Assessing a Complex Patient

Collecting Data

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Opioid
Response
Network
STR-TA/SOR-TA

Working with communities to address the opioid crisis.

- SAMHSA's State Targeted Response Technical Assistance (STR-TA) and State Opioid Response Technical Assistance (SOR-TA) grants created the *Opioid Response Network* to assist states, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis .
- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

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Working with communities to address the opioid crisis.

- The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.
- The ORN accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Contact the Opioid Response Network

- To ask questions or submit a request for technical assistance:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org
  - Call 401-270-5900

Disclosure

Neither the presenter nor planners disclose any commercial or conflict of interest associated with this learning activity.

Agenda

Background stats about Co-occurring MH + SUDs

Questions to be addressed for each facility

Medical Model

Evidence based tools

Case presentations

Background stats about Co-occurring MH + SUDs

Commonly associated disorders

Bilateral relationship between the two (three, four)

Psychiatric mimicry- Intoxication and withdrawal

Commonly seen MH Disorders in Patients Presenting for SUD Treatment

Depressive disorders, bipolar I disorder

Posttraumatic stress disorder (PTSD)

Personality disorders (PDs)

Anxiety disorders

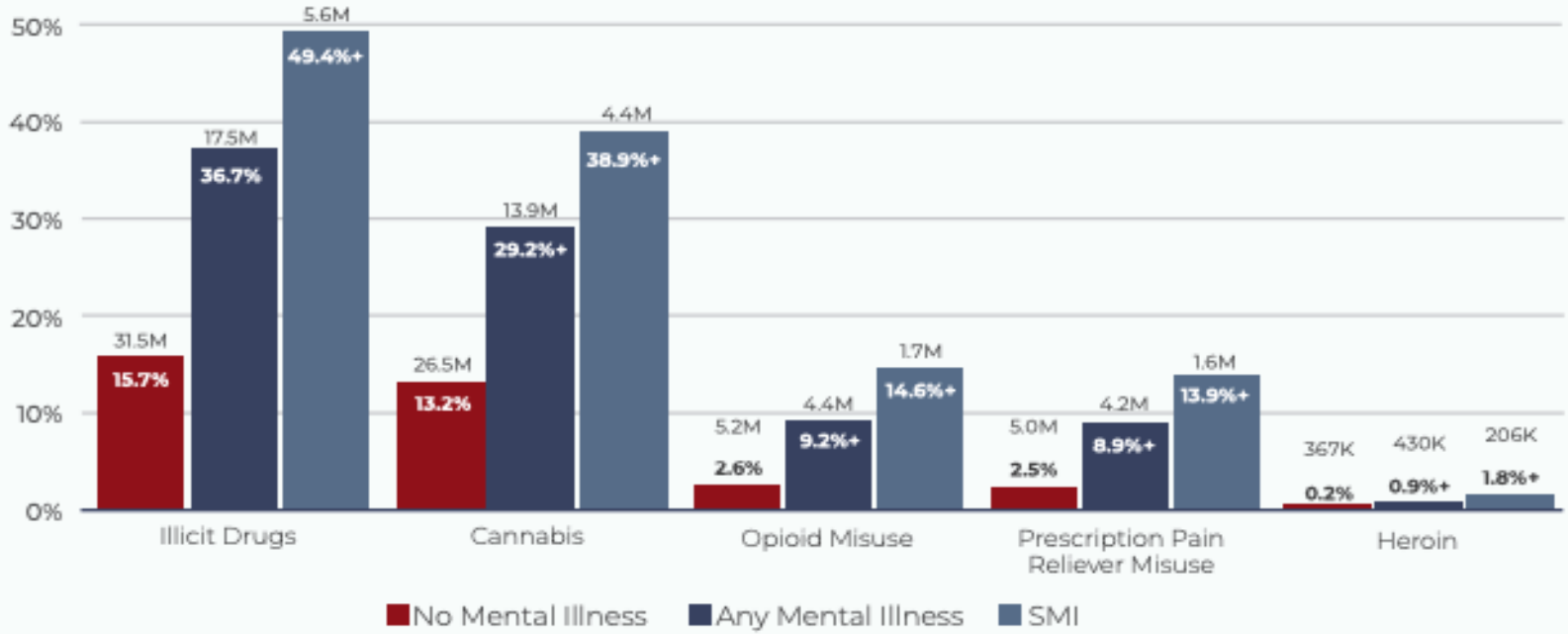
Schizophrenia and psychosis

Attention deficit hyperactivity disorder (ADHD)

Feeding and eating disorders.

Expect there to be co-occurring conditions!

EXHIBIT 1.2. Co-Occurring Substance Misuse in Adults Ages 18 and Older With and Without Any Mental Illness and SMI (in 2018)



Source: McCance-Katz (2019). Adapted from material in the public domain.

Substances and Corresponding Substance-Induced Mental Disorders

EXHIBIT 4.16. Substances and Corresponding Substance-Induced Mental Disorders

SUBSTANCE	SUBSTANCE-INDUCED MENTAL DISORDER	
Alcohol	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders
Caffeine	• Anxiety disorders	• Sleep disorders
Cannabis	• Psychotic disorders	• Anxiety disorders
Hallucinogens	• Psychotic disorders • Bipolar disorders	• Depressive disorders • Anxiety disorders
Inhalants	• Psychotic disorders • Depressive disorders	• Anxiety disorders
Opioids	• Depressive disorders • Anxiety disorders	• Sleep disorders
Sedatives	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders
Stimulants (e.g., cocaine, amphetamines)	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders

Psychiatric Mimicry

EXHIBIT 4.19. Substances That Precipitate or Mimic Common Mental Disorders

MENTAL DISORDER	SUBSTANCES THAT MIMIC MENTAL DISORDERS DURING USE (INTOXICATION)	SUBSTANCES THAT MIMIC MENTAL DISORDERS AFTER USE (WITHDRAWAL)
Depression and dysthymia	Alcohol, benzodiazepines, opioids, barbiturates, cannabis, steroids (chronic), stimulants (chronic)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic), stimulants (chronic)
Anxiety disorders	Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, intoxicants and PCP, inhalants, stimulants	Alcohol, cocaine, opioids, sedatives, hypnotics, anxiolytics, stimulants
Bipolar disorders and mania	Stimulants, alcohol, hallucinogens, inhalants (organic solvents), steroids (chronic, acute)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic)
Psychosis	Alcohol, anxiolytics, cannabis, hallucinogens (e.g., PCP), inhalants, sedatives, hypnotics, stimulants	Alcohol, sedatives, hypnotics, anxiolytics

Huge Gap between need and services provided

A serious treatment gap exists between the mental disorder and SUD needs of people with CODs and the number of people who actually receive services.

According to the 2018 National Survey on Drug Use and Health, of the 9.2 million U.S. adults ages 18 and older who had CODs in the past year, more than 90 percent did not receive treatment for both disorders, and approximately 50 percent received no treatment at all (Center for Behavioral Health Statistics and Quality, 2019).

Underlying these statistics is the failure of addiction and mental health professionals to adequately recognize CODs.

Tip 42

Screening and Assessment

What is screening? Screening is a simple process of determining whether more in-depth assessment is needed, often consisting of asking the client basic "yes" or "no" questions.

The action or an instance of making a judgment about something : the act of assessing something

QUESTIONS or INTERNAL ASSESSMENT

What are the most common mental health complaints that your patients have?

What is your facility able to manage? Dx vs Acuity

Do you have access to a psychopharmacologist?

Evidence Based Level of COD

- ASAM criteria for COD-capable and -eligible programs are as follows:
- Co-occurring–capable (COC) programs in addiction treatment focus primarily on SUDs but can treat patients with subthreshold or diagnosable but stable mental disorders (Mee-Lee et al., 2013). Mental health services may be onsite or available by referral. COC programs in mental health are those that mainly focus on mental disorders but can treat patients with subthreshold or diagnosable but stable SUDs (Mee-Lee et al., 2013). Addiction counselors are onsite or available through referral.
- Co-occurring–enhanced (COE) programs have more integrated addiction and mental health services and have staff who are trained to recognize the signs and symptoms of both disorders and are competent in providing integrated treatment for both mental disorders and SUDs at the same time.
- Complexity-capable programs are designed to meet the needs of individuals (and their families) with multiple complex conditions that extend beyond just CODs. Physical and psychosocial conditions and treatment areas of focus often include chronic medical illnesses like HIV, trauma, legal matters, housing difficulties, criminal justice system involvement, unemployment, education concerns, childcare or parenting difficulties, and cognitive dysfunctions.

Mee-Lee, Shulman, Fishman, Gastfriend, & Miller 2013)

Medical Model

- Chief Complaint
- History of Present Illness
- Past mental health and substance use disorder history
  - Treatment history
  - Medications
  - Suicide or self harm history
  - Trauma
- Medical History
- Collateral information and releases of information

Food for thought

Even when the psychiatric diagnosis has not been established, the client's co-occurring symptoms should still be treated (with nonmedication). Counselors should not withhold treatment simply because a determination about the origin of the mental disorder has not yet been made.

Tip 42

Use of evidence based tools

Patient or clinician administered

Consistency between patients and colleagues

Helps address psychiatric mimicry of SUDs

Guides treatment planning

Examples:

- TAPS Tool https://www.drugabuse.gov/taps/#/
  Directs toward diagnosis and potential consequences of the SUD
- DSM-V Diagnosis and Severity of symptoms
- ASAM Criteria Determination of level of care
- The LOCUS Determination of Level of care
- The Primary Care PTSD Screen for DSM-5
- Patient Health Questionnaire-9 (PHQ-9) Depression

Case 1

Patient is a 26 year old Caucasian woman, new to treatment for OUD on buprenorphine who complains of anxiety and depression.

She denies other substance use other than occasional THC but this is less than once a month.

She reports that she started using prescribed narcotics after a MVA, but reports that she soon “started to like” the feeling she experienced when taking it.

Her provider stopped prescribing narcotics when she started asking for early prescriptions. She purchased pills on the street and found the heroin was less expensive. She denies having used IV but was afraid she might start which is what lead her to seek treatment.

No SI/HI or previous mental health treatment or medications. She does complain of “anxiety and depression” that began prior to her MVA but have worsened since.

Questions

What would your next question be?

How would you approach the management of her symptoms?

Case 2

36 year old male who has had multiple treatment experiences who is on bupropion, escitalopram, carbamazepine and alprazolam.

He has been on a variety of psychotropic medications since age 21 when he was hospitalized for depression.

No SI/HI

Currently on methadone but continuing to use THC regularly and cocaine app once a week.

He complains of high degree of anxiety and would like medications to address this. Reports diagnosis of PTSD and bipolar disorder that he medicates with THC.

He reports that if his medications were adjusted correctly that he would no longer need to use drugs and hopes that you will start this process today.

Same questions

What would your next question be?

How would you approach the management of his symptoms?

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Additional NIDA CTN DI Resources

- NIDA CTN DI website: https://www.drugabuse.gov/nidamed-medical-health-professionals/ctn-dissemination-initiative
  - Overdose Prevention Education for Clinicians Treating Patients for an Opioid Use Disorder – Video from NIDA's Center for the Clinical Trials Network
  - Screening Tools for Adolescent Substance Use https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/screening-tools-adolescent-substance-use
- Shutting Down Stigma Against SUD https://pa-foundation.org/substance-use-disorder/

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Questions?

We need your feedback!

https://tinyurl.com/44adczkn