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](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
Shared Decision Making
Online Tool: Tobacco Cessation and choice to use medicine

● 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>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>X</td>
</tr>
<tr>
<td>Social/interpersonal problems related to use</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Neglected major roles to use</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Legal problems</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Withdrawal&lt;sup&gt;d&lt;/sup&gt;</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Tolerance</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Used larger amounts/longer</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Repeated attempts to quit/control use</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Much time spent using</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Physical/psychological problems related to use</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Activities given up to use</td>
<td>–</td>
<td>X</td>
</tr>
<tr>
<td>Craving</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

<sup>a</sup> At least 1 criterion
<sup>b</sup> At least 3 criteria
<sup>c</sup> At least 2 criteria

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
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, 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
Dual Recovery Anonymous

- 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
Co-Occurring Disorder Pharmacotherapy in Mental Health Settings

- 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