Addressing Psychiatric Disorders in OMT Patients

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Overview

- Guiding principles of programming
- How untreated psychiatric conditions affect recovery and quality of life
- Basic counselor competencies
- Distinguishing between substance-induced symptoms and independent disorders
- Psychosocial issues
- Medication
- Collaboration with physicians
Influences Promoting the Paradigm Shift (1990’s)

- Epidemiological data: ECA and NCS
- Collaboration of federal agencies
- Merging of local mental health and substance abuse agencies
- Intense interest in cross-training events in local communities
- Revised Patient Placement Criteria
Policy Direction on COD’s

- Co-occurring disorders are the norm, not the exception
- Stronger levels of service coordination are needed to improve outcome. This can be done through consultation, collaboration, or integration.
- Clients’ needs should be appropriately addressed at whatever point they enter the system. There is “no wrong door,” and referrals should be actively guided.
Terminology: Common Confusions

- Dual vs multiple disorders
- Medical comorbidities
- AOD and any coexisting psychiatric disorder
- AOD and severe and persistent mental illness
- What is funded in your community, and how?
Barriers to Addressing Psychiatric Disorders

- Program may not have good diagnosticians
- Belief that methadone and counseling (or TC or 12-step participation) will fix everything
- Inappropriate expectations about time course for improvement
- Resistance/misunderstanding about psychototropic meds; lack of training on how to facilitate adherence
Epidemiology: Opioid Users

- Increased rates of psychiatric disorders in opioid users
- Rates vary depending on whether it is a community or treatment-seeking sample, and by other demographic factors
- Common disorders: mood disorders, anxiety disorders, personality disorders
- Beware of misdiagnosis, especially ASPD
Untreated Psychiatric Disorders

- low self esteem
- low mood
- distorted relationships & family functioning
- impaired judgment
- lower productivity
- less favorable outcome for alcohol and drug treatment
Untreated Psychiatric Disorders

- reluctance to commit to abstinence (fear of symptoms)
- difficulty in achieving abstinence - possibility of more distressing withdrawal symptoms, emergence of psychiatric symptoms with abstinence
- harder to maintain abstinence; more frequent relapses
Women’s Issues

- heightened vulnerability to mood/anxiety disorders
- prevalence of childhood physical/sexual abuse and adult traumatic experiences
- treatment complications of PTSD
- practical obstacles: transportation, child care, homework help
Screening & Assessment Issues
Screening & Assessment

**Screening** is a process for evaluating the possible presence of a particular problem.

**Assessment** is a process for defining the nature of that problem and developing specific treatment recommendations for addressing that problem.

(COD TIP, 2005)
Steps in the Assessment Process

1. Engage the client
2. Identify and collaterals to gather additional information
3. Screen to detect COD’s
4. Determine quadrant and locus of responsibility
5. Determine level of care
6. Determine diagnosis

(COD TIP, 2005)
Steps in the Assessment Process (2)

7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify problem domains
11. Determine stage of change
12. Plan treatment

(TIP 42, 2005)
Assessment: Substance-Induced Conditions

Are the presenting symptoms consistent with the drug(s) used recently?

- cognitive dysfunction/disorder: delerium, persisting dementia, amnestic disorder
- psychotic disorder
- mood symptoms/disorder
- sexual dysfunction
- sleep disorder

See DSM-IV-TR, pages 193, 748-749
AOD use can produce symptoms characteristic of other disorders:

- Alcohol: impulse control problems (violence, suicide, unsafe sex, other high risk behavior); anxiety, depression, psychosis, dementia
- Stimulants: impulse control problems, mania, panic disorder, depression, anxiety, psychosis
- Opioids: mood disturbances, sexual dysfunction
Distinguishing Substance Abuse from Psychiatric Disorders

- wait until withdrawal phenomena have subsided (usually by 3-4 weeks) and methadone dose has been stabilized
- physical exam, toxicology screens
- history from significant others
- longitudinal observations over time
- construct time lines; inquire about quality of life during drug free periods
Treatment Issues
Programming: Guiding Principles

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to tx
4. Address specific real-life problems early in tx
5. Plan for the clients’ cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness

(TIP 42, 2005)
Depression: A Medical Illness

- Beyond neurotransmitters: it is a disease with abnormalities in brain anatomy, as well as neurologic, hematologic, and cardiovascular elements.
- Episodes damage the brain. It is important to prevent or shorten them.
- Episodes also impair resiliency, or the brain’s ability to repair itself.
- Depression is associated with an increase in heart attacks and strokes, and mortality from these diseases. Antidepressants reduce mortality.
Depression in Opiate Users

- atypical reactions to heroin reported by clinicians
- “feeling normal” vs “getting high”
- treatment-seeking opiate users have higher levels of depression (Rounsaville & Kleber, 1985)
- evaluate for medication after stabilized on opioid replacement; consider alcohol and stimulant use
- be alert to relapsing and remitting course of depressive symptoms
Treating Depression in Patients on OMT Therapy

- Antidepressants are compatible with methadone. Monitor cardiac function if SSRI’s are used.
- Presence of depression is associated with favorable treatment response for those who remain in tx (Kosten et al 1986)
- Addition of psychotherapy is helpful for this group (Woody et al 1986)
- Evaluate for PTSD
Methadone & Buprenorphine: Psychiatric Effects

- Buprenorphine appears to have stronger antidepressant properties (pt may still need antidepressants)
- Methadone may be preferred by anxious patients or those with insomnia because it can be sedating
- No systematic investigation (yet)
Depression: Issues for Clarification

- Alcohol and drug use as the great imitator
- Inquire carefully about the quality of experience. Distinguish between clinical depression and upset, distress, sadness, grief, misery, guilt, shame, etc.
- Key elements: 1) 5 of the 9 symptoms; 2) most of the day, nearly every day, at least 2 weeks; 3) clinically significant distress or impairment
- Post-traumatic stress disorder
Depression: Symptom Domains

- Dysphoric mood (includes irritability)
- Vegetative signs: sleep, appetite, sexual interest
- Dysfunctional cognitions (obsessive thoughts, brooding)
- Anxiety: fearfulness, agitation
DSM-IV: Major Depressive Episode

Five or more during same 2 week period, representing a change from previous functioning. Must include 1 & 2

1) depressed mood most of the day, every day (subjective report or observation)
2) diminished interest or pleasure
3) significant weight lost (not dieting) or weight gain
4) insomnia or hypersomnia nearly every day
Major Depressive Episode (2)

5) psychomotor agitation or retardation nearly daily
6) fatigue or loss of energy nearly every day
7) feelings of worthlessness or inappropriate guilt
8) diminished ability to think or concentrate, or indecisiveness
9) recurrent thoughts of death (not just fear), suicidal ideation without specific plan, suicide attempt or a specific plan for committing suicide
Depression

Caveat: Does the study separate substance-induced mood symptoms from an independent condition?

National Comorbidity Study

- major depression & alcohol dependence the most common disorders
- history of major depressive episode: 17%
- episode within last 12 months: 10%
- any affective disorder, lifetime prevalence: women 23.9% (MDE 21.3%), men 14.7% (MDE 12.7%) (Kessler et al 1994)
Suicidality

- AOD use is a major risk factor, especially for young people
- Alcohol: associated with 25%-50%
- Alcohol & depression = increased risk
- Intoxication is associated with increased violence, towards self and others
- High risk when relapse occurs after substantial period of sobriety, especially if it leads to financial or psychosocial loss
Suicidality

- Suicide does not imply depression; may be anxiety and/or despair
- Addiction: higher probability of completed suicide
- There is no data that supports the view that antidepressants prevent suicide (but, studies are only 3 months long)
- Lithium and clozaril reduce suicide attempts

Rick Ries, MD  CSAM 2004
Suicidality: Counselor Recommendations

- Treat all threats with seriousness
- Assess risk of self harm: Why now? Past attempts, present plans, serious mental illness, protective factors
- Develop safety and risk management process
- Avoid heavy reliance on “no suicide” contracts
- 24 hour contact available until psychiatric help can be obtained

Note: must have agency protocols in place
Assess Suicide Risk

- Prior suicide attempt(s)
- Recent increase in suicidal preoccupation
- Level of intent; formulation of plan
- Availability of lethal means
- Family history of completed suicide
- Active mental illness or high risk forms of drug use
- Serious medical illness
- Recent negative life events
Guns

- Firearms are by far the most common method to commit suicide
- Ask: Is there a firearm in your home?
- Ask: How is it stored?
- Recommend removing guns from the home; putting in safe storage
- Establish a method for clients to turn in their guns (e.g., hospital police)
Agency Protocol for Suicidal Patients

- Screening: who does it and how are they trained?
- Assessment: who does it and what are their qualifications?
- Are there clear procedures for monitoring high risk patients?
- Are there clear procedures for hospitalization if necessary?
Treatment Issues

- gender differences (Kessler et al. 1994)
- psychotherapy - target affective symptoms or psychosocial problems; 50% efficacy
- medications - SSRI’s, tricyclics; 50% efficacy
  counselor attention to adherence is essential
- combination tx for those who with more severe or chronic depression or partial responders to either treatment
  (American Psychiatric Association 1993; Schulberg & Rush 1994)
PTSD: National Comorbidity Study

Representative national sample, n = 5877, aged 14-54

- Women more than twice as likely as men to have lifetime PTSD (10.4% vs 5.0%)
- Strongly comorbid with other lifetime psychiatric disorders
- More than one third with index episode of PTSD fail to recover even after many years
- Treatment appears effective in reducing duration of symptoms

(Kessler et al 1995)
Post Traumatic Stress Disorder

- Exposed to traumatic event with both present:
  - experienced, witnessed, or was confronted with an event(s) involving actual or threatened death or serious injury, or threat to physical integrity of self or others
  - person’s response involved in tense fear, helplessness, or horror

- Event persistently re-experienced:
  - recurrent and intrusive distressing recollections, including images, thoughts, perceptions
  - recurrent distressing dreams of the event
PTSD (2)

- acting or feeling as if the traumatic event were recurring
- intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
PTSD (3)

- Persistent avoidance of stimuli associated with the trauma; numbing of general responsiveness. Three or more:
  - efforts to avoid thoughts, feelings or conversations associated with the trauma
  - efforts to avoid activities, places or people
  - inability to recall an important aspect of trauma
  - diminished interest or participation in significant activities
PTSD (4)

- feeling of detachment or estrangement
- restricted range of affect
- sense of foreshortened future

Persistent sx of increased arousal (2 or more)

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response
Relationships between Trauma and Substance Abuse

- Traumatic experiences increase likelihood of substance abuse, especially if PTSD develops
- Childhood trauma increases risk of PTSD, especially if it is multiple trauma
- Substance abuse increases the risk of victimization
- Need for linkages between systems: medical, shelters, social services, mental health, criminal justice, addiction treatment

(Zweben et al 1994)
PTSD Among Inner City MMT Patients

Women:
- lifetime prevalence 20% (community sample: 10.4%)
- most common stressor: rape

Men:
- lifetime prevalence 11% (community sample: 5%)
- most common stressor: seeing someone hurt or killed

(Kessler et al 1995; Villagomez et al 1995)
Screening Questions to Detect Partner Violence

- Have you ever been hit, kicked, punched or otherwise hurt by someone within the past year? If so, by whom?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now? (Feldhaus 1997)
Impact of Physical/Sexual Abuse on Treatment Outcome

N=330; 26 outpatient programs; 61% women and 13% men experienced sexual abuse
- abuse associated with more psychopathology for both; sexual abuse has greater impact on women, physical abuse has more impact on men
- psychopathology is typically associated with less favorable tx outcomes, however:
- abused clients just as likely to participate in counseling, complete tx and remain drug-free for 6 months post tx (Gil Rivas et al 1997)
PTSD Treatments

- Stress inoculation training and prolonged exposure (PE, flooding) (Foa et al 1991; 1998)
- Cognitive-Behavioral Therapy (Najavits et al 1996)
- Eye Movement Desensitization and Reprocessing (Shapiro 1995)
- Anger management/temper control (Reilly et al 1994)
- Substance Dependence-Post Traumatic Stress Disorder Treatment (SDPT) (Triffleman, under investigation)
How PTSD Complicates Recovery

More difficulty:

- establishing trusting therapeutic alliance
- obtaining abstinence commitment; resistance to the idea that AOD use is itself a problem
- establishing abstinence; flooding with feelings and memories
- maintaining abstinence; greater relapse vulnerability
How Substance Abuse Complicates Resolution of PTSD

- early treatment goal: establish safety (address AOD use)
- early recovery: how to contain or express feelings and memories without drinking/using
- firm foundation of abstinence needed to work on resolving PTSD issues
- full awareness desirable, vs emotions altered by AOD use
- relapse risk: AOD use possible when anxiety-laden issues arise; must be immediately addressed
BEWARE OF DOGMA

May need to work with client who continues to drink or use for a long time

- avoid setting patient up for failure
- reduce safety hazards; contract about dangerous behavior
- carefully assess skills for coping with feelings and memories; work to develop them
Anger Management & Temper Control

- Identifying cues to anger: physical, emotional, fantasies/images, red flag words and situations
- Developing an anger control plan
- Cognitive-behavioral strategies for anger management
- Breaking the cycle of violence; understand family of origin issues (Reilly et al 1994)

Beware of gender bias; ask about parenting behaviors
Seeking Safety: Early Treatment Stabilization

- 25 sessions, group or individual format
- Safety is the priority of this first stage tx
- Treatment of PTSD and substance abuse are integrated, not separate
- Restore ideals that have been lost
  - Denial, lying, false self – to honesty
  - Irresponsibility, impulsivity – to commitment
Seeking Safety: (2)

- Four areas of focus:
  - Cognitive
  - Behavioral
  - Interpersonal
  - Case management

- Grounding exercise to detach from emotional pain

- Attention to therapist processes: balance praise and accountability; notice therapists’ reactions
Seeking Safety (3): Goals

- Achieve abstinence from substances
- Eliminate self-harm
- Acquire trustworthy relationships
- Gain control over overwhelming symptoms
- Attain healthy self-care
- Remove self from dangerous situations (e.g., domestic abuse, unsafe sex)

(Najavits, 2002)
Safe Coping Skills

- Ask for help
- Honesty
- Leave a bad scene
- Set a boundary
- When in doubt, do what is hardest
- Notice the choice point
- Pace yourself
- Seek understanding, not blame
- Create a new story for yourself

(from Handout in Najavits, 2002)
Detaching from Emotional Pain: Grounding

- Focusing out on external world - keep eyes open, scan the room, name objects you see
- Describe an everyday activity in detail
- Run cool or warm water over your hands
- Plan a safe treat for yourself
- Carry a grounding object in your pocket to touch when you feel triggered
- Use positive imagery

(Najavits, 2002)
Next Step:
Address Traumatic Experiences

**Seeking Safety**
- Present-focused
- Mechanism: coping skills
- 25 topics
- Goal is safety

**Creating Change**
- Past-focused
- Change mechanism: processing
- 17 topics
- Goal is narrative truth

(Najavits 2010)
Comparison: Seeking Safety & Creating Change

**FOCUS on PRESENT**
- focusing on “today”
- coping, gaining control
- containing intense feelings
- emphasis on action
- being strong
- improving functioning in the “outside” world

**FOCUS on PAST**
- focusing on “yesterday”
- exploring memories
- expressing intense feelings
- emphasis on process
- being vulnerable
- coming to terms with one’s “inner” world
Topics in Creating Change

- Choose a path
- Explore
- Sustain yourself
- Respect your defenses
- Encourage along the way
- Create a safety net
- Keep others on your side
Topics

- Suffering
- Why substances?
- Tell your story
- See clearly
- Balance dark and light
- Relationship patterns
- Honor your body
- The larger context
- Transform pain
- Growth
Mindfulness: Another Useful Tool

- Combines psychological strategies with meditation practices
- Address depression, anxiety, impulsivity
- Recognize triggers, cravings and how they manifest in feelings, cognitions, behaviors
- Stay in the present; slow time down
- Use techniques like “urge surfing”; craving passes on its own
- Move from impulsive behavior to ability to tolerate experiences
Psychosocial Treatment Issues

- client attitudes/feelings about medication
- client attitude about having an illness
- other clients’ reactions: misinformation, negative attitudes
- staff attitudes
- medication compliance
- control issues: whose client?
Issues in the Collaboration between Counselors, Physicians and Other Professionals
Barriers to Accessing Offsite Psychiatric Services

- Distance, travel limitations
- Obstacle of enrolling in another agency
- Stigma of mental illness
- Cost
- Fragmentation of clinical services
- Becoming accustomed to new staff

(TIP 42, 2005)
Prescribing Psychiatrist Onsite

- Brings diagnostic, behavioral and medication services to the clients
- Psychiatrist learns about substance abuse
- Case conferences, supervision allow counselors to learn more about dx and tx
- Better retention and outcomes

(TIP 42, 2005)
Some Common Issues

- Defining the roles of team members
- Communication pathways
- Communication breakdowns
- Struggles for control
- Integrating the physician into the team
- Educating physicians about addiction
Role of the Physician

- Establish good screening and assessment protocols
- Establish protocols for managing crises
- Training plan to upgrade staff skills
- Medication evaluation and management
- Commit to increasing knowledge about addiction if appropriate
Role of the Counselor

- Screening for COD
- Clear evaluation request for MD - specific observations and questions
- Explore charged issues
  - Client resistance to getting an evaluation
  - Client resistances to medication
  - Family history of problems
- Periodic inquiry
- Support medication adherence
- Keep physician informed
Educate Clients about Psychiatric Conditions

- The nature of common disorders; usual course; prognosis
- Important factors: genetics, traumatic and other stressors, environment
- Recognizing warning signs
- Maximizing recovery potential
- Misunderstandings about medication
- Teamwork with your physician
Reasons to Avoid Medications

- Don’t believe they ever needed it; never were mentally ill or had a real disorder
- Don’t believe they need it anymore; cured
- Don’t like the side effects
- Fear the medication will harm them
- Struggle with objections or ridicule by friends and family members
- Feel that taking meds means they are not personally in control
Attitudes and Feelings about Medication

- shame
- feeling damaged
- needing a crutch; not strong enough
- “I’m not clean”
- anxiety about taking a pill to feel better
- “I must be crazy”
- medication is poison
- expecting instant results
Preparing Clients to See Physician about Meds

- Explore fears and hopes
- Encourage client to be a good observer and reporter; written notes are good
- Discourage client from insisting on a particular medication
- Encourage client to write out questions
- Encourage client to make notes about what the doc recommends
- Getting the right medication is often a process requiring ongoing teamwork
Medications: Counselor’s Queries (1)

- **Adherence**
  - “sometimes people forget their medications...how often does this happen to you? (% not taking)

- **Effectiveness**
  - “how well do you think the meds are working?”
  - “What do you notice?
  - Here is what I notice
Medications: Counselor’s Queries (2)

- **Side Effects**
  - “Are you having any side effects to the medication?”
  - “What are they?”
  - “Have you told the physician?”
  - “Do you need help talking with the doc?”

(Richard K. Ries, MD  CSAM 2004)
When Clients Admit to Choosing Not to Take Their Meds

- Acknowledge they have a right to make this choice;
- Stress that they owe it to themselves to make a good decision; this choice should be thought out and not impulsive;
- Explore their reasons; probe beyond initial statements like “I just don’t like pills.”
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Medication Adherence

- Avoiding medication can cause further harm.
- Appropriate medications improve treatment outcome.
- Reasons for non-compliance: denial of illness, attitudes and feelings, side effects, lack of support, other factors.
- Role of the counselor: periodic inquiry, exploring charged issues, keeping physician informed.
- Work out teamwork, procedures with docs.
The Affordable Care Act

- Expanded enrollment
- Transition from private pay to public/insurance funding
- More continuous treatment possible
- Do benchmark plans include OMT?
- Is Medicaid closed to new providers?
- Can you bill for your work force?
Resources

- Addiction Technology Transfer Centers: www.nattc.org
- NIDA Blending Initiative – partnership with SAMHSA to disseminate research findings: www.nida.nih.gov/Blending/
- NIDA Dissemination Library: http://ctndisseminationlibrary.org/
- Download slides from: www.ebcrp.org
Treatment Improvement Protocols (TIPS)

- Substance Abuse Treatment for People with Co-Occurring Disorders (TIP 42)
- Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery (TIP 48)
- Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (TIP 50)

Download Slides from: www.ebcrp.org