2015-10-24

Integrating Recovery-Oriented Practices for Individuals with Co-Occurring Disorders: With Tobacco & Schizophrenia Case Example

Douglas M. Ziedonis
University of Massachusetts Medical School

Let us know how access to this document benefits you.
Follow this and additional works at: https://escholarship.umassmed.edu/sparc_multimedia

Part of the Mental Disorders Commons, Psychiatry Commons, and the Substance Abuse and Addiction Commons

Recommended Citation

This material is brought to you by eScholarship@UMMS. It has been accepted for inclusion in iSPARC Multimedia and Webinars by an authorized administrator of eScholarship@UMMS. For more information, please contact Lisa.Palmer@umassmed.edu.
Integrating Recovery-Oriented Practices for Individuals with Co-Occurring Disorders: With Tobacco & Schizophrenia Case Example

Douglas Ziedonis, M.D., M.P.H.
Professor and Chair
Department of Psychiatry
UMass Memorial Medical Center/
University of Massachusetts Medical School
President, UMass Memorial Behavioral Health Services
Professor, Graduate School of Nursing & Graduate School of Biomedical Sciences

SPARC Webinar Series
Wednesday, October 14th, 2015
Disclosures

- No financial arrangement or affiliation with pharmaceutical or devise commercial interests

- Research/Grants: National Institutes of Health; SAMHSA; Veterans Affairs; Massachusetts Department of Mental Health; Foundation for Mental Health Excellence; Physicians Foundation

- Advisory Boards: RiverMend Health; Skyland Trail

- Board of Directors: National Network Depression Centers; UMass Memorial Behavioral Health Services; Community Health Link; Marlborough Hospital; Massachusetts Hospital Association
Learning Objectives:

Learners will be able to:

1) create motivation-based, recovery-oriented treatment plans for co-occurring disorders

2) describe how to integrate recovery-oriented practices into their work, including dual recovery therapy, mindfulness-based interventions, MET, community resources, and 12-Step Facilitation

3) Case Example: Tobacco Use Disorder & Schizophrenia
COD: Common & Complex

- High Rates of COD
- Many Combinations of Psychiatric Diagnoses
- Increased Consequences
Integrated COD Treatment

- COD treatment outcomes improve with integrated treatments, programs, and coordinated systems and services
- Blend Psychosocial Treatments
- Medications for both MI & SA
  - Numerous Resources: SAMHSA Principles, CO-MAP, SAMHSA TIPS, APA & VA practice guidelines
- Recovery Orientation
  - Wellness oriented – tobacco, obesity, & stress
1. **Engagement**
   - welcome, access, meds & psychosocial treatment, community options and education

2. **Relationship Building**
   - collaborator in recovery process, empathic, hopeful, strength based, process of assessment and reassessment

3. **Shared Decision Making**
   - partnership, prognosis, risks & benefits, understanding of options, document process
Online Interactive Tool for Consumers

Are you Ready to quit smoking?

Guides consumer through options, what matters to them, and helps them to make a decision.

Tool to talk with clinician or loved ones about decision

Psychology of Taking Medications

- “Pills Fix Problems”
- Soothing – Quick
- Switch / Add an addiction in vulnerable individual
- How does it fit in working my program?
- Manage aversion to taking medications once in recovery for addiction
- Substances alter impact of Medications
4. **Screening & Assessment**
   - mental health, substance use, physical
   - adherence monitoring
   - laboratory findings

5. **Assessment of Co-Occurring Disorders**
   → Timeline – input from significant others
   → Substance induced disorders
   → Past History, Family History

6. **Integrated Interventions**
   - both “primary”
   - best practices – psychosocial & meds
### DSM-5 Criteria for Substance Use Disorders: 11 criteria (no abuse or dependence)

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV Abuse&lt;sup&gt;a&lt;/sup&gt;</th>
<th>DSM-IV Dependence&lt;sup&gt;b&lt;/sup&gt;</th>
<th>DSM-5 Substance Use Disorders&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous use</td>
<td>X</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Social/interpersonal problems related to use</td>
<td>X</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Neglected major roles to use</td>
<td>X</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Legal problems</td>
<td>X</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Withdrawal&lt;sup&gt;d&lt;/sup&gt;</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tolerance</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Used larger amounts/longer</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Repeated attempts to quit/control use</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Much time spent using</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physical/psychological problems related to use</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Activities given up to use</td>
<td>–</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Craving</td>
<td>–</td>
<td>–</td>
<td>X</td>
</tr>
</tbody>
</table>

<sup>a</sup> At least one criterion of DSM-IV Abuse is required.

<sup>b</sup> At least one criterion of DSM-IV Dependence is required.

<sup>c</sup> At least two criteria of DSM-5 Substance Use Disorders are required.

DSM-5 Substance-Related and Addictive Disorders

Substance Use Disorders (SUD)

- 11 criteria
- Severity (3 levels):
  - Mild: 2-3 symptoms
  - Moderate: 4-5
  - Severe: >6
- No poly-substance category
- Each substance a unique disorder

Ongoing COD Assessments: Dual Recovery Status Exam

- Assess current mental status
  → Psychiatric symptoms & withdrawal symptoms
- Assess last substance use
  → Cravings/thoughts
- Assess for motivational level/changes
- Assess treatment involvement
  → Medication compliance
  → Therapy
  → 12-step/recovery activities
Integrated Psychosocial: Dual Recovery Therapy

- Integrate and modify 4 traditional addiction psychosocial treatments
  - Motivational Enhancement Therapy
  - Relapse prevention
  - 12-Step facilitation
  - Mindfulness based interventions

- Blend evidence-based mental illness treatments
  - CBT
  - Social Skills Training

- Individual, group, couples, family therapy

- Many subtype examples: Seeking Safety, etc
MISSION-VET Implementation Materials

• DRT in MISSION
• www.missionmodel.org

• The Treatment Manual & The Consumer Workbook
7. **Treatment Readiness**
   - likely different levels of motivation
   - monitor for relapse

8. **Interdisciplinary Communication**
   - regular communication, team orientation, consistent message

9. **Integrated Treatment**
   - individualized treatment plan through person-centered planning process
Case Example #1: Schizophrenia & Tobacco Use Disorder

● 39 year old male patient
  → Doesn’t want to quit now, but willing to listen
  → Stable on Olanzapine 20mg per day
  → Other medical problems: obesity & hypertension

● Medical Examination
  → Expired CO = 43
  → BP 132 / 82

● Social and Family Histories:
  → Single & lives in group home with many smokers
  → No history of alcohol or drug use
  → Drinks 8 cups of coffee per day
Assessment & Treatment Plan

- Mental Health Assessment – MSE, meds, strengths
- Tobacco Use Assessment (Current & Past)
  - What using? how much?
  - Heaviness scale: TTF & Cig/day
  - Assess patterns of use – triggers, associations
  - CO meter or cotinine level
- Past quit attempts
- Current motivational level to quit / to engage in treatment
- Support or lack of support – social network
- Other medications, caffeine, substances & medical problems
Emerging Tobacco Products: Smokeless Tobacco Products

Electronic Cigarettes (E-Cigs)
E-Cigarette

- Not FDA approved
- Not proven as cessation aides – patients may use
- Could be harmful &/or addictive
- Attracting adolescents
  - Thousands of flavors, including candy, chocolate, bubble gum
- Technologically appealing
- Cost
  - $140 one month supply
Emerging Tobacco Products

- Hookahs and water pipes
- Little cigars
Past Quit Attempts

- Create timeline
  - Dates for each quit attempt
- Reason for quit attempt
- Method used to quit
- Duration using that method
- Withdrawal symptoms
- Understanding of relapse
Case - Tobacco History

- Started smoking at age 14
- Smokes 40 cigarettes per day
- Smokes in middle of night at times
- Smoke first cigarettes in 1 minute of waking
- 3 previous quit attempts
  - Quit for 4 weeks as part of acute hospitalization
  - Gum didn’t work 3 years ago
  - Tried Patch to quit about 9 months ago
    - Smoked with patch
- Currently ambivalent about starting to quit now
Assessing Motivation to Change

- Assessment strategies:
  - Importance, readiness, and confidence rulers
  - DARN-C (Desire, Ability, Reason, Need, and Commitment)
  - Decisional balance
  - Time-line/quit date
  - Counter-transference and non-verbal cues

- What level of motivation? Precontemplation, contemplation, preparation, action, maintenance

- Formal tools: SOCRATES and URICA

Treatment Plan

- Schizophrenia to problem list
- Add Tobacco Use Disorder to problem list
  - Consider motivational level
- Educational materials
  - Resources (Health and other consequences/benefits)
- Psychosocial treatment
  - What can you integrate?
- Medication treatment
  - Monotherapy
  - Combination therapy
- Community resources
Strategies for Lower-Motivated

● Feedback Tools & MET
● Behavioral Disconnects
● Wellness and Recovery Groups
  → Learning About Healthy Living Groups
● Nicotine Anonymous
Personalized Feedback: What Matters

- Carbon monoxide meter score and feedback
  - Big impact on patients
  - Short- & long-term benefits to quit
- Yearly cost of cigarettes
- Medical conditions affected by tobacco
- Links with other substance abuse & relapses

Advise: Relevance of Quitting

- Personalize the message
  - Better health
  - Fresher breath
  - More money
  - Role model
  - Freedom
  - More energy

- Impact on their family and social life
  - Environmental tobacco smoke (pets, friends, family, children, etc)

- Financial
  - Fewer sick days from work
  - Cost of cigarettes
MET = MI + Feedback

- **Motivational Interviewing (Style)**
  - Empathy, respects readiness to change, embraces ambivalence, and directive
  - OARS: Open-ended questions; affirmations; reflective listening; summaries

- **Personalized Feedback (Content)**
  - Assessment, including motivational level
  - Decisional balance: pros and cons
  - Personalized feedback
  - Change plan, shared decision-making, and menu of options

MET = Motivational interviewing and personalized feedback
Learning About Healthy Living

TOBACCO AND YOU

Jill Williams, MD
Douglas Ziedonis, MD, MPH
Nancy Speelman, CSW, CADC, CMS
Betty Vreeland, MSN, APRN, NPC, BC
Michelle R. Zechner, LSW
Raquel Rahim, APRN
Erin L. O’Hea, PhD

Free Online Resource
For Lower & Higher Motivated
Case Continues:

- Excellent progress in LAHL group & your use of personalized feedback. Now interested to quit and willing to try medications. Modify the Treatment Plan

- What Medication, Psychosocial Treatments, Community Resources would you consider?
10. Pharmacological Strategies & Drug Interaction / Toxicity

11. Medications & Crossover Benefits

12. Risk / Benefit Assessment
13. **Coordinated Treatment Approach**
   - medical comorbidities
   - coordinated treatments

14. **Relapse Prevention**
   - monitor signs of relapse
   - relapse analysis
Updated Treatment Plan

- Schizophrenia & Tobacco Use Disorder on problem list
  → update enhanced motivational level
- Educational materials
  → Resources / Health and other consequences/benefits
- Psychosocial treatment
  → What can you integrate?
- Medication treatment
  → Monotherapy
  → Combination therapy
- Community resources
  → Peer Support Specialists / NicA
Strategies for Higher Motivated

- 7 FDA-approved medications
  - Five nicotine replacement therapies (NRTs)
    - Patch, gum, spray, lozenge, inhaler
    - Bupropion
    - Varenicline
  - Psychosocial treatments
    - Cognitive-behavioral therapies
    - Mindfulness-based interventions
    - Social support

- Community resources
CBT: Relapse Prevention

- Identifying cues / triggers for substance use or cravings / thoughts
- Do an analysis of a “relapse”
- Goal to improve self-efficacy to avoid / handle specific people, places, things, moods, other addictive acts, etc
- Examples: Drug refusal skills, seemingly irrelevant decisions, managing moods / thoughts, and stimulus control

CBT = Cognitive Behavior Therapy
Integrating Mindfulness into Clinical Practice

- Enhanced Presence & Listening
  → Brief 5 minute Moments
- Mindfulness Based Stress Reduction (MBSR)
- Acceptance and Commitment Therapy (ACT)
- Mindfulness-Based Cognitive Therapy (MBCT)
- Dual Recovery Therapy (DRT)
- Dialectical Behavior Therapy (DBT)
  → “what” and “how” skills
- Mindfulness Based Relapse Prevention (MBRP)
  → Addiction Treatment & 12-Step Recovery
- Apps & websites & mp3s
Applied Mindfulness: RAIN

- **Recognize**
  → “I’m feeling anxious”

- **Accept/allow**
  → See if you are resisting the experience

- **Investigate**
  → “What’s happening in my body right now?”

- **Note**
  → Label or mentally note the body sensations from moment to moment

[http://www.mindful.org/mindful-magazine/craving-to-quit](http://www.mindful.org/mindful-magazine/craving-to-quit), Judson Brewer, MD, PhD author
Community Resources

- Quit lines (phone)
  → 1-800-QUIT-NOW

- Online (internet / apps)
  → www.becomeanex.org
  → www.quitnet.com
  → www.ffsonline.org

- Local treatment groups

- Nicotine Anonymous
  → In person meetings
  → Telephone meetings
  → Internet meetings
12-Step Facilitation

- Accepts disease model
- Encourages use of 12-Step social network, including sponsor and home group
- Coach “working their program”
- Fellowship and higher power are the agents of change - spirituality key
- Initial labeling of self as alcoholic is encouraged to address denial, minimization, and rationalization
- Abstinence model - loss of control with use
- Acceptance, Surrender, and Get Active
Is the Patient Working Their 12-Step Program?

- Working the steps
- Sponsor, mentor, or guide
- Group support and involvement
- Self-evaluation
- Spiritual Activity – Connection to Higher Power (prayer, meditation, ..)
- Daily reading or reflections
- Health care (recreation, exercise, diet, tobacco)
- Celebrate successes
- Being of service to others
Several different types of modified 12-step groups

Recovery concepts supports increased sense of hope and connection to others

Shared experience:
  → Experience, Strength, & Hope)

12-step phrases describe complex concepts in simple and easy way to remember
  → One day at a time
  → Stinking thinking
  → HALT (Hungry, Angry, Lonely, Tired)
  → Serenity prayer
Peer Support Specialists

- Consumer involvement on leadership committees, treatment, and engagement
- Genesis Club House
- www.NJChoices.org
- www.Rxforchange.org
- Wellness & Health Fairs
Principles of Pharmacology for Mental Illness in COD

- Avoid psychiatric medications with:
  - abuse liability
  - overdose risk
  - causing seizure
  - Sedation
  - liver toxicity

- Simplify dosing strategies (start low – go slow)
- Stress education and compliance
- Minimize refills
Principles of Pharmacology for COD

- Specificity of psychiatric & addiction disorders
- All medications are not created equal
  - Abuse liability - Benzos / Sedatives, Stimulants, Pain Medications
  - Safety - in general & when using substances
- Interaction with substances
  - Ex. MAOI & Stimulants
  - Few studies / lots of natural experiments
Focus on treating the mental illness(es)

Shared decision on psychiatric medication(s)
- Prior treatment, side effect profile, family history
- Likelihood of adherence
- **Substance Use / Addiction considerations**

Consider adding addiction treatment meds
- Specific for treating an Alcohol, Tobacco & Other Drugs Use Disorder
- Detox, Protracted Withdrawal, & Maintenance
Medication Treatments for COD in Addiction Settings

- Substance Detoxification
- Protracted abstinence
- Harm reduction / opioid agonists
- Co-occurring psychiatric disorders

Helpful Alcoholics Anonymous Brochure to give patients going to 12-Step Meetings:

-> The AA Member: Medications and Other Drugs, 1984
Medication Algorithm Considerations

- Patient preference
- Past experience
  - Failed monotherapy attempts
  - Incorrect administration of medication
  - Multiple failed attempts
- Medical comorbidities
- Severity of withdrawal & dependence
- Breakthrough cravings
- Oral cravings/hand-to-mouth motion
- Weight gain concerns
Medication Algorithm

- **Monotherapy (any of 7 FDA med choices)**
  - Varenicline
  - Patch
  - Oral NRT
  - Bupropion

- **Combination pharmacotherapy**
  - Multiple NRTS
    - Patch and oral NRT
  - Bupropion & NRT
Each cigarette contains about 13 mgs nicotine → About 1 – 3 mgs of nicotine are absorbed per cigarette

SMI tend to absorb the 2 – 3 mgs nicotine per cigarette → Higher CO and cotinine levels than expected

Some practitioners and researchers match cotinine level to nicotine replacement dosage

Example:

→ 3 packs per day = 20 cigarettes times 2 mgs per cigarette times 3 packs per day = 120 mgs nicotine
Smoking induces the P450 1A2 isoenzyme secondary to the polynuclear aromatic hydrocarbons.

Smoking increases metabolism of:
  - Haloperidol, fluphenazine, olanzapine, clozapine, thioridazine, chlorpromazine, etc
  - Caffeine is metabolized through 1A2

Check for medication side effects

Nicotine use alone (versus tobacco smoking) does not change medication blood levels (2D6)
  - Nicotine replacement therapy (NRT) does not affect medication blood levels
Reluctance to Prescribe Psychiatric Medications to Substance Abusers

- Worries about Toxic interaction
- Medication effect negated by drugs of abuse
- Manipulation
- Treating substance-induced symptoms
- Enabling
General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders

14 Principles for Prescribers

HHS Publication No. SMA-12-4689