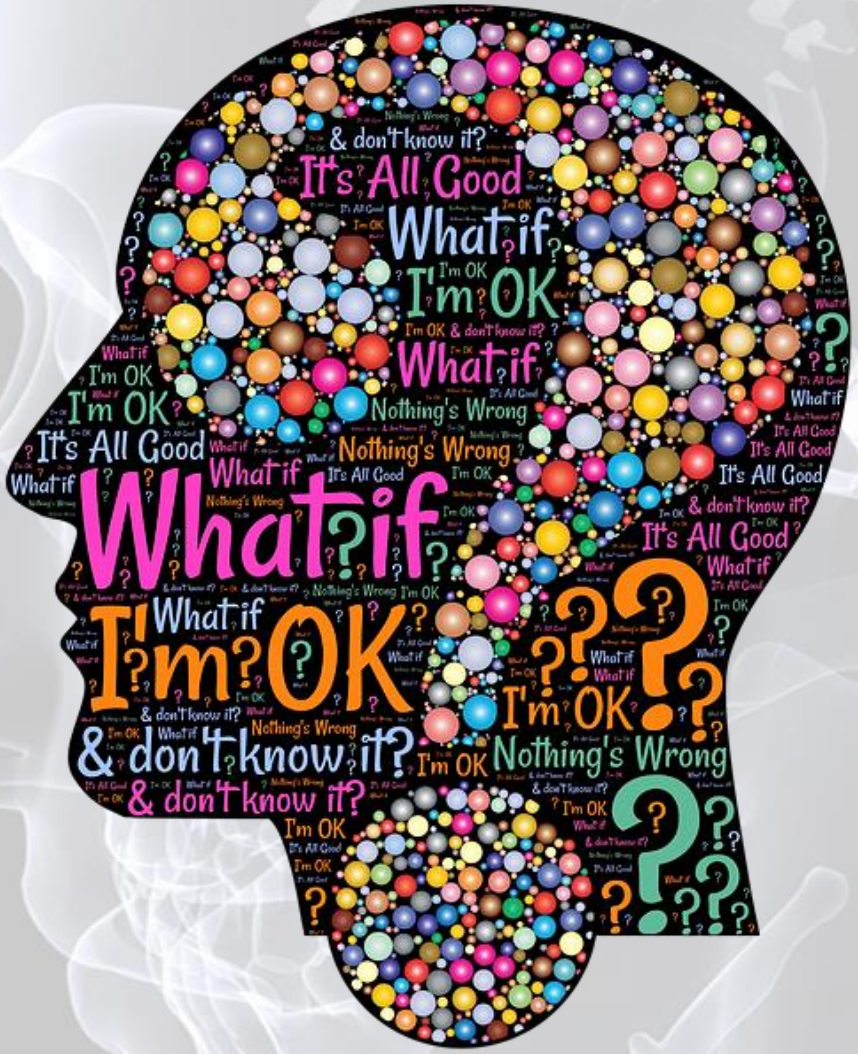
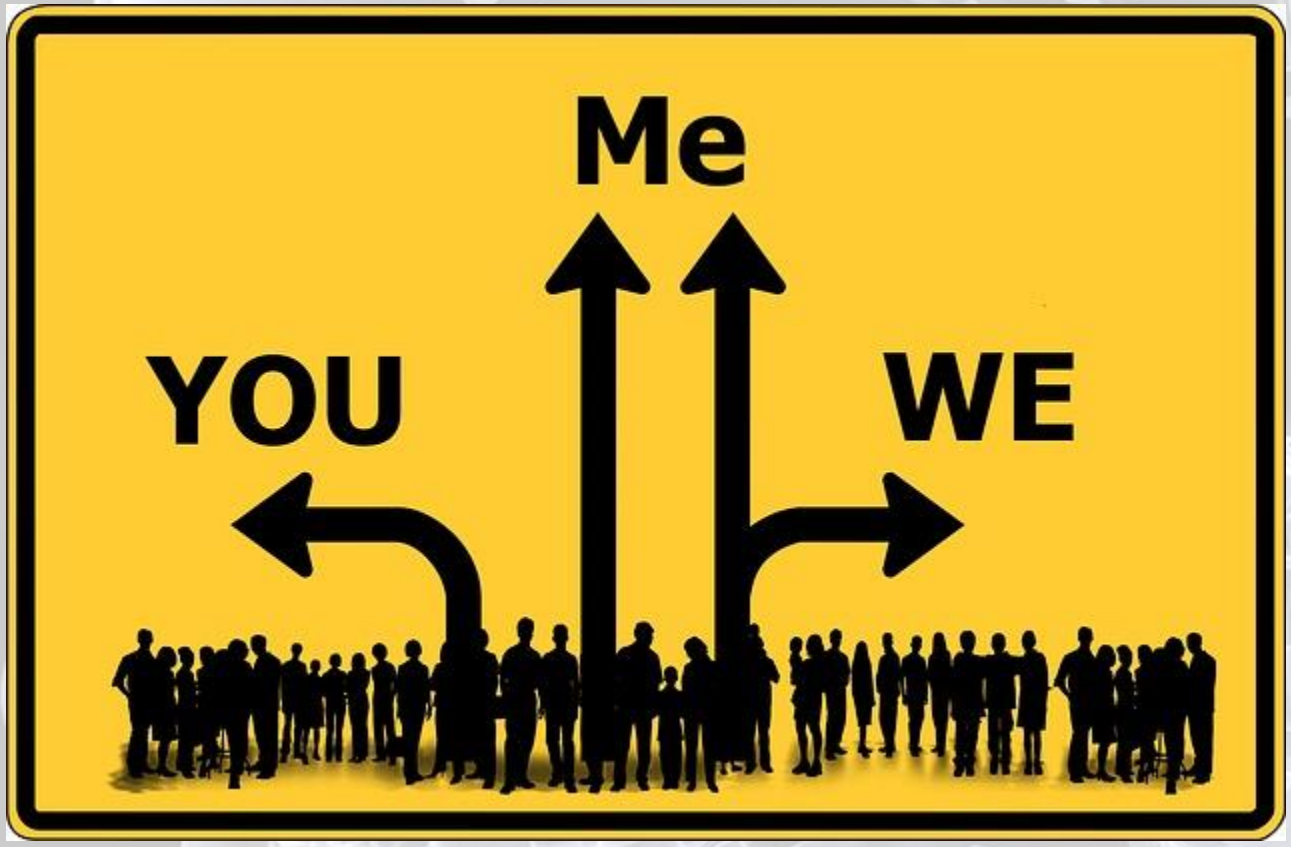


Co-Occurrent Anxiety Disorders



Co-Occurrent Borderline Personality Disorder



Co-Occurrent Antisocial Personality Disorder

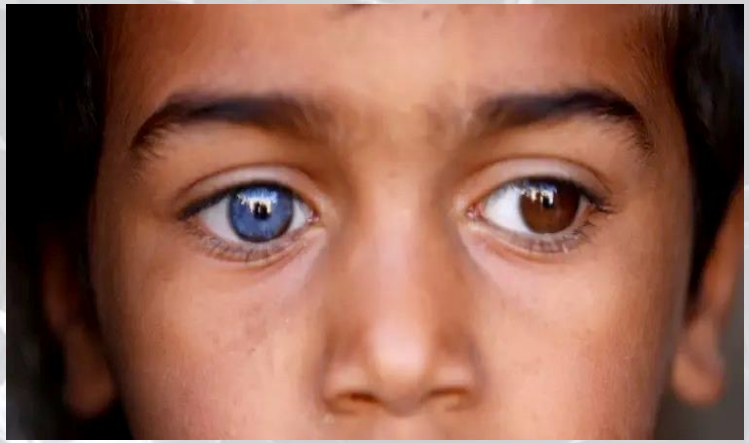
Co-Occurrent Eating Disorders

Co-Occurrent Behavioral Addictions

Co-Occurring Disorders

IN SUMMARY

Definition of Co-Occurring Disorders – The Chimera



Ending: The Good News

Fellowship

Gastroenteritis and ectopic

FP Residents to psych/AOD

Summary

- Screen for it! You can't treat what you have not diagnosed.
- Integrated treatment is optimal.
- Parallel treatment should involve close communication between providers.
- Do not withhold treatment for one disorder while prioritizing the other.

If you don't ***THINK*** about it, you won't ***ASK*** about it, and you don't ask about it, you won't ***DO*** anything about it.

Co-Occurring Disorders

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QUESTIONS?

Co-Occurring Disorders

QUESTIONS

Question 1

Which of the following statements is false:

a) Cocaine decreases negative symptoms in individuals with schizophrenia.

b) When cocaine-free, individuals with schizophrenia have more negative symptoms.

c) Chronic cocaine use increases depression in individuals with schizophrenia

d) Chronic cocaine decreases positive symptoms of schizophrenia.

Question 2

Reasons for diagnostic confusion in substance use and psychiatric disorders are:

a) Alcohol/drug intoxication or withdrawal can cause psychiatric symptoms in anyone (acute toxicity)

b) Prolonged alcohol/drug use can cause short- or long-term psychiatric illness.

c) Alcohol/drug use can escalate in episodes of psychiatric illness.

d) Substance use disorders sometimes co-occur with mental illness as an independent disorder.

e) All the above

Question 3

Compared to other races, Black overdose deaths increased by _____ from 2014 to 2017, with synthetic opioids being the main culprit.

a) 10%
b) 1500%
c) 80%
d) 818%
e) 35%

Question 4

Which of the following statements is true?

a) An individual with a substance use disorder is at least two times more likely to have a second psychiatric disorder than an individual without a substance use disorder.
b) Psychotherapy within therapeutic communities is effective in treating opiate use disorders.
c) Recovery Capital refers to the safest place an individual should live when getting out of a treatment program.
d) One can tell by how much someone drinks if they have a mild, moderate, or severe alcohol use disorder.
e) The proportion of users who ever became dependent (from high to low) is nicotine, heroin, cocaine, alcohol, marijuana.