When One Plus One Equals Three: The Chimerism of Co-Occurring Disorders

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African-American Training & Technical Assistance

Co-Occurring Disorders

INTRODUCTION

Primary Goal

The aim of this presentation is to provide you with the most up-to-date, evidence-based, practice-informed knowledge regarding Co-Occurring Disorders (CODs).

How Will We Accomplish Our Primary Goal?

By using evidence-based knowledge to answer these and related questions:

1) How do the World Health Organization (WHO) and the Substance Abuse and Mental Health Services Administration (SAMSHA) define COD?
2) Why is the identification of CODs important, and what are the associated complications?
3) How are CODs diagnosed, and what factors complicate the process?
4) How do you non-pharmacologically and pharmacologically treat CODs?
5) Where do race and the diagnosis and treatment of CODs intersect?

Case Example of Co-Occurring Disorders

The Confounding Case of Mr. S. (audio to be included). . .

Important questions:

1) Is this a substance-induced psychotic disorder, or is it the onset of a psychotic 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?

Co-Occurring Disorders: Big Picture 2022 (1)

a) Quadruples

b) Triples

c) 50%

d) 50%

e) 25-33%

Co-Occurring Disorders: Big Picture 2022 (2)

- 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."

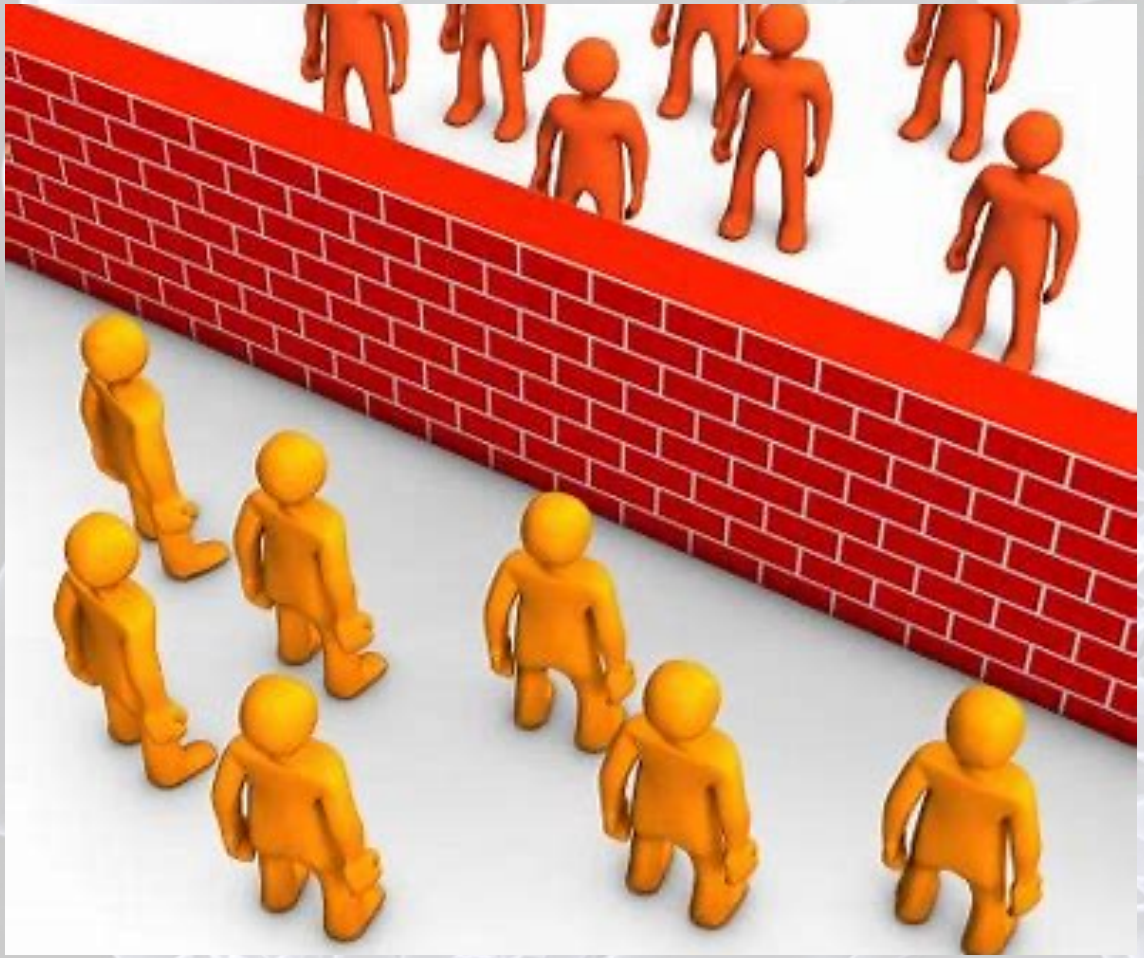
- According to the President's New Freedom Commission on Mental Health:

  "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."

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

The Wall of Health Care



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

It is recommended that providers use caution when prescribing SSRIs to patients who have:

a) Early-onset alcohol or drug use disorders
b) Co-Occurring alcohol use disorder
c) Antisocial personality disorder or features
d) A and C
e) A and B

Question 3

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 4

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 5

In primary alcohol use disorder, what is the most experienced anxiety symptom?

a) Panic while drinking.
b) Panic while not drinking.
c) General anxiety while drinking.
d) Shortness of breath and palpitations associated with withdrawal.
e) Agoraphobia while intoxicated or in withdrawal.

Question 6

Which co-occurring condition is most associated with substance use disorders?

a) Antisocial Personality Disorder.
b) Bipolar Disorder.
c) Generalized Anxiety Disorder.
d) Agoraphobia.
e) Dementia.

Question 7

Which of the following statements is true?

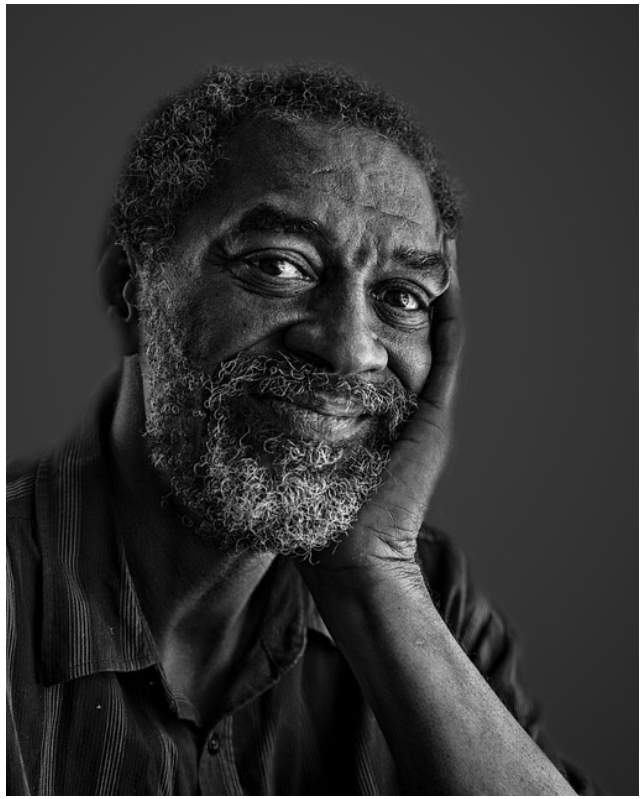
a) An individual with a substance use disorder is at least two times more likely to have a second psychiatric disorder than an individual without a substance use disorder.
b) Psychotherapy within therapeutic communities is effective in treating opiate use disorders.
c) Recovery Capital refers to the 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.

Question 8

Which of the following statements is false:

a) Psychiatric disorders can cause substance use disorders.
b) Substance use can cause psychiatric disorders.
c) If both a substance use disorder and a psychiatric disorder are present, treating the psychiatric disorder is usually not necessary.
d) Treating an underlying psychiatric disorder usually does not adequately treat the substance use disorder.

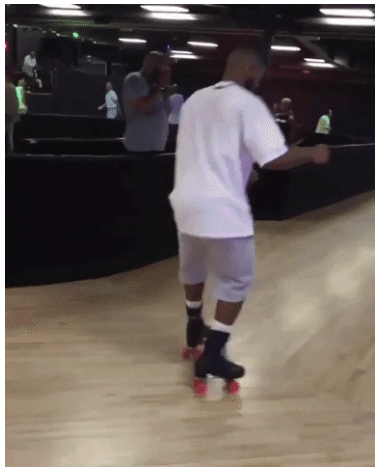
Race and Co-Occurring Disorders



Twenty-five to
Thirty-three
percent less likely

Mental Health
Or
Substance Use Disorder
Or
Co-Occurring Disorder
Treatment

Introduction: The Good News



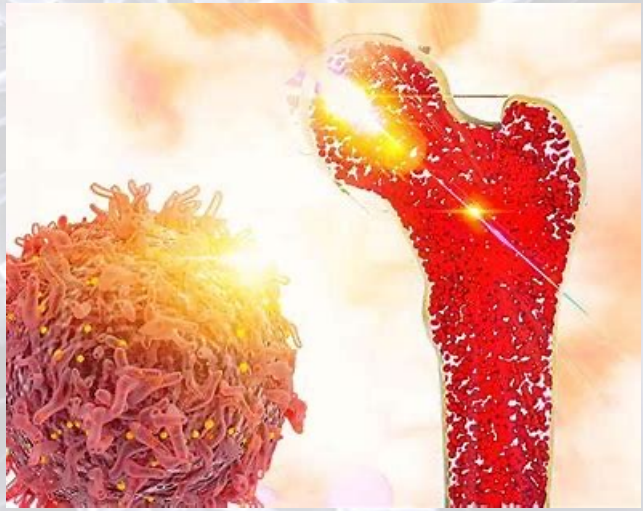
The Impact of A 4-Week Intensive Psychiatric Resident Rotation on Clinical Outcomes of a Substance Abuse Intensive Outpatient Program (SAIOP)

Jose R. Feliberti, MD1, Juan R. Sosa, MD2, Lester E. Love, MD3 and Donald M. Hilty, MD, MBA

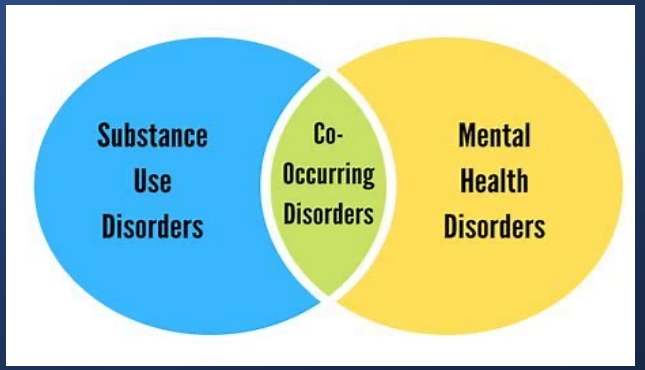
Co-Occurring Disorders

DEFINING

Definition of Co-Occurring Disorders – The Chimera



Definition of Co-Occurring Disorders



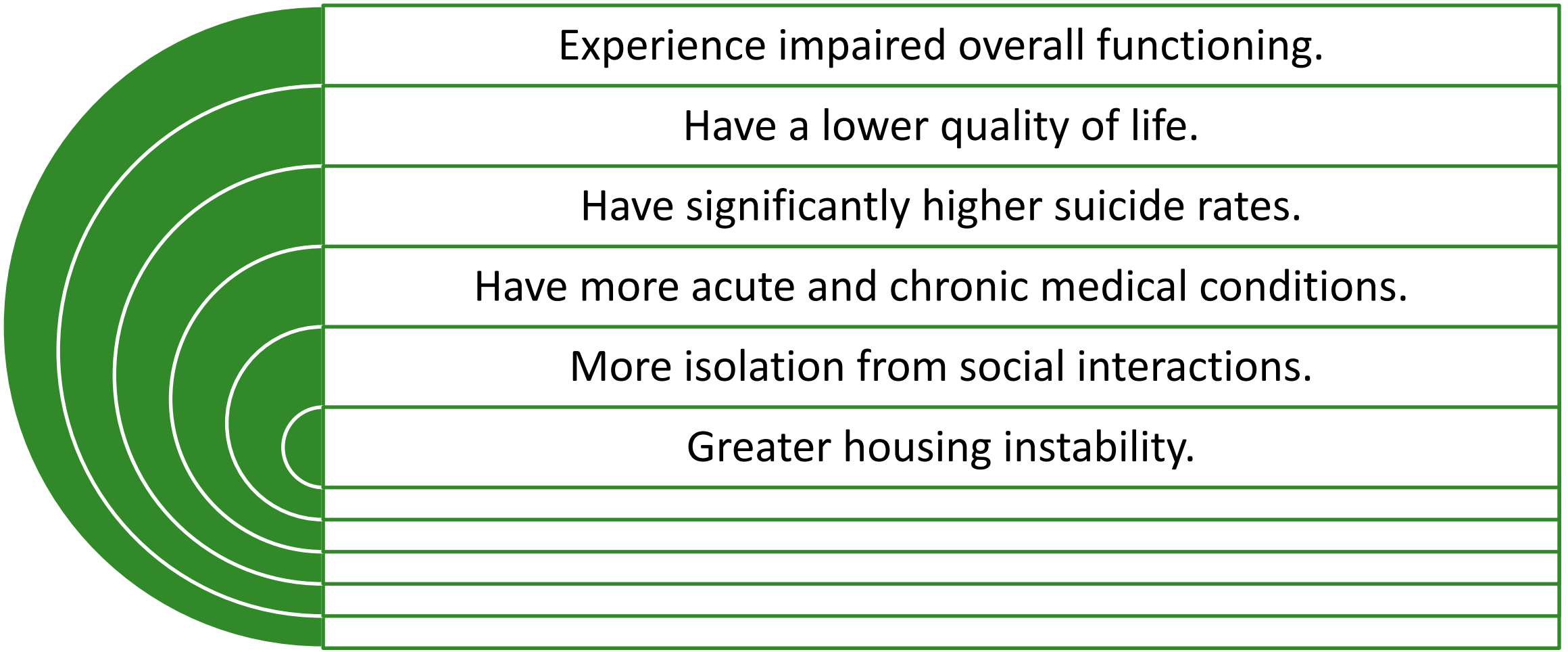
SAMHSA defines people with “co-occurring disorders” as individuals who have at least one mental disorder, as well as at least one alcohol or drug use disorder.

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

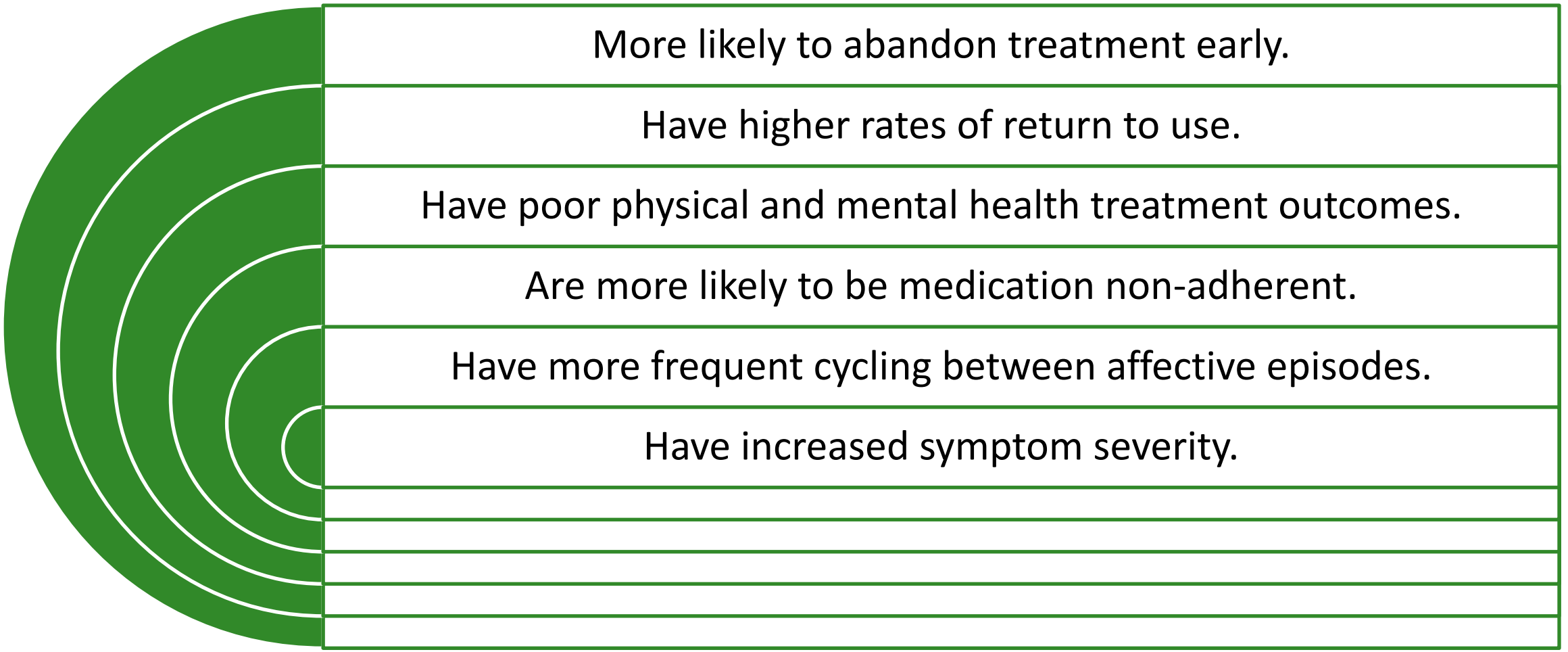
Co-Occurring Disorders

PROGNOSIS

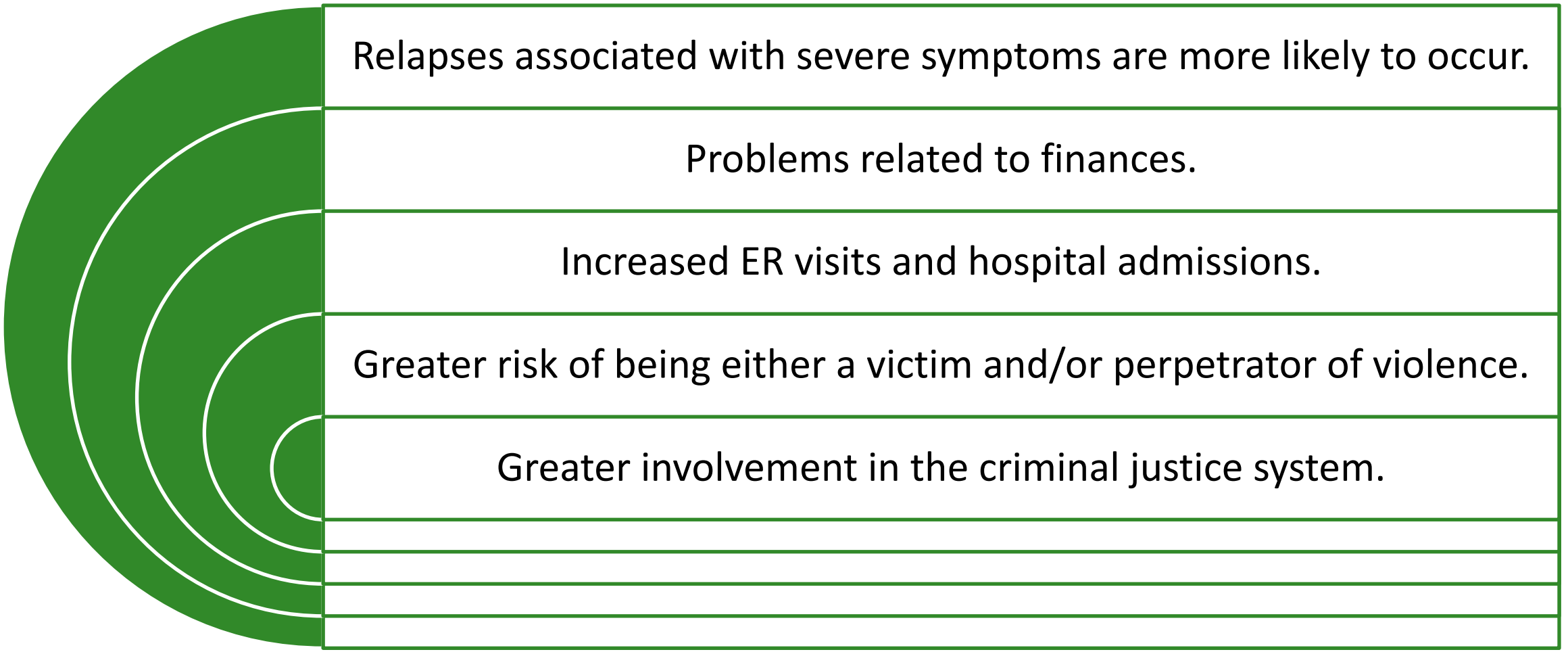
Prognosis of Co-Occurring Disorders



Prognosis of Co-Occurring Disorders



Prognosis of Co-Occurring Disorders



Co-Occurring Disorders: "Relapse"

Psychostimulants and Negative Symptoms of Schizophrenia

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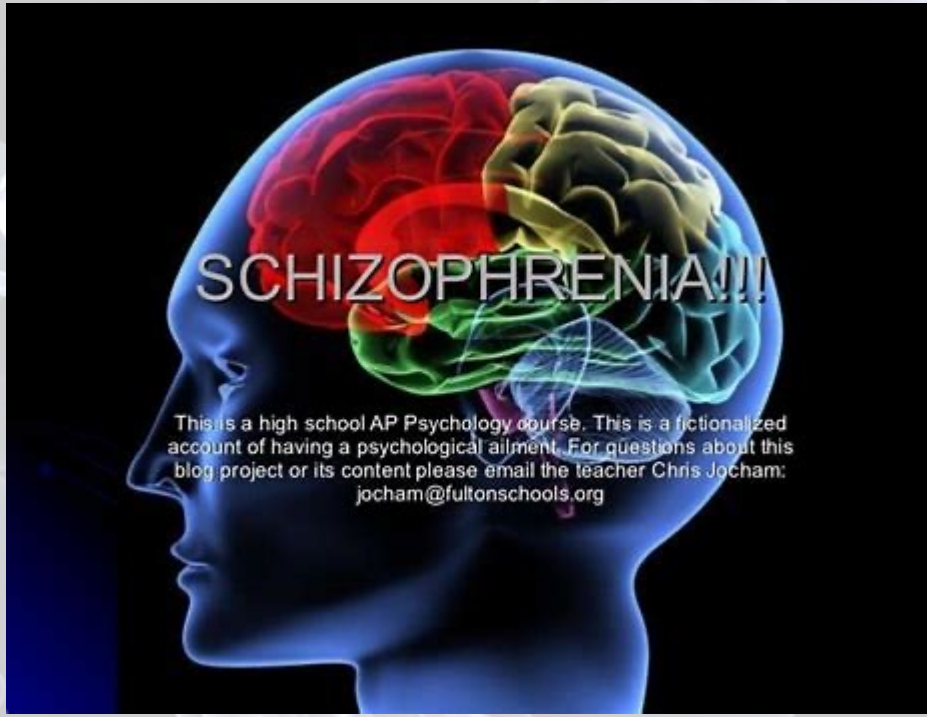
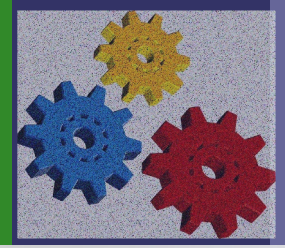


Worsen Outcomes

- 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).

Prognosis of Co-Occurring Disorders: The Complex, Unstable, and Bidirectional Nature of Co-Occurring Disorders



- Mental Health disorder causes substance use disorder.
  - Self-medication hypothesis (Khantzian 1985, 1997)
  - Some patients use substances to enhance their psychiatric symptoms, e.g., bipolar mania, antisocial personality (Weiss et al 1986, 1988).
  - Impaired judgment or appreciation of consequences
  - Psychopathology exacerbates withdrawal (opponent process theory)
  - Sensitization of reward circuitry.
- Substance use disorder causes Mental Health disorder.
  - Psychiatric symptoms may result from chronic intoxication or withdrawal.
  - Long-term neuropsychiatric sequelae of substance use may result in psychopathology.
  - Sensitization of the hypothalamic-pituitary-adrenal axis
  - Exposure to traumatic/stressful events (Cottier et al 1992).
- Common cause (genetic, environmental, developmental)
- The two are unrelated.

Co-Occurring Disorders

EPIDEMIOLOGY

Big Picture 2022

Most Common and Significant

Two Out Five People

One Out of Ten People

Big Picture 2022

+

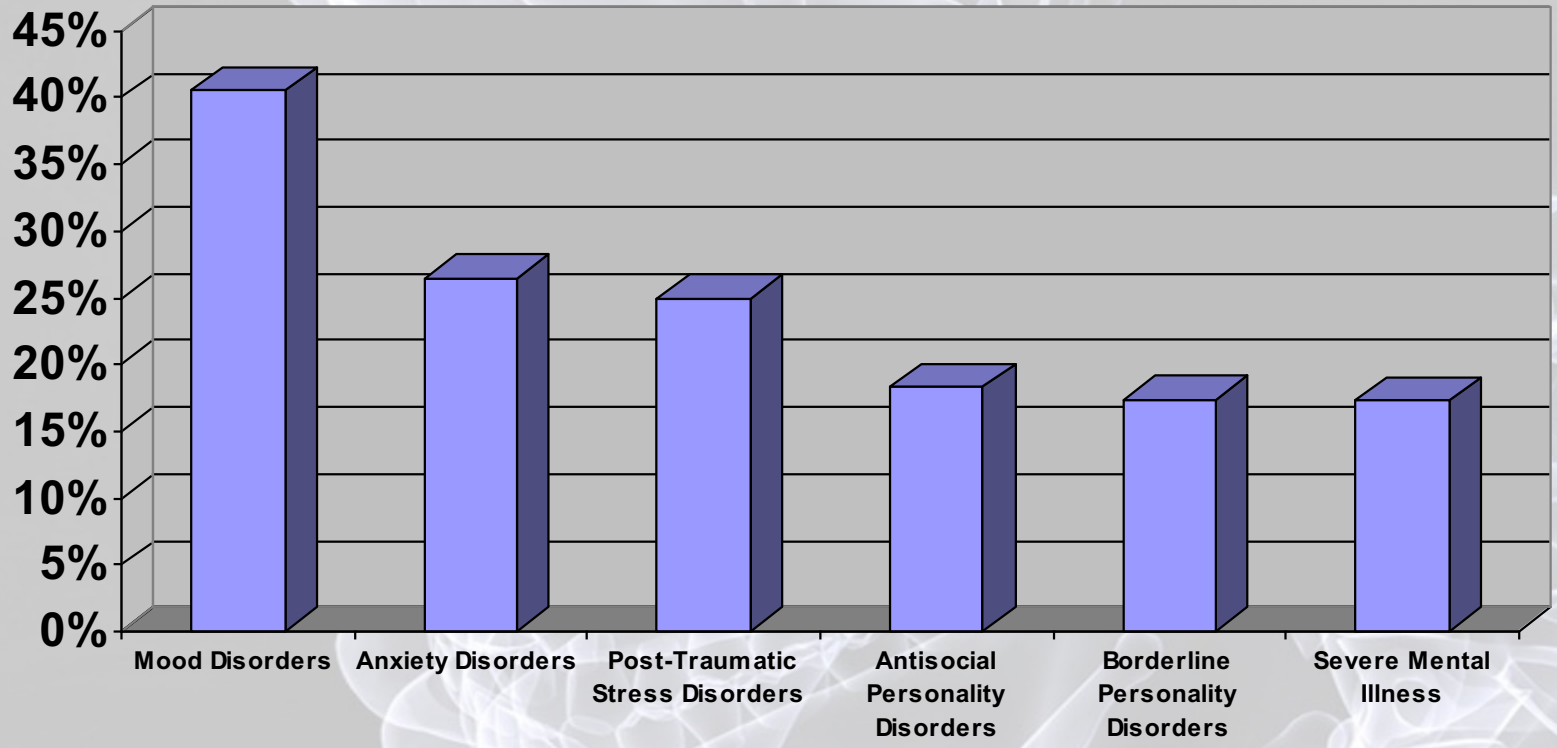
+

Co-Occurring Disorders: 2019 Population Estimates

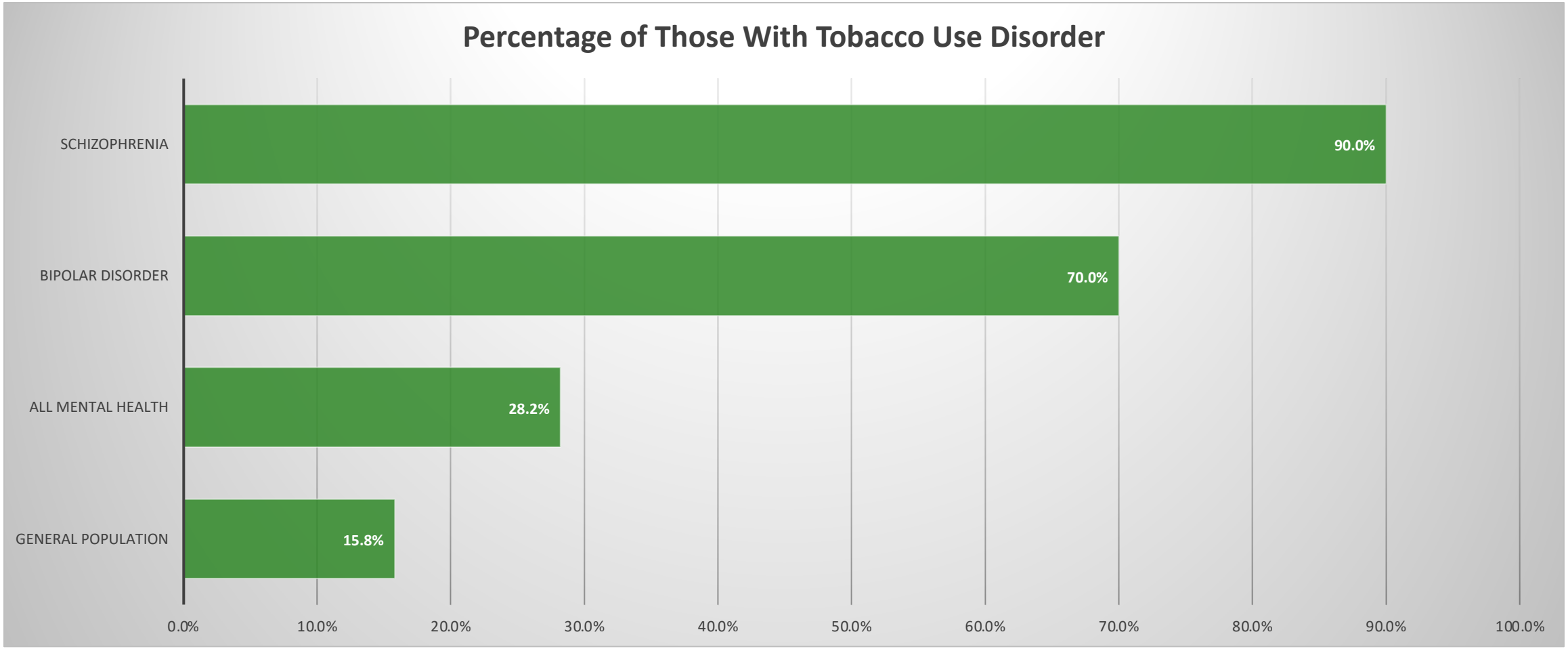
- Approximately 10 million people in the U.S. have co-occurring substance and serious and persistent mental health disorders (SAMHSA).
  - 10 million affected by two illnesses
  - 3 million affected by three illnesses
  - 1 million affected by four or more illnesses

- When patients with other mental disorders are considered, (anxiety disorders, personality disorders) these numbers are even higher.

Substance Use Disorder Treatment Provider Estimates by Psychiatric Disorder



Tobacco Use Disorder



Gateway Drugs and Later Substance Use Disorders

- Alcohol, nicotine, marijuana.
- Use before age 15.
- Earlier use increases the risk of progression to a substance use disorder.
- Risk of substance use disorder varies by drug.

Anxiety In One Hundred Seventy One Patients with Alcohol Use Disorder

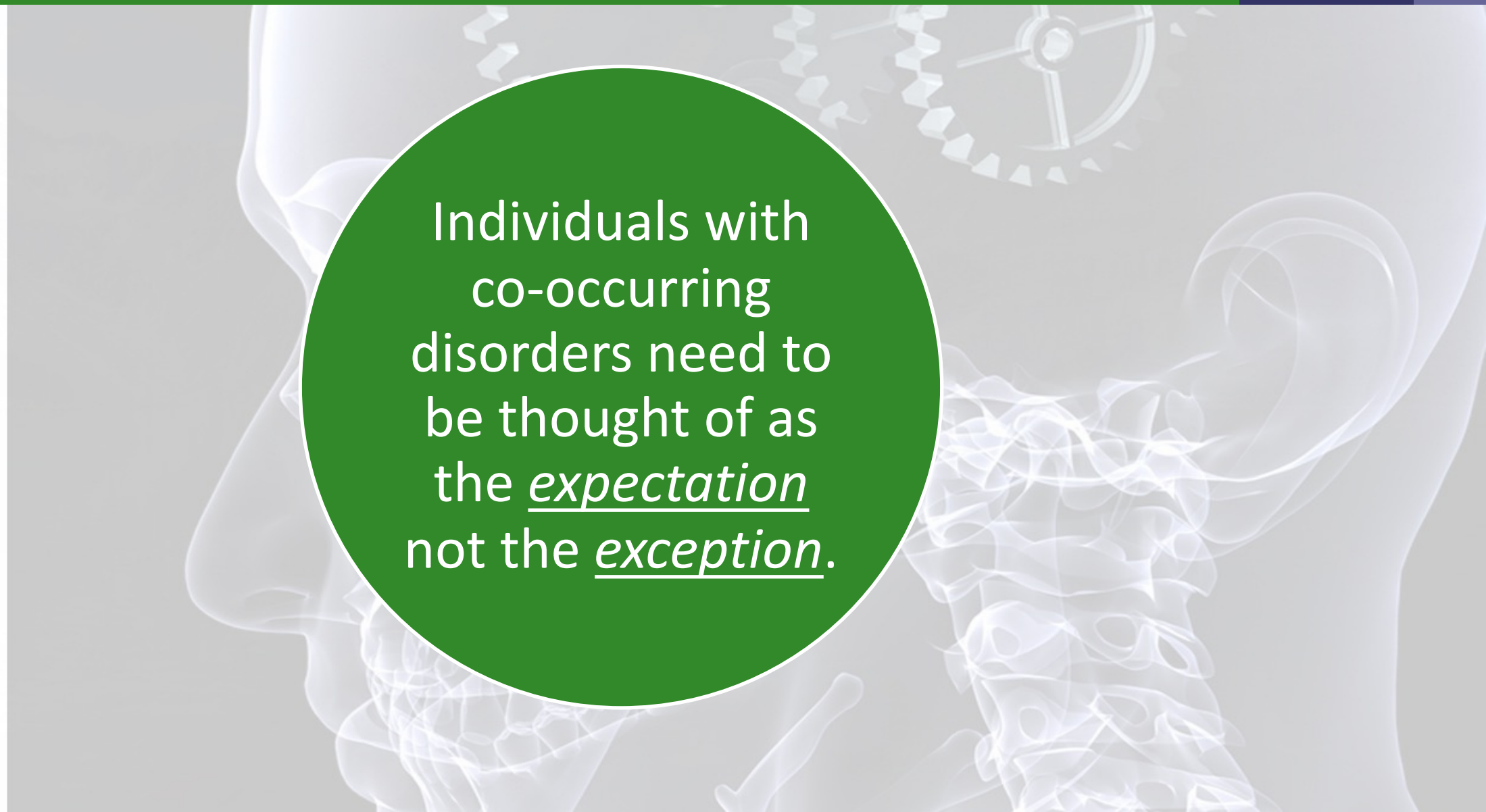
Symptom	
• Withdrawal palpitations and/or shortness of breath	80%
• Panic while drinking	4%
• Panic while not drinking	2%
• Generalized anxiety while not drinking	4%

Source: Brown S, Schuckit M. J Stud Alcohol. 1990;51:34-41.

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

RACE

Race, Racism, and COD

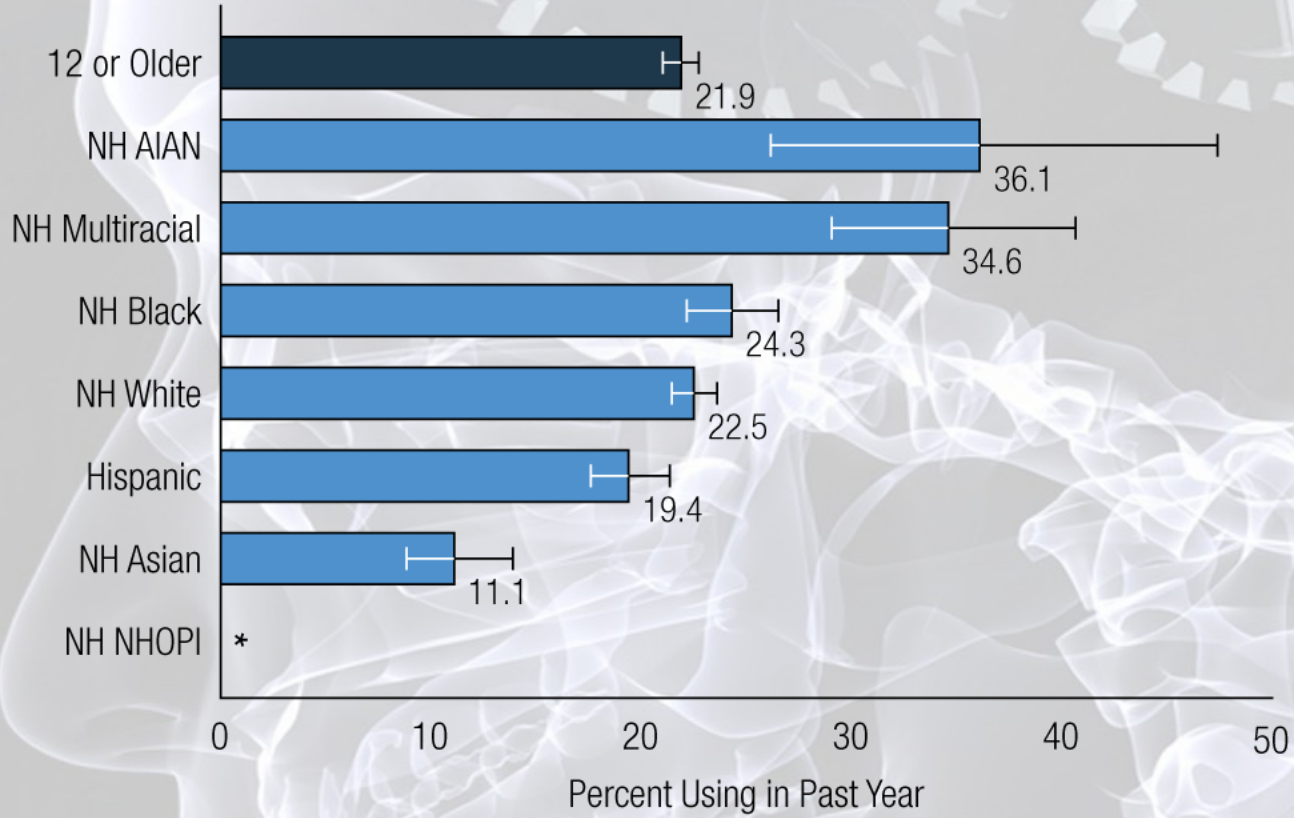
- Racial Disparities and COD
  - Burden of substance use disorder/COD in Black, Hispanic, and Indigenous people
  - Race and substance use disorder treatment, availability, retention, and outcomes
- Structural factors:
  - The war on drugs: Treatment versus punishment
  - Racism and stress
  - Bias within substance use treatment systems

Race, Racism, and COD

- From 1999 to 2001, Black people in Metropolitan areas had higher substance related death rates compared to other racial groups. Overdose death rates from 2014 to 2017 increased in the black population, with the sharpest rise from synthetic opioids, increasing by 818% compared to other races.

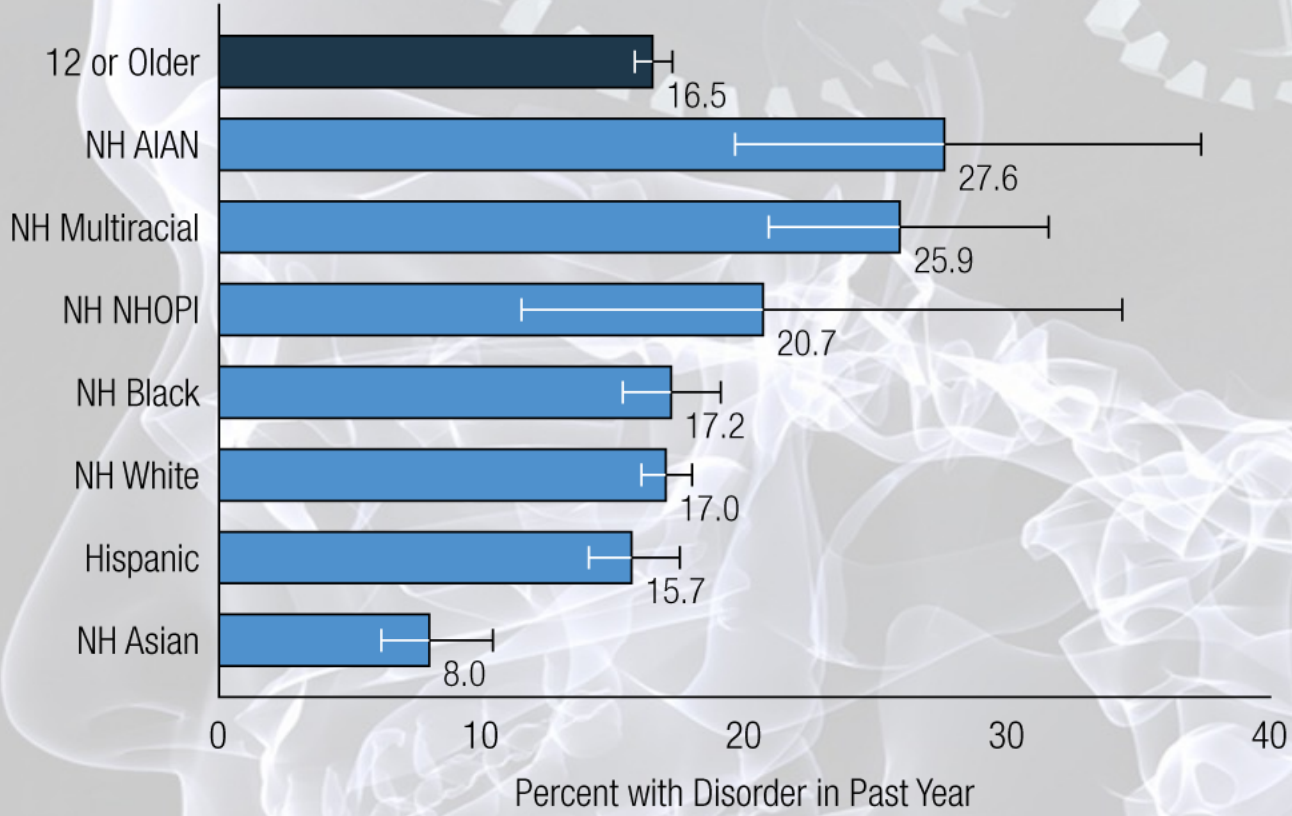
- Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas - United States. MMWR Surveill Summ. 2017 Oct 20;66(19):1-12. doi: 10.15585/mmwr.ss6619a1. Erratum in: MMWR Morb Mortal Wkly Rep. 2017 Nov 17;66(45):1262. PMID: 29049278; PMCID: PMC5829955.
- Zemore SE, Karriker-Jaffe KJ, Mulia N, Kerr WC, Ehlers CL, Cook WK, Martinez P, Lui C, Greenfield TK. The Future of Research on Alcohol-Related Disparities Across U.S. Racial/Ethnic Groups: A Plan of Attack. J Stud Alcohol Drugs. 2018 Jan;79(1):7-21. doi: 10.15288/jsad.2018.79.7. PMID: 29227222; PMCID: PMC5894859.
- Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths - United States, 2013-2017. MMWR Morb Mortal Wkly Rep. 2018 Jan 4;67(5152):1419-1427. doi: 10.15585/mmwr.mm675152e1. PMID: 30605448; PMCID: PMC6334822.

Past Year Illicit Drug Use: Among People Aged 12 or Older; by Race/Ethnicity, 2021



- * Low precision; no estimate reported.
- AIAN = American Indian or Alaska Native; Black = Black or African American; Hispanic = Hispanic or Latino; NH = Not Hispanic or Latino; NHOPI = Native Hawaiian or Other Pacific Islander.

Past Year Substance Use Disorder: Among People Aged 12 or Older; by Race/Ethnicity, 2021



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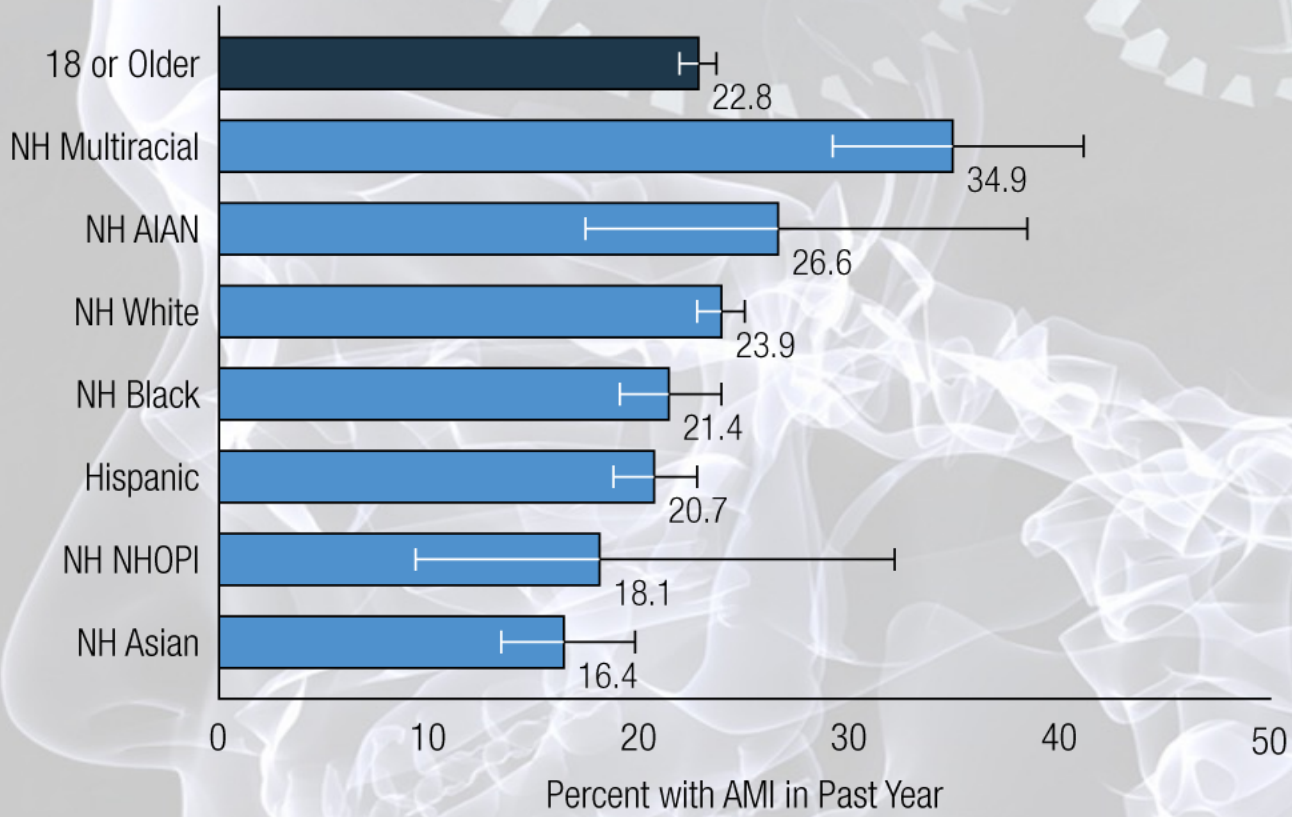
- Note: Error bars were calculated as 99 percent confidence intervals. Wider error bars indicate less precise estimates. Large apparent differences between

Any Mental Illness (AMI): Among Adults Aged 18 or Older; by Race/Ethnicity, 2021



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- Note: Error bars were calculated as 99 percent confidence intervals. Wider error bars indicate less precise estimates. Large apparent differences between groups

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.

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/

What is Statistical Significance?

$$f(x) = a_0 + \sum_{n=1}^{\infty} \left(a_n \cos \frac{n\pi x}{L} + b_n \sin \frac{n\pi x}{L} \right)$$

$$\sin \alpha \pm \sin \beta = 2 \sin \frac{1}{2}(\alpha \pm \beta) \cos \frac{1}{2}(\alpha \mp \beta)$$

$$(1 + x)^n = 1 + \frac{nx}{1!} + \frac{n(n-1)x^2}{2!} + \cdots$$

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.

Co-Occurring Disorders

DIAGNOSIS

Diagnosis of a Substance Use Disorder

DSM-5 Criteria for Opioid Use Disorder

1	Opioids are often taken in larger amounts or over a longer period than was intended	The presence of at least 2 of these symptoms indicates an Opioid Use Disorder (OUD) The severity of the OUD is defined as: MILD: The presence of 2 to 3 symptoms MODERATE: The presence of 4 to 5 symptoms SEVERE: The presence of 6 or more symptoms
2	There is a persistent desire or unsuccessful efforts to cut down or control opioid use	
3	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects	
4	Craving or a strong desire to use opioids	
5	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home	
6	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	
7	Important social, occupational, or recreational activities are given up or reduced because of opioid use	
8	Recurrent opioid use in situations in which it is physically hazardous	
9	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.	
10	Tolerance,* as defined by either of the following: a) Need for markedly increased amounts of opioids to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of opioid	
11	Withdrawal,* as manifested by either of the following: a) Characteristic opioid withdrawal syndrome b) Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	

Severity and Remission of Illness

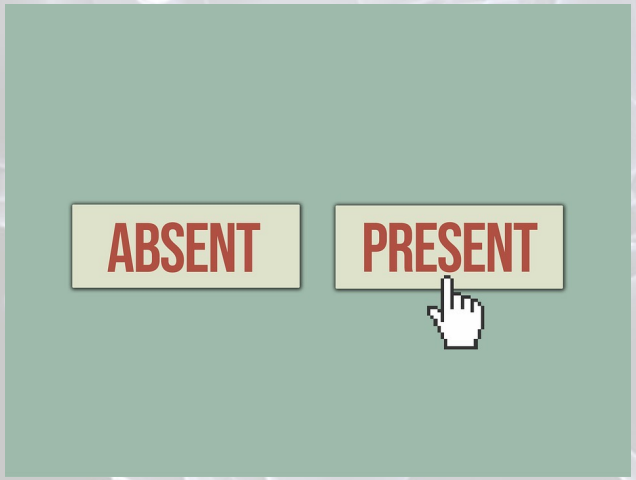
DSM 5 CRITERIA FOR SUBSTANCE USE DISORDER ....CONT.

7. Important social, occupational, or recreational activities are given up or reduced because of use
8.
9.
10.
11.

Mild Substance Use Disorder	**2 – 3 Symptoms**
Moderate Substance Use Disorder	**4-5 Symptoms**
Severe Substance Use Disorder	**>6 Symptoms**

of

11. ____ is taken to relieve or avoid withdrawal symptoms.



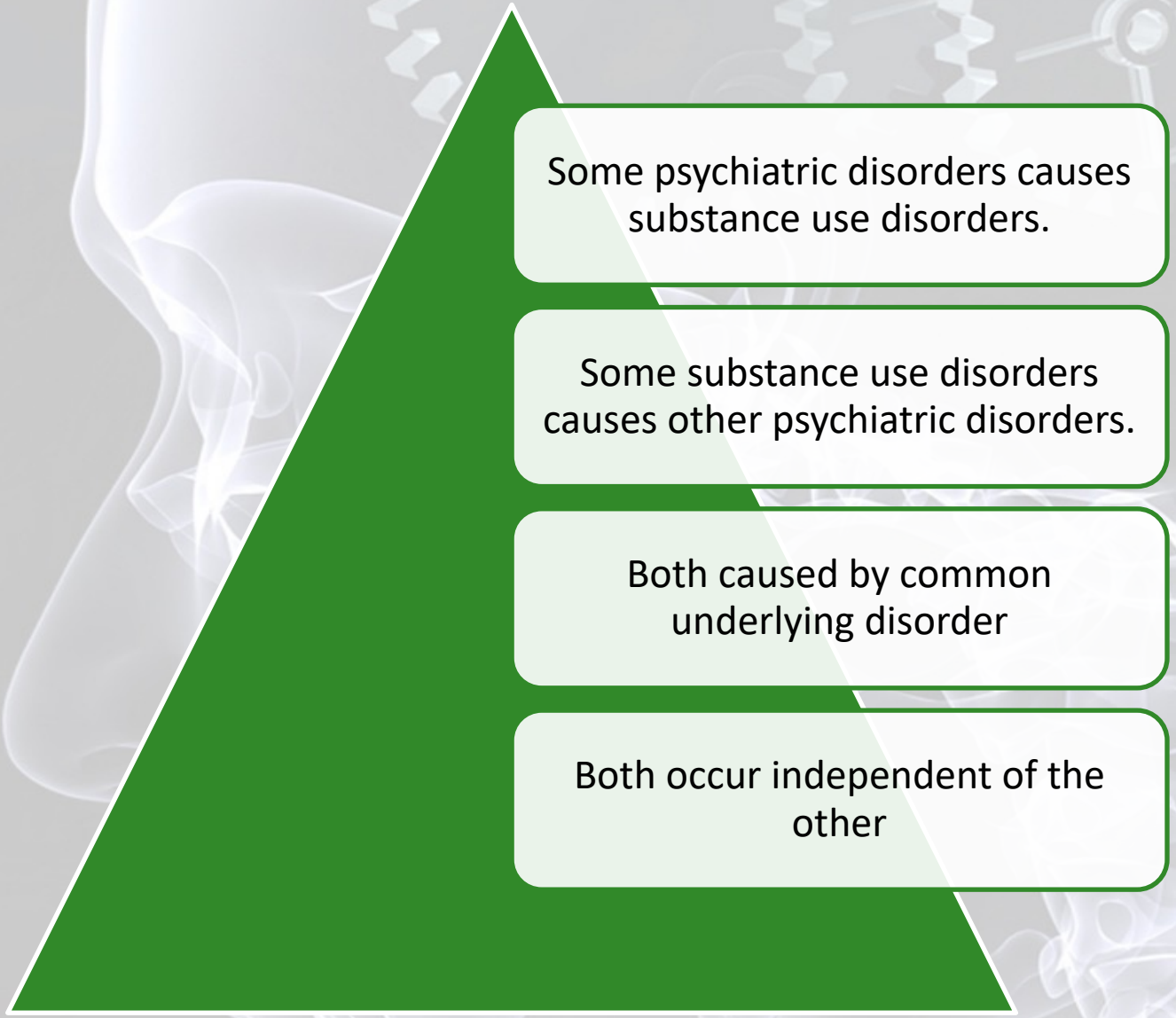
Case Example of Co-Occurring Disorders

The patient is a 45-year-old male who has regularly used cocaine for five years. He fears he is being watched at all times, and he appears to be depressed. While defending himself from an "intruder" in his truck, he stabbed himself. An officer who witnessed the stabbing brought him to the hospital. There was no evidence of an intruder

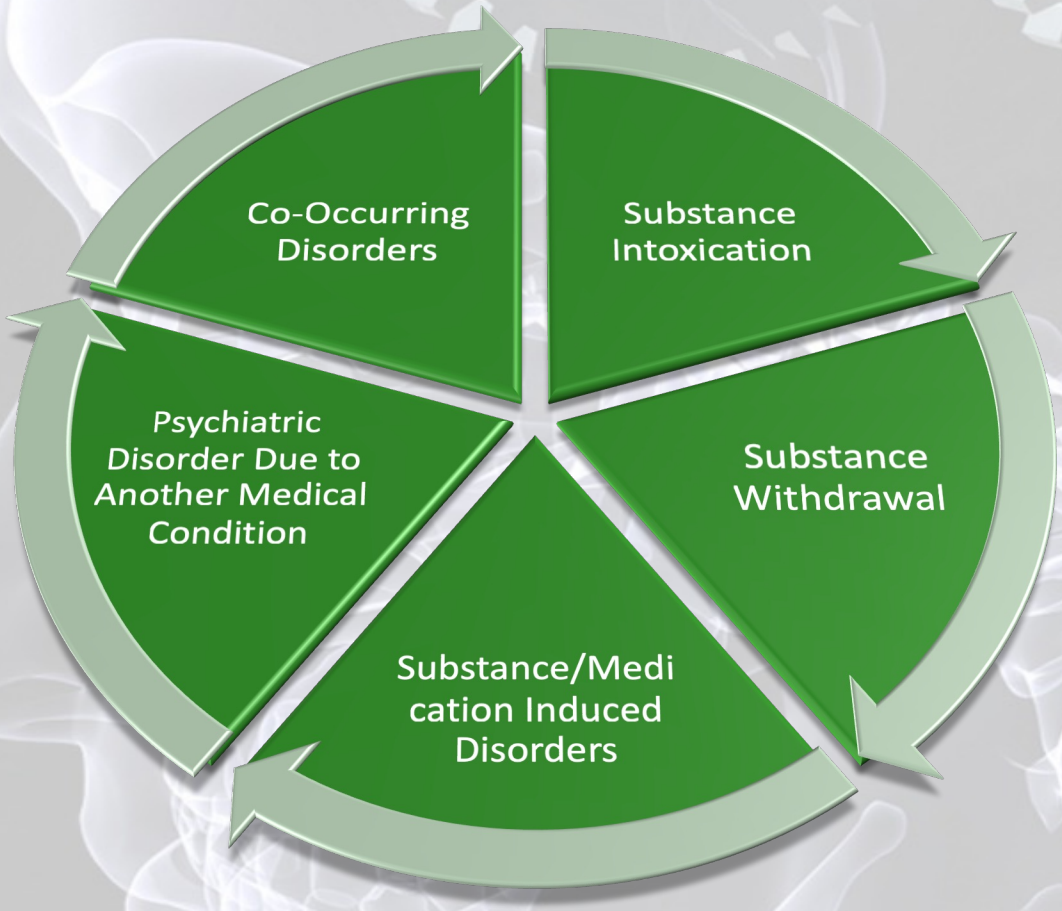
Important questions:

1. Is it possible that psychiatric symptoms preceded his ongoing cocaine use?
2. Have there been any periods of time in the last five years when he had psychiatric symptoms and had not used cocaine for at least four weeks?
3. In your opinion, what is the presumptive diagnosis?

Possible Relation Between Substance Use Disorders and Other Psychiatric Disorders



Diagnosis/Differential Diagnosis



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

Diagnostic Challenges

1. Ensure that you conduct a comprehensive screening.
2. Take into account the effects of intoxication and withdrawal following the consumption of a particular drug.
3. Consider metabolic disturbances, head trauma, and personality disorders as well.
4. Obtain information regarding the timeline of symptoms. In which order did it occur?
5. It is important to ask about symptoms that occur during extended periods of abstinence (at least four weeks).
6. Obtain information about the family history.
7. The symptoms of some disorders, such as PTSD or eating disorders, do not overlap with the effects of drugs, so diagnosis should not be delayed.

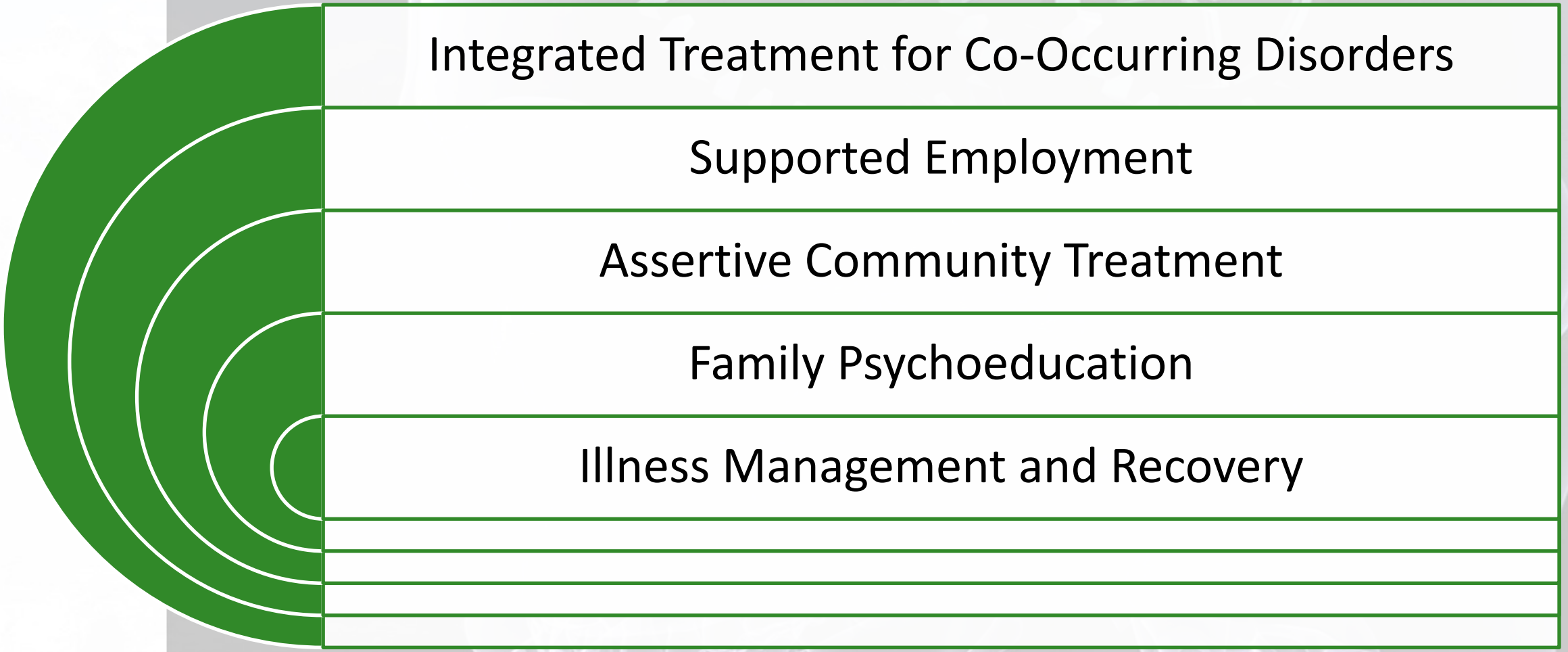
Co-Occurring Disorders

TREATMENT

Treatment

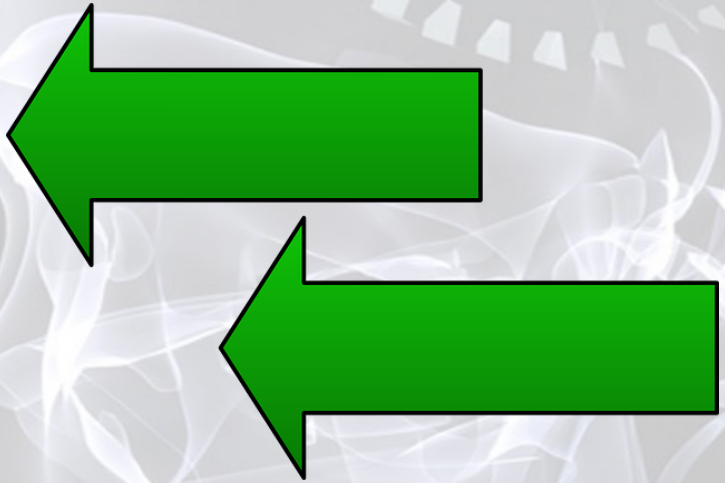
Models of Treatment

Examples of Evidence-Based Practices



Co-Occurring Disorder Treatment Models

Sequential



Parallel

Integrated

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

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).

Summary

- Integrated Treatment for Co-Occurring Disorders is effective in the recovery process for patients with co-occurring disorders

- The goal of this evidence-based practice is to support patients in their recovery process

- In Integrated Treatment programs, the same practitioners, working in one setting, provide mental health and substance abuse interventions in a coordinated fashion

- Patients receive one consistent message about treatment and recovery

Treatment of Co-occurring Disorders

One team, one plan, for one person

Treatment

Non-Pharmacological Treatment

Involving the Patient's Family

Peer Support: Mutual Self-Help

Psychotherapy

Contingency Management for Stimulant Use Disorder

Treatment

Pharmacological Treatment

Treatment

Pharmacological Treatment: Medications for Addiction Treatment

New Language for MAT

16

12 APPOINTMENTS

32% INCREASE

Medications for Addiction Treatment

26 March

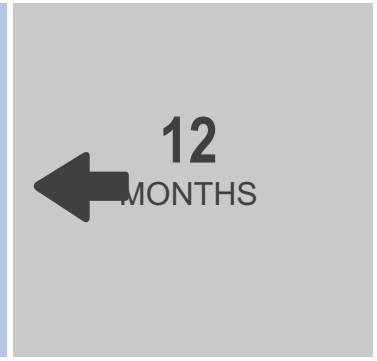
5 SOLUTIONS

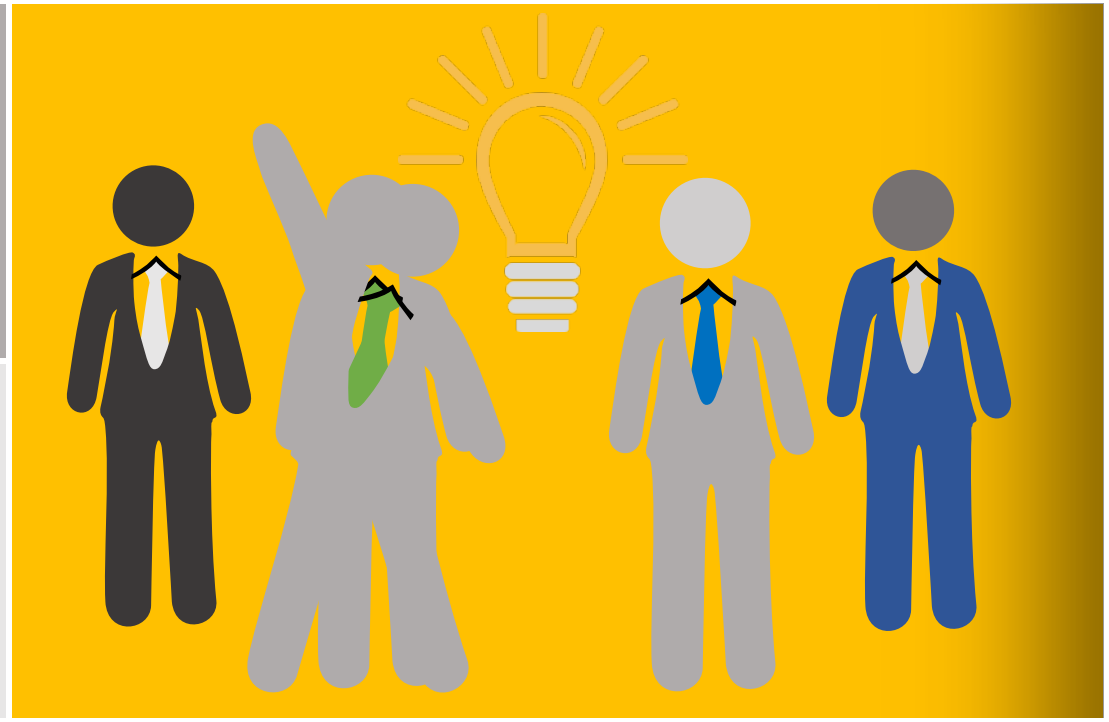
18 OPTIONS

WHY

The NAME

CHANGE?



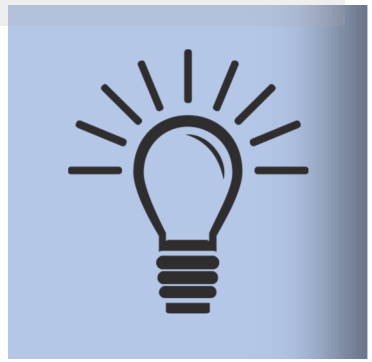


Medication *Assisted Treatment* → → **Medications for Addiction Treatment**

EFFECTIVENESS FOR ADDICTION TREATMENT

16

12 APPOINTMENTS



↑ RETENTION IN TREATMENT

02

↓ CRIMINAL SYSTEM CONTACT & ILLICIT SUBSTANCE USE

03

IMPROVE PATIENT SURVIVAL

01

↓ HIV, HEPATITIS B, OR C RISKS

07

↑ GAINING & MAINTAINING EMPLOYMENT

04

06

IMPROVED SOCIAL FUNCTIONING

05★

IMPROVE BIRTH OUTCOMES

FDA APPROVED
MEDICATIONS FOR ADDICTION TREATMENT

Opioid Use Disorder (OUD)
- ✅ Methadone
- ✅ Buprenorphine
- ✅ Naltrexone

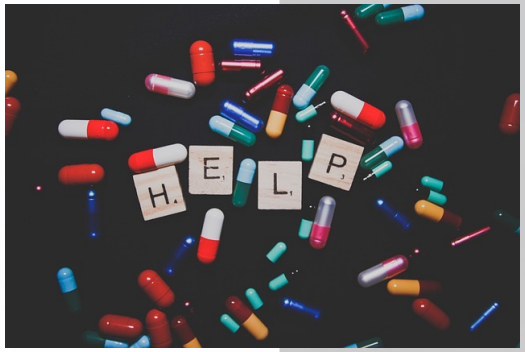
Alcohol Use Disorder (AUD)
- ✅ Acamprosate
- ✅ Disulfiram
- ✅ Naltrexone

Tobacco Use Disorder
- ✅ Nicotine replacement therapy (NRT)
- ✅ Bupropion
- ✅ Varenicline

Treatment

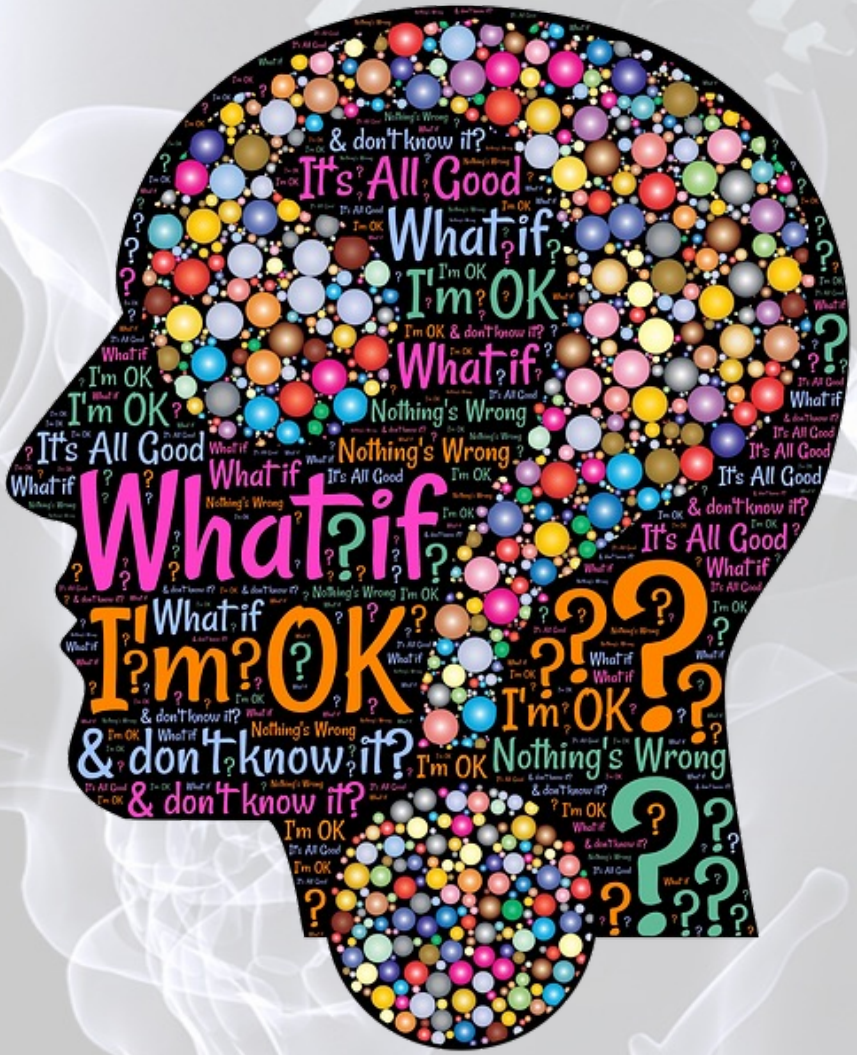
Pharmacological Treatment: Condition Specific

C-Occurrent Major Depressive Disorder

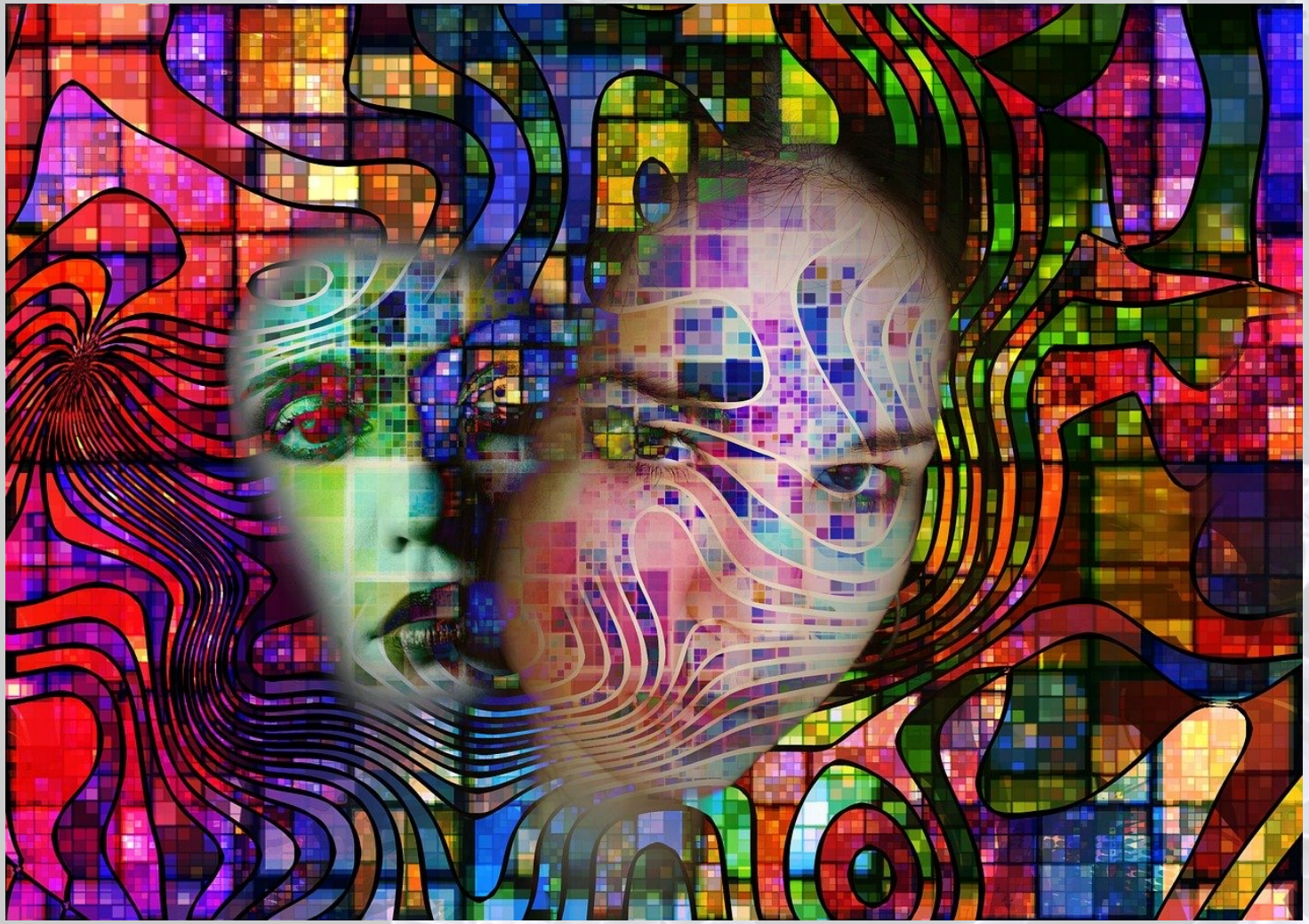


Co-Occurrent Bipolar Disorder

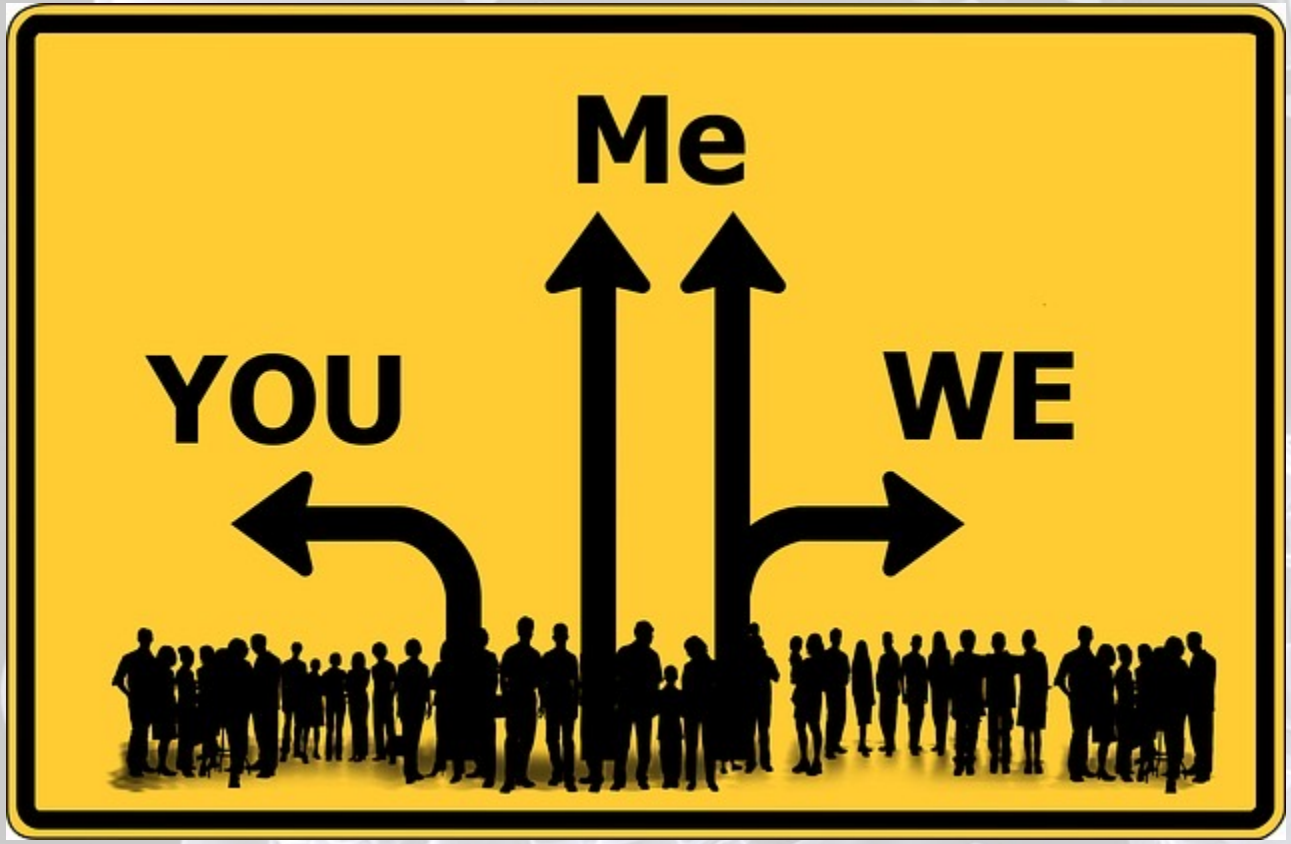
Co-Occurrent Anxiety Disorders



Co-Occurrent Schizophrenia Spectrum Disorders



Co-Occurrent Borderline Personality Disorder



Co-Occurrent Antisocial Personality Disorder

Co-Occurrent Eating Disorders

Co-Occurrent Behavioral Addictions

Co-Occurring Disorders

STIGMA AND UNCONSCIOUS BIAS

The individual becomes “invisible” precisely because of the visibility and social meaning of the racial or mental health stigmata.

LIVE

Stigma is a socially constructed and reinforced, pervasive and global, interpretive, moral, and cultural attribute that is indicative of disfavor, devaluation, and disgrace.

BREAKING NEWS

Stigma and Co-Occurring Disorders

The past never dies. If fact, it's never even past.

— "Requiem for a Nun" by William Faulkner

Unexpressed emotions will never die. They are buried alive, and will come forth later, in uglier ways.

— Sigmund Freud

Attitudes Toward the Treatment of Individuals with Co-Occurring Disorders

At completion of residency, more physicians have negative attitudes toward substance use disorder pts and are less optimistic about benefits of treatment than at the start of med school

--Geller, et al, 1989

Attitudes Toward Individuals With Mental Illness and Substance Use Disorders Among Resident Physicians

Disorders Among Resident Physicians. Avery JD, et al. Prim Care Companion CNS Disord. 2019.

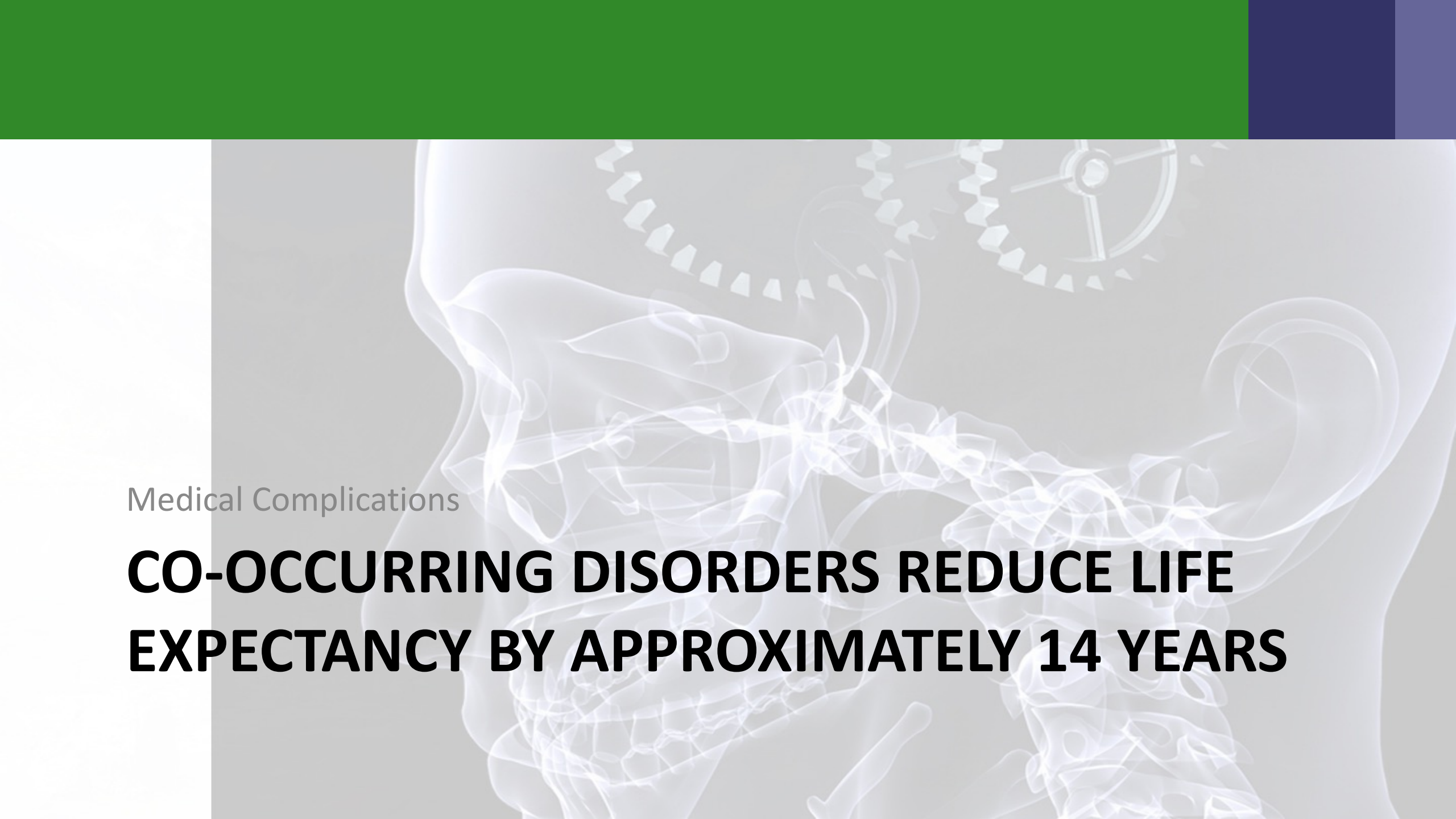
Stigma and Co-Occurring Disorders

- How can this be explained?
  - Substance use disorders (SUDs) were traditionally treated by paraprofessionals on an independent basis from traditional healthcare.
  - Patients with substance use disorders were also rejected by mental health services.
  - It is common for house staff to be confronted with recidivist patients who have multiple complex problems and are not adequately trained to handle them.
  - Research study exclusion criteria.
- So what do we do?
  - It is necessary to have an adequate knowledge base.
  - Training in CBT, Motivational Interviewing, Mindfulness
  - Experience with seeing success.
  - Taking responsibility for the clinical problem.

Medical and Other Sequalae

Of Co-Occurring Disorders

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



Medical Complications

CO-OCCURRING DISORDERS REDUCE LIFE EXPECTANCY BY APPROXIMATELY 14 YEARS

Medical Co-Occurring Disorders

Factors to Consider

- The drug
- The contaminants, dissolving agents, and paraphernalia
- The infections pathogens
- The host
- The route

Medical Complications of Substance Use Disorders

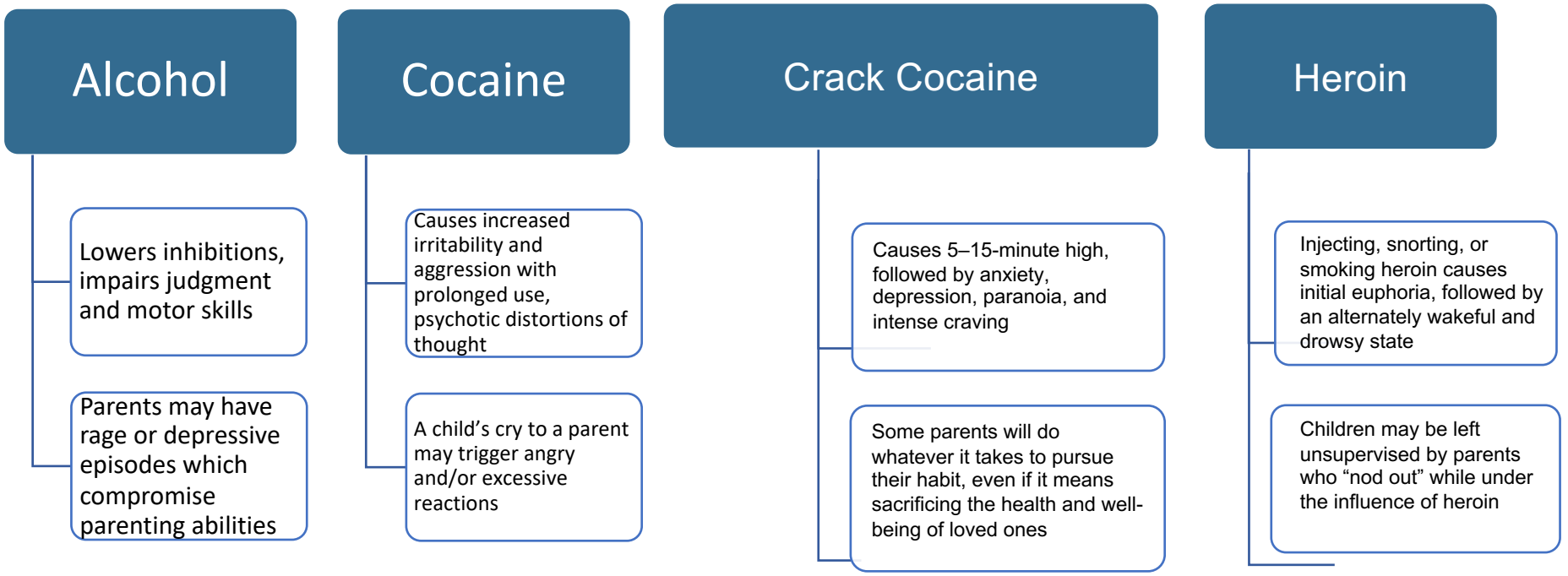
Type of Substance	Medical Complications
Alcohol	Liver disease (e.g., acute alcohol-related hepatitis, alcohol-related fatty liver disease, cirrhosis); cardiovascular disease (e.g., hypertension, cardiomyopathy); gastrointestinal illnesses (e.g., pancreatitis, gastritis, esophagitis); bone marrow suppression; 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
Cannibis	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

- www.cdc.gov/tobacco/overview/Fast_Facts.htm - 12/1/06 - "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."

The Risks of Parental Substance Use Disorders on Children: Alcohol and Illegal Drugs



(Breshears, 2009; National Institute on Drug Abuse, 2018a)

The Risks of Parental Substance Use Disorders on Children: Alcohol and Illegal Drugs

Methamphetamine

- Releases high levels of dopamine, which stimulates brain cells, enhancing mood and body movement
- Children may be the victims of parental violence, aggression, and paranoia due to parental meth use

Marijuana

- Slows down the nervous system function, producing a drowsy or calming effect
- Children may be left unsupervised, as parents may fall asleep while under the influence of marijuana.

(Breshears, 2009; National Institute on Drug Abuse, 2018a)

Co-Occurring Disorders

IN SUMMARY

Ending: The Good News

Fellowship

FP Residents to psych/AOD

Gastroenteritis and ectopic

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.

Primary Goal

The aim of this presentation is to provide you with the most up-to-date, evidence-based, practice-informed knowledge regarding Co-Occurring Disorders (CODs).

How Will We Accomplish Our Primary Goal?

By using evidence-based knowledge to answer these and related questions:

1) How do the World Health Organization (WHO) and the Substance Abuse and Mental Health Services Administration (SAMSHA) define COD?
2) Why is the identification of CODs important, and what are the associated complications?
3) How are CODs diagnosed, and what factors complicate the process?
4) How do you non-pharmacologically and pharmacologically treat CODs?
5) Where do race and the diagnosis and treatment of CODs intersect?

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.

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QUESTIONS?