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## CENTER FOR EVIDENCE-BASED PRACTICES

*at Case Western Reserve University*



A partnership between the Jack, Joseph and Morton Mandel School of Applied Social Sciences & Department of Psychiatry at the Case Western Reserve School of Medicine


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### Service innovations for people with mental illness, substance use disorders




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### Co-Occurring Disorders (COD) Treatment Quadrants

<p>Mild to moderate Mental illness symptoms <i>Low to moderate substance use disorder</i></p>	<p style="text-align: center;"><b>I</b></p> <p>Severe mental illness symptoms <i>Low to moderate Substance use disorder</i></p>
<p>Mild to moderate Mental illness symptoms <i>Severe substance use disorder</i></p>	<p style="text-align: center;"><b>III</b></p> <p>Severe mental illness symptoms <i>Severe substance use disorder</i></p>


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### What Is So Different About Quadrant IV?

#### Stress Vulnerability Model (Zubin and Spring, 1977)

- Heightened stress and intensity of circumstances contributes to exacerbation of and/or more rapid onset of MH symptoms
- High intensity interventions are counter-productive



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### Mental Status Implications

#### Why Don't They "Get It"??!

- Insight & judgment are essential to processing consequences
  - Symptom manifestation in SPMI compromises insight and judgment
  - Thus, consequences are not being processed
- Anosognosia (Babinski,1914; Lehrer and Lorenz, 2014)



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### Mental Status Implications

- Anosognosia is a deficit of self-awareness, a condition in which a person seems unaware of the existence of his or her disability.
- Anosognosia results from physiological damage to brain structures, typically to the parietal lobe or a diffuse lesion on the fronto-temporal-parietal area in the right hemisphere of the brain.



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**Mental Status Implications**

- Substance abuse affects neurotransmission (serotonin, dopamine, et al) and interactions within reward structures of the limbic system (McLellan et al, 2000; Robbins and Everitt, 2002)
  - "The hijacked brain"
- Disruption of the prefrontal cortex in addiction underlies not only compulsive drug taking, but also accounts for the disadvantageous behaviors that are associated with addiction and the erosion of free will. (Goldstein and Volkow, 2011)
- Essentially, the brain's basic functions have been "rewired"



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**The neurobiology of addiction encompasses more than the neurochemistry of reward.**

- The frontal cortex of the brain and its circuits of reward, motivation and memory is fundamental in the manifestations of:
  - Altered impulse control
  - Altered judgment
  - Dysfunctional pursuit of rewards
- Despite cumulative adverse consequences experienced from engagement in substance use and other addictive behaviors.



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**Implications for Diagnostic Assessment**

- You have no idea what you are looking at after a 90 minute psychosocial and diagnostic assessment encounter.
- Could be months or longer before all of the variables are understood in proper context
- Comprehensive Longitudinal format vs. Parallel Categorical format



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### Stages of Change and Stages of Treatment

- Pre-contemplation -> Engagement
- Contemplation and Preparation -> Motivation
- Action -> Active Treatment
- Maintenance -> Relapse Prevention



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### Different services are helpful at different stages of treatment

- **Engagement**
  - Outreach, Practical help, Crisis intervention, Develop alliance, Assessment  
**(Build Relationship)**
- **Motivation**
  - Understand what matters to the person, Explore goals, Explore concerns and awareness of problem (Motivational counseling)  
**(Tip Ambivalence)**



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### Different services are helpful at different stages of treatment

- **Active Treatment**
  - Substance abuse counseling, Recovery skills training, Self help groups  
**(Develop Skills)**
- **Relapse prevention**
  - Relapse prevention plan, Continue skills building in active treatment, Expand recovery to other areas of life  
**(Support Life Changes)**



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**Outreach & “Enabling”**

- If your insight and judgment have failed you because of the symptoms of your mental illness...
- If your brain's reward circuitry has been physically altered...
- If your anosognosia has left you unable to comprehend you have an illness...
- If your coping skills have forced you to adapt to one bad circumstance after another...
- **...then, you are not very likely to come seek help from the place that offers help for the problem that you don't think you have.**



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**Outreach & “Enabling”**

- And, if you are not very likely to come seek help from the place that offers help for the problem that you don't think you have....
- We have to go to you, as it may be a matter of life and death.
- Death is a poor predictor of recovery.
- Community based vs. Clinic based services  
(Bond et al, 2001, Drake et al, 2008, White, 2008)



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**COD Service Strategy:  
Assertive Approaches to Continuing Care**

- Post-treatment monitoring & support (recovery checkups)
- Stage-appropriate recovery education & coaching
- Assertive linkage to communities of recovery
- If and when needed, early re-intervention & re-linkage to Tx and recovery support groups
- **Focus not on service episode but managing the course of the disorder to achieve lasting recovery.**



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**COD Service Strategy:  
Assertive Approaches to Continuing Care**

1. Provided to all clients not just those who "graduate"
2. Responsibility for contact: Shifts from client to the treatment organization/professional

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**COD Service Strategy:  
Assertive Approaches to Continuing Care**

3. Timing: Capitalizes on critical windows of vulnerability (first 30-90 days following treatment) and power of sustained monitoring (Recovery Checkups)
4. Intensity: Ability to individualize frequency and intensity of contact based on clinical data

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**COD Services Strategy:  
Assertive Approaches to Continuing Care**

5. Duration: Continuity of contact over time with a primary recovery support specialist for up to 5 years
6. Location: Community-based versus clinic-based
7. Staffing: May be provided in a professional or peer-based delivery format
8. Technology: Increased use of telephone- & Internet-based support services

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### A Fundamental Flaw

- Repeated episodes of brief interventions have little ability to fundamentally alter the course of substance dependence and its related consequences.
- Failure does not result from client or the inadequate execution of clinical protocol by service professionals.



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### A Fundamental Flaw

- It flows instead from a fundamental flaw in the design of the intervention - an acute-care model of treating addiction that is analogous to treating diabetes or asthma through a single, self-contained episode of inpatient stabilization.
- In the Acute Care model, brief symptom stabilization is misinterpreted as evidence of sustainable recovery.
- It is misleading to frame single episode of care as "graduation", "completion", "discharge" when dealing with a chronic illness



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### COD Service Vulnerability: Frequency of Discharge, Relapse, Re-admission

- The majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2002).
- ***Of those who consume alcohol and other drugs following discharge from addiction treatment, 80% do so within 90 days of discharge*** (Hubbard, Flynn, Craddock, & Fletcher, 2001).



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**COD Services Vulnerability:  
Failure to Manage Addiction/Tx/Recovery  
Careers**

- Most persons treated for substance dependence who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years (Anglin, et al, 1997; Dennis, Scott, & Hristova, 2002).
- See also: Bill W.



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**Fragility of Early Recovery**

- Individuals leaving addiction treatment are fragilely balanced between recovery and re-addiction in the hours, days, weeks, months, and years following discharge (Scott, et al, 2005).
- *Recovery and re-addiction decisions are being made at a time that we are often disengaging from their lives, but many sources of recovery sabotage are present.*



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**COD Service Vulnerability:  
Timing of Recovery Stability**

- Durability of alcoholism recovery (the point at which risk of future lifetime relapse drops below 15%) is not reached until 4-5 years of remission (Jin, et al, 1998).
- 20-25% of narcotic addicts who achieve five or more years of abstinence later return to opiate use (Simpson & Marsh, 1986; Hser et al, 2001).



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### Harm Reduction

- Consumers with COD are at higher risk for negative consequences than general population
- Examples of negative consequences
  - Physical effects, disease, malnutrition
  - Relapse of "other" disorder
  - Unsafe sex
  - Victimization
  - Loss of family support, housing
  - Legal, incarceration, DUI



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### Harm Reduction

Strategies to promote health and safety:

- Teaching safe sex practices
- Needle exchange programs
- Tobacco cessation
- Support switching to use of less harmful substance



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### Harm Reduction

Strategies to promote health and safety:

- Assisting consumers to avoid high risk situations for victimization
- Secure housing (wet, damp)
- Safe driver programs
- Providing support to families
- Payeeship/Guardianship



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### The Interactive Course of Co-occurring Disorders

- Too often, we don't have the luxury of determining whether the chicken or the egg came first...they're both here now, so now what?
- "Primary" and "Secondary" distinctions are insurance concepts, not clinical treatment classifications.
- Substance use is a potential threat to mental health recovery, and unmanaged mental health symptoms are a threat to substance abuse recovery



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### Traditional Co-Occurring Disorders Treatment

- Treat each disorder separately
  - May be parallel or sequential
- Separate treatment is less effective (Drake et al, 2008)



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### Pharmacological Best Practices

- Medical professional trained in COD
- Works with client and team to support medication adherence
- Abstinence is not a requirement for medications



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### Pharmacological Best Practices

- Avoid prescribing addictive psychotropic medications
- Offer medications that may reduce addictive behavior
  - Naltrexone, et al
- Role of nursing...



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### Self-Help Participation & Active Linkage

- Practitioners connect clients in **active treatment or relapse prevention stages** with substance abuse and/or mental health self-help programs
- How might symptoms of SPMI affect an individual's experience of self help?



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### Program Checklist

- Do our providers understand Stress Vulnerability dynamics and implications for the Quadrant Model of COD?
- Are we taking Mental Status implications into account?
- Is our Diagnostic Assessment:
  - A process and not an event?
  - Longitudinal vs. Parallel?
- Is our programming Stage appropriate?



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### Program Checklist

- Are we providing sufficient, timely and targeted Outreach?
- Does our program accommodate the needs associated with multiple chronic illnesses, taking into account the interactive course of those disorders?
- Does our program accommodate those needs in an integrated (not parallel or sequential) manner?



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### Program Checklist

- Does our program incorporate individualized and structured harm reduction interventions when warranted?
- Does our program incorporate Pharmacological best practices?
- Does our program make appropriate and well informed use of Self Help resources?



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### Join Our Mailing List

create account | sign in

Online!



- Get connected to ...
- Training events
  - Educational resources
  - Consulting resources
  - Evaluation resources (fidelity & outcomes)
  - Professional peer-networks



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## Events & Stories

- Training events & online registration
- News about us and our collaborators
- Recovery stories told by consumers, family members, service providers, employers



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## Tools | Education & Advocacy

Booklets



Posters



Reminder Cards



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## Contact Us

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## Our Mission

The Center for Evidence-Based Practices at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people diagnosed with mental illness or co-occurring mental illness and substance use disorders.

Our technical-assistance services include the following:

- Service-systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Program evaluation (fidelity & outcomes)
- Professional peer-networks
- Research



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