

Interdisciplinary Co-Occurring Disorders (COD) consultations

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Professional & Financial Disclosures

Dr. Muvvala and Dr. Jegede have no conflicts of interest to disclose

Objectives

1. Discuss common themes identified through state-wide COD consultations.
2. Enumerate evidence-based interventions identified through state-wide COD consultations.
3. Review best practices related to the engagement and treatment, including medication for addiction treatment for clients with co-occurring disorders.

Overview

Addiction in America

- 2020 NSDUH, 138.5 million people aged 12 and older used alcohol in the past month
- 61.6 million people in the US reported binge drinking in the past month
- 140,000 deaths in the US were due to excessive alcohol use (380 deaths per day)
- 2 million people in the U.S. have opioid use disorder (OUD)
- Nearly 190 people die every day from an opioid overdose
- 59.3 million people used illicit drugs in the past year (21.4%)
- 40.3 million people (14.5 percent of the population) met criteria for SUD
- Only 2.6 million individuals (6.5 percent) received any type of treatment.
- Majority in a specialty substance use disorder treatment facility

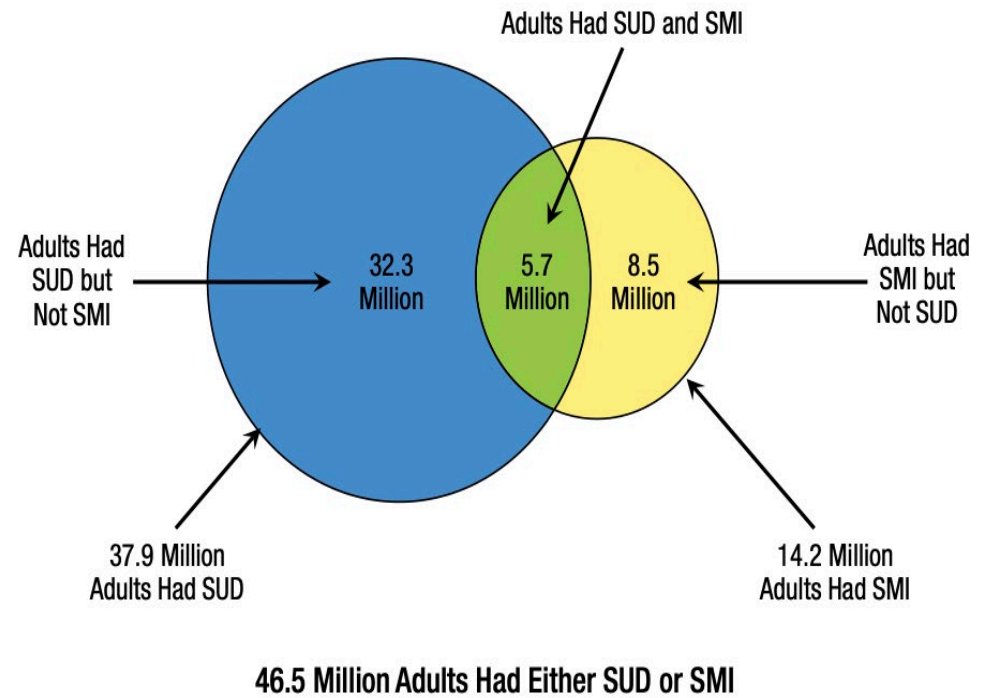
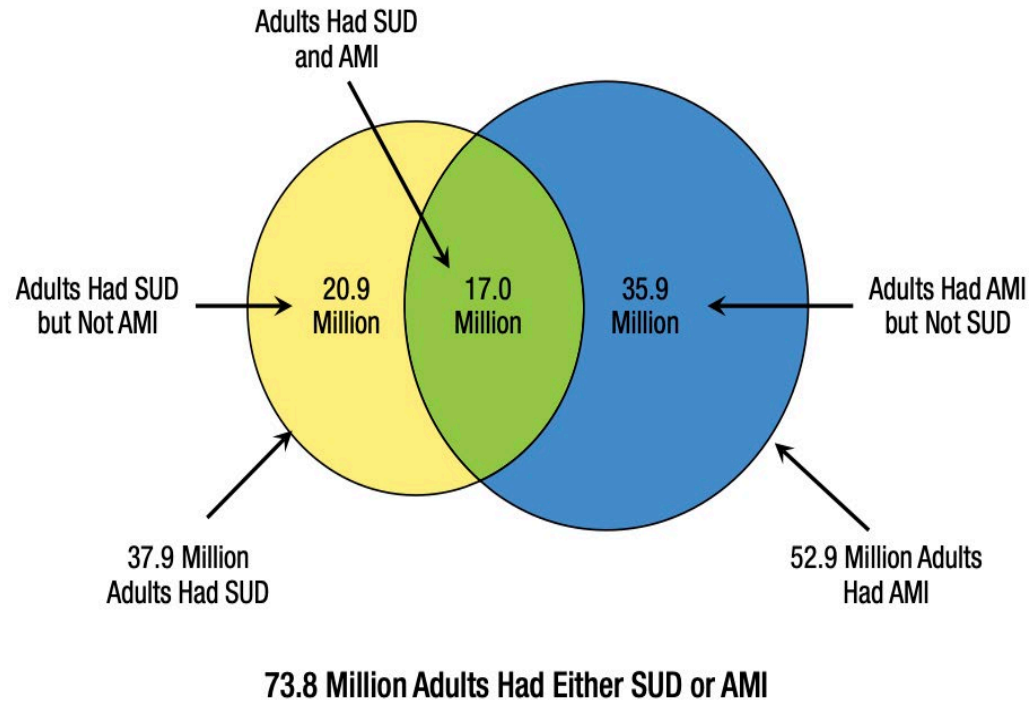
www.samhsa.gov/data/report/2020-nsduh-annual-national-report

www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html

Co-occurring disorders in America

- Using data from the National Comorbidity Survey (NCS), individuals with any lifetime psychiatric disorder were 2.4x more likely to have any lifetime SUD.
- 51.4% of participants in the NCS who reported a lifetime alcohol or SUD, also met criteria for at least one lifetime psychiatric disorder,
- 50.9% of those with a lifetime psychiatric disorder also had a history of SUD.
- 55% of those with schizophrenia and 62% of those with bipolar disorder had a lifetime diagnosis of SUD.
- SUD diagnosis must be expected and not an exception in patients with mental illness

National Survey of Drug Use and Health (NSDUH)



Co-occurring psychiatric and substance use disorders

The relationship between psychiatric and SUD is complex in terms of etiopathology, bidirectional causality (i.e., mutual exacerbation), and shared biological and genetic risks.

This complexity is reflected in shared vulnerabilities, clinical course and treatment challenges of COD.

Patients may be self-medicating their symptoms or the adverse effects of their psychotropic medications.

Substance use may be the gateway for acceptance into certain social groups.

A review of COD consultations: Thematic Analysis

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COD consultation: selected questions

1. What are some strategies for working with people with cognitive processing problems and intellectual disabilities with SUDs.
2. What else can be done given the client's recent accidental overdose?
3. What are some new or additional recommended treatment modalities?
4. How would you encourage the client's parents to become more active in his treatment?
5. Are there any other suggestions on how to help the client take the dangers of his use more seriously?
6. The client glamorizes or glorifies his substance use. He regularly states that he enjoys using substances and loves the way it makes him feel.

Providing Feedback

DHMAS consultations: Emerging themes

Harm Reduction

MAT

Peer Support

Mutual Recovery
Programing

Motivational
Interviewing

Strength
Perspective

Family Support

Assets
Identification &
Residential
Treatment

Individual &
Group Therapy

Psychiatric
Comorbidity

Harm Reduction

- Harm reduction is:
 - A person-centered, public health approach that seeks to reduce the harms of substance use to individuals and communities.
 - Interventions aimed at reducing the negative effects of health behaviors without necessarily extinguishing these behaviors completely.
- Harm reduction seeks to address the multiple needs of persons with SUDs and their families through practical and evidence-based interventions.
- Harm reduction protects the rights of people who use drugs.

(Denning, 2001; Drucker, 1995; Marlatt, 1996)

Harm reduction: practical recommendations

- Targeting risk and harms to people who use substances, understanding the roots of these risks, and tailoring interventions to reduce them.
- Practical recommendations:
 - Naloxone (Narcan)- even in people who may not be opioid dependent
 - Fentanyl test strips
 - Xylazine test strips
 - Recognition of and education on safe use
 - Importance of benefits of reduction in use

Medication for Addiction Treatment

- Opioid use disorder
 - Methadone
 - Buprenorphine
 - Extended-release buprenorphine
 - Naltrexone [oral and extended release]
- Alcohol use disorder
 - Naltrexone [oral and extended release]
 - Disulfiram
 - Acamprosate
 - Other non-FDA approved
- Other Substance use disorders
 - non-FDA approved medications

Peer Support

- Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations.
- Peer support workers engage in a wide range of activities. These include:
 - Advocating for people in recovery
 - Sharing resources and building skills
 - Building community and relationships
 - Leading recovery groups
 - Mentoring and setting goals
- Peer coaches hold positive attitudes toward MOUDs, but coaches without any personal history of OUD or MOUDs may be less likely to encourage MOUD treatment.

Mutual Recovery Programing

- Alcoholics Anonymous
- Other 12- step programs: Narcotics, Cocaine, Gamblers Anonymous
- Other non-12 step: SMART Recovery (smartrecovery.org)
 - The forerunner of SMART recovery is Rational recovery established in 1985.
 - SMART Recovery offers a 4-point program: building and maintaining motivation, coping with urges, managing thoughts, feelings, and behaviors, and living a balanced life.
 - The traditional spiritual orientation of AA is not emphasized and online/ face to face meetings are available.
- AA predicted alcohol abstinence in large trials (meetings attended functions in a dose dependent relationship).

Community Assets Identification

- Advocacy as a core skill
- Identifying treatment assets in the community
- Community engagement
 - Community MAT provider
 - Short- or medium- or long-term recovery facilities, IOP, sober homes
 - Addressing social determinants of health e.g., housing

Strength based approaches

- Recognizing the strengths and skills of individuals with SUD is designed to help clients develop their best qualities on the recovery journey.
- Such strengths include resilience, perseverance, and determination.
- This model encourages client's autonomy as they are guided in the search for resources (housing and employment) while utilizing their strengths and assets as the “vehicle for resource acquisition”

TIP 27: Comprehensive Case Management for Substance (Ab)use Treatment

Strategies for Family Support

- Addiction affects the patient's entire family with each member developing coping strategies.
- The families of PWUD can play a huge part in the care of patients with SUDs.
- Involving families can help prevent, reduce harms and can improve treatment initiation, engagement, completion and treatment outcomes.
- Strategies to working with families:
 - Family based approaches for SUD treatment reflect the principles of systems theory.
 - Acknowledge family dynamics (meet the family where they are) and extra-familial social networks
 - Collaborative approach
 - Approach care with cultural humility
 - Link to culturally appropriate services

Individual and Group therapy

- Clinicians are encouraged to consider individual or group psychotherapy to address some of client's concerns.
- Individual psychotherapy has been necessary in clients presenting with co-occurring PTSD or other high-risk behaviors (CBT for SUD). Benefits include provision of a sense of safety, confidentiality and development of personalized treatment plans.
- Group therapy models help patients practice recovery strategies, build interpersonal skills, and reinforce and develop social support networks.

Motivational Interviewing

- Motivational interviewing (MI) is a person-centered counseling style for addressing the common problem of ambivalence about change.
- We encourage clinicians to practice MI as a collaborative partnership in which the client is the expert as an empathic, supportive counseling style provides conditions under which change can occur.
- Modifications as appropriate for individuals with cognitive processing issues and intellectual disabilities.

What about the psychiatric piece of COD?

- It is important to center both components of the COD complex
- A determination of the complex interaction of the symptoms may bear importance in treatment
- Pharmacokinetic interactions between psychotropic medications via the Cytochrome P450 system occurs often
- Dynamic interactions can also have significant implications in COD:
 - Disulfiram inhibition of dopamine beta hydroxylase could worsen psychosis
 - Bupropion could be anxiogenic
 - Buprenorphine has anti-depressant properties
 - Naltrexone may have mood and affective adverse effects.
 - Psychostimulants could exacerbate psychotic symptoms

Language Matters

TABLE 1. Recommendations for Nonstigmatizing, More Clinically Accurate Language

Avoid	Prefer
Abuse ¹⁻⁵	Use (or specify low-risk or unhealthy use; the latter includes at-risk/hazardous use, harmful use, substance use disorder, and addiction)
Addicted baby	Baby experiencing substance withdrawal
Addict, user, abuser, alcoholic, crack head, pot head, dope fiend, junkie	Person with (the disease of) addiction, a substance use disorder, or gambling disorder
Dirty vs clean urine ²⁴	Positive or negative, detected or not detected
Drunk, smashed, bombed, messed up, strung out	Intoxicated
Meth	Methamphetamine, methadone, methylphenidate
Medical marijuana	Consider using instead “cannabis as medicine”*
Misuse, problem [†]	More accurate terms include at-risk or risky use, hazardous use, unhealthy use to describe the spectrum from risky/at-risk/hazardous use through disorder
Inappropriate use	More accurate terms should specify what is meant
Fix	Dose, use
Binge [‡]	Heavy drinking episode
Relapse ^{§,30}	Use, return to use, recurrence (of symptoms) or disorder vs remission specifiers (early or sustained) as defined by DSM-5
Substitution, replacement, medication assisted treatment	Opioid agonist treatment, medication treatment, psychosocially assisted pharmacologic treatment, treatment
Smoking cessation	Tobacco use disorder treatment, reduction or cessation of tobacco use ³²
Moderate drinking (or drug use)	Low- or lower-risk use
Detoxification	Withdrawal management, withdrawal

Treating Co-occurring disorders: Exploring Best Practices

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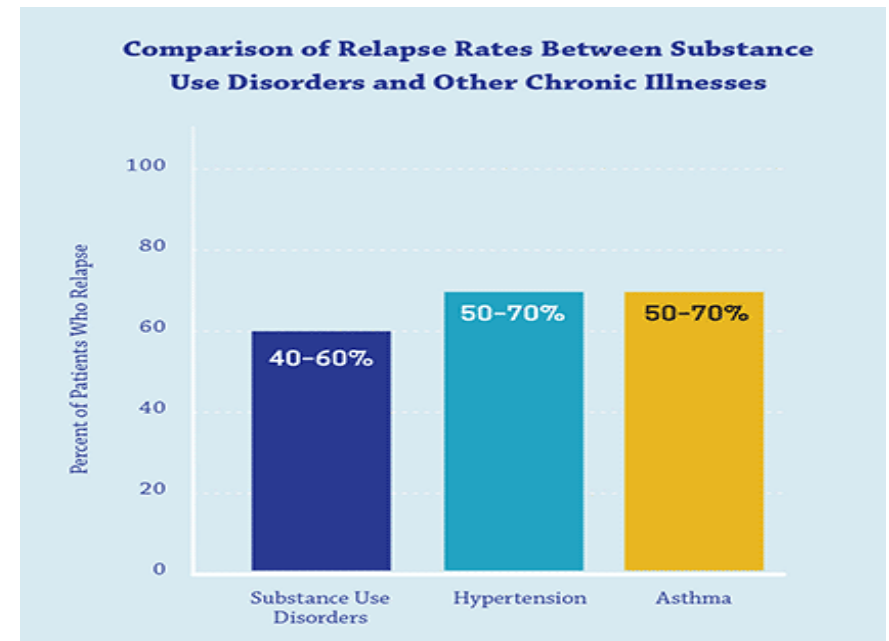
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Substance use disorders are treatable

"Groundbreaking discoveries about the brain have revolutionized our understanding of addiction, enabling us to respond effectively to the problem"

*- Dr. Nora Volkow,
National Institute on Drug Abuse*

- Substance use disorders are preventable and treatable
- Successful SUD treatments are highly individualized and entails:
 - Medication
 - Behavioral interventions
 - Peer support

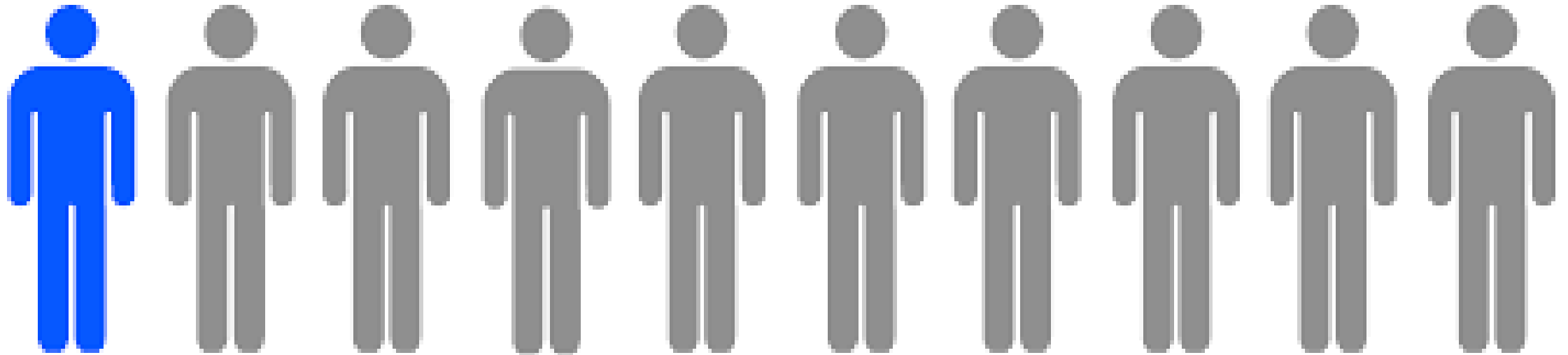


(National Institute on Drug Abuse, 2018)

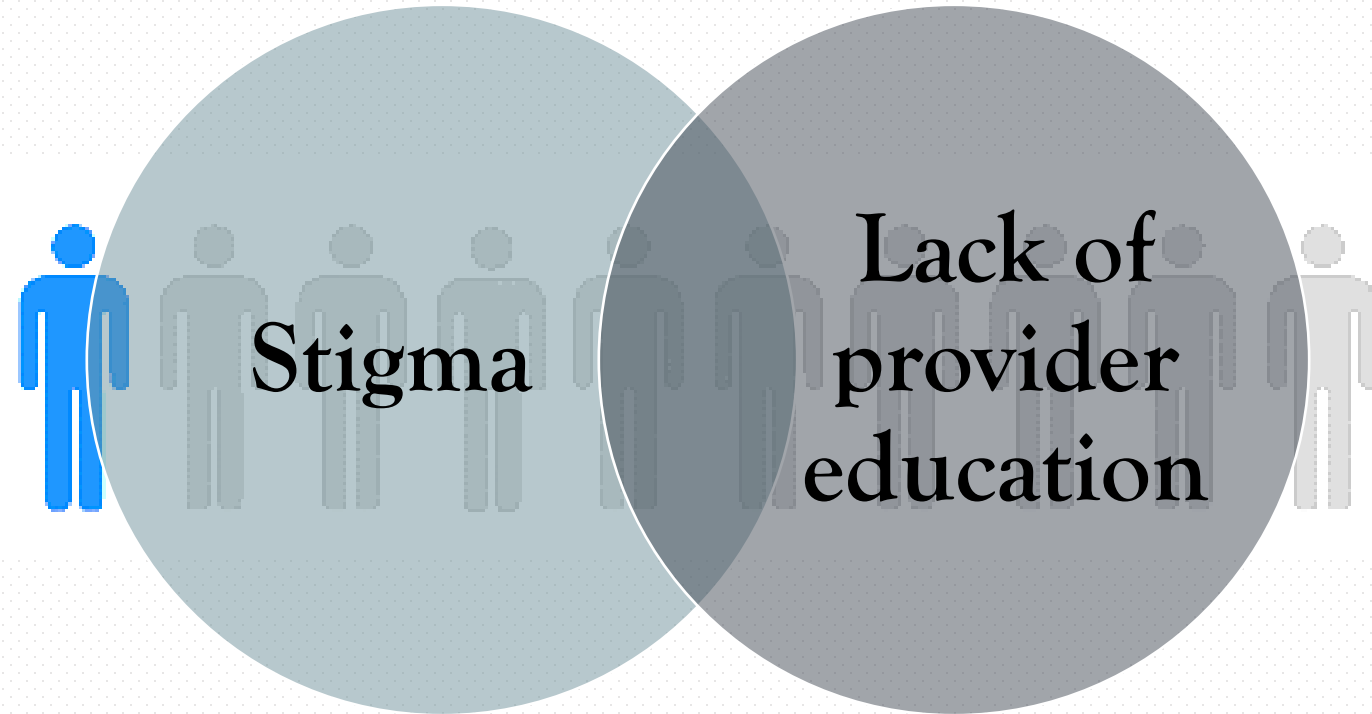
(McLellan et al., 2000)

The Problem

Only one in ten people with addiction receive care
5.7% with AMI (Any Mental Illness) and SUD receive
both treatments



Why are SUDs undertreated?



Role of Psychiatrists and other Mental Health Providers

1100 Addiction Psychiatrists only

Significant comorbidity of SUD's and mental illness (anxiety, depression, ADHD, psychosis, suicide)

National survey of psychiatrists indicates that more than 80% were uncomfortable with providing office-based opioid treatment

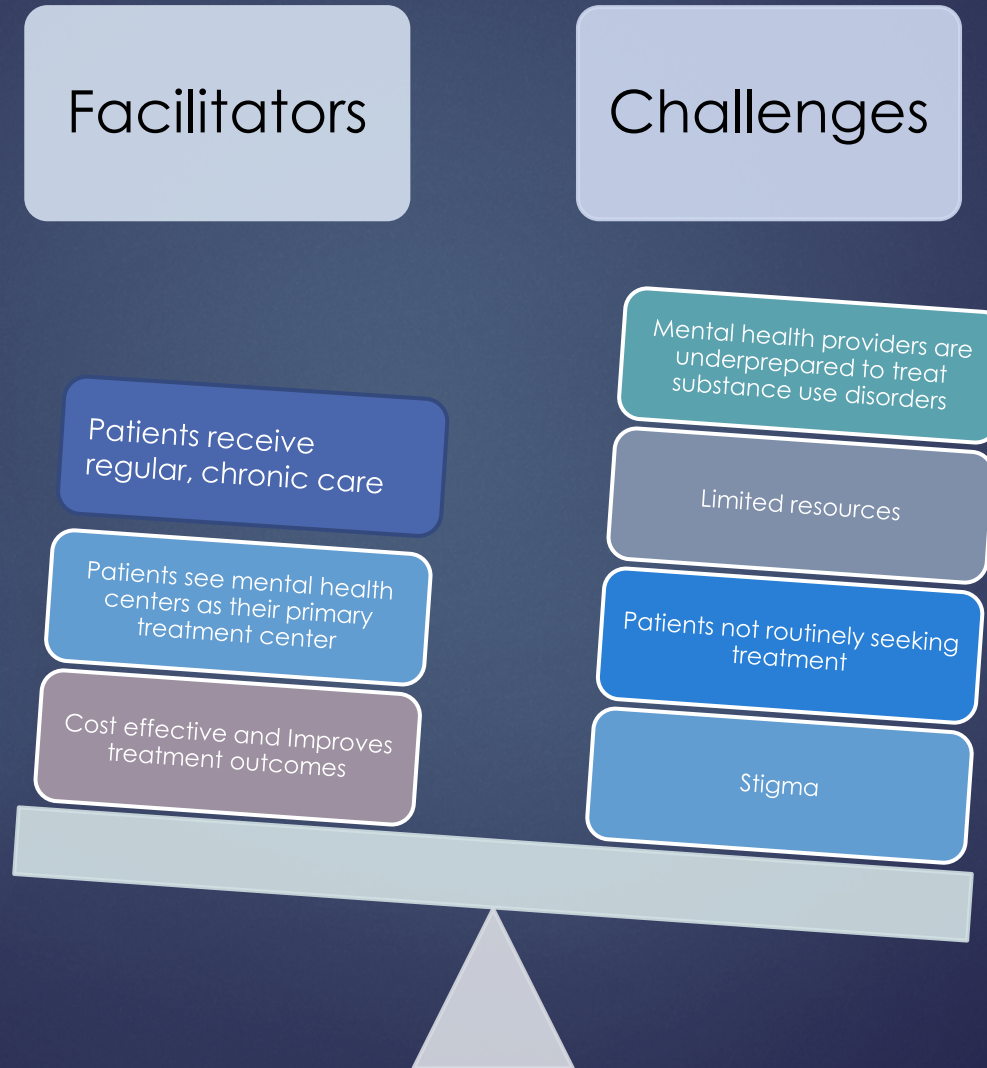
Shift of buprenorphine prescribing to primary care (Psychiatrists 92.2% in 2003 to 32.8% by 2013)

Psychiatrists are knowledgeable about neurobiology and psychological principles underlying behavior and the treatment of behavioral disorders

Psychiatrists are uniquely skilled: Specialty training in treating trauma, depression, and other co-occurring psychiatric disorders and assessing/ treating suicidal behavior

General psychiatrists and mental health providers must own and integrate addiction treatments into their routine practice

Integrating Addiction Treatment



Integrating addiction treatments into health care

- Traditional separation of substance use disorder treatment from mainstream health care has created obstacles.
- Evidence supports integrated treatment:
 - Improves outcomes (substance use, physical and mental health)
 - Reduces health disparities
 - Reduces health care costs for both patients and families
- Individuals seek health care treatment for reasons other than for substance use
- Current addiction workforce does not have the capacity to meet the existing need for integrated health care.
- General health care workforce is undertrained to deal with substance use-related problems.
- Larger more diverse work force is needed to provide more personalized and integrated care.

Mental health providers role?

Prevention interventions

Screening/ SBIRT/
Early intervention

Increase engagement,
Medications for
Treatment (starting early
and in all possible
settings)

Harm reduction/
Overdose education/
Avoiding polypharmacy

Multidisciplinary
Collaboration/
Integrated care/
Comorbidities

Preventing infections
(Education regarding
safe use, needle
exchange programs)

Long term care/
Chronic disease model

Recovery supports and
family involvement

Coordinating care
across services: legal,
child welfare, housing,
employment

CHANGE the NARRATIVE

Common provider barrier: “Too busy”, “One more thing to do when we are already busy”

Change the narrative: “What can we do to provide better quality care for our patients?”

Provide integrated treatment

Practical strategies

- Comorbidity is highly prevalent
- Welcoming approach and engagement are the cornerstones of treatment success
- Effective screening, empathic approach, hopeful relationship, building trust
- “I know it’s difficult for you to come here, asking for help. Thank you for coming, and for sharing the information about your substance use”

Minkoff K, 2013



Multidisciplinary approach

- Successful psychopharmacological interventions for patients with comorbid psychiatric and substance use disorders are more likely to be successful when the clinician is a collaborator in the recovery process.
- Partnership
- Motivational engagement
- Skills training



Case Examples

Case Example 1

30-year-old with history of Major depression and OUD, presents for intake to the clinic reporting IV heroin use for the past year. Last use was the night before, they used 10 bags and came in asking to be initiated on buprenorphine treatment. In addition, the patient presents with symptoms of depression, but denied suicidal thoughts. There are no prescriber appointments until the following week.

1. How can we best manage this patient?
2. What is the role of the multidisciplinary team?

Case Example 2

65-year-old male with schizophrenia, stable on monthly Invega Sustenna, engaged in therapy at the clinic, smoking a pack and half of cigarettes per day, drinking 10 to 12 beers on each occasion about twice a week.

1. How can we approach the treatment of this patient?
2. How can we integrate SUD and mental health treatment in this patient?



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