SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 30—CO-OCCURRING DISORDERS, PART TWO
PAUL BRASLER, LCSW, CAIP
MARCH 8 & 10, 2022

Department of Medical Assistance Services
Welcome & Meeting Information

• WebEx participants are muted
• Please use the Q & A feature or the Chat feature if you have a question

• The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

• We do not offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Naloxone Resources

• Get trained now on naloxone distribution
  ▪ REVIVE! Online training provided by DBHDS every Wednesday
  ▪ https://getnaloxonenow.org/
    • Register and enter your zip code to access free online training
• Medicaid provides naloxone to members at no cost and without prior authorization!
• Call your pharmacy before you go to pick it up!
• Getting naloxone via mail
  ▪ Contact the Chris Atwood Foundation
  ▪ https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bba1b0&i=96A94A1A422
  ▪ Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website -
https://www.dmas.virginia.gov/#/artssupport
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven’t already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. [https://redcap.vcu.edu/surveys/?s=C8HERT9N3P](https://redcap.vcu.edu/surveys/?s=C8HERT9N3P)

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
WINTER 2022 WEBINARS

• Co-occurring Disorders, Part 2: 3-8, 10 – 11 AM & 3-10, 1 – 2 PM
• ASAM Criteria Assessment Dimension 4: 3-15, 10 – 11 AM & 3-17, 1 – 2 PM
• SUD Treatment for Adolescents: 3-22, 10 – 11 AM & 3-24, 1 – 2 PM
• ASAM Criteria Assessment Dimensions 5 & 6: 3-29, 10 – 11 AM & 3-31, 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
An initial/provisional diagnosis is usually made following the end of a full assessment.

This provides a “road map” for selecting initial treatment interventions and developing a more comprehensive/long-term treatment plan.

An accurate diagnosis is a **dynamic**, not static, process that usually proceeds through a process of elimination.

The diagnosis guides, but does not dictate, treatment.
Whenever possible, gather information from **collateral sources** in addition to the patient.

In cases when you are not certain, defer to the more conservative diagnosis (e.g., Unspecified depressive disorder instead of Major Depressive Disorder).

Always remember that individuals can differ dramatically in how they present with the same disorder.

Avoid allowing a cookie-cutter diagnosis to turn into cookie-cutter intervention planning and delivery.
When making a diagnosis, you must take the following into account:

• The symptoms **must** cause a significant disturbance in the individual’s life over a stated minimal timeframe that is specific to the diagnosis, (i.e., two weeks, six months, etc.)

• The disturbance **must** impact several of the patient’s life domains unless otherwise specified

• The disorder **cannot** be the result of a **medical condition**

• The disorder **cannot** be the result of a **substance of misuse or a medication**

*BASICALLY, FOLLOW WHAT IS IN THE DSM-5™*
• Over half the people (a low estimate in my opinion) with a serious mental illness also have a serious substance use problem

• **Co-occurring disorders** (which used to be called Dual Diagnosis) are defined as the existence of at least one independent major mental disorder and one independent SUD

• Since most mental illnesses and SUD symptoms are identical, it is often difficult to determine if the symptoms are because of a mental illness or the effects of a drug
DIFFERENTIATING SUBSTANCE-INDUCED MENTAL DISORDERS & NON-SUBSTANCE RELATED DISORDERS
Substance-Induced

- Admitted use of a substance
- No history of mental illness symptoms
- Short duration of symptoms
- Manifestation of symptoms occur at any time
- Variation in symptoms severity over several hours
- Cessation of symptoms when the substance is metabolized and excreted

Non-Substance Related

- No evidence of recent substance use (UDS results are unreliable)
- Documented history of mental illness symptoms
- Long duration of symptoms
- Manifestation of symptoms started in late-adolescence/early adulthood
- Little variation in symptoms over time
- Symptoms continue without treatment
SUBSTANCE-INDUCED MENTAL DISORDERS

• Alcohol-induced Depressive Disorder:
  • Alcohol-Induced Anxiety Disorder
  • Alcohol-Induced Bipolar Disorder
  • Alcohol-Induced Psychotic Disorder
  • Alcohol-Induced Neurocognitive Disorder (Dementia)
  • Alcohol-Induced Delirium
  • Alcohol-Induced Sleep Disorder
  • Alcohol-Induced Sexual Dysfunction

• Cannabis-Induced...
• Opioid-Induced...
• Stimulant-Induced...
• Hallucinogenic-Induced...
• Inhalant-Induced...
The following is a partial list of mental health disorders than can co-occur with substance use disorder:

- Anxiety Disorders
- Posttraumatic Stress Disorder
- Eating Disorders
- Personality Disorders (Cluster B)
- Attention Deficit Hyperactivity Disorder
“Individuals should be engaged in treatment that addresses their co-occurring psychiatric symptoms, even if the origin of the co-occurring mental disorder is unclear”

(SAMHSA, 2020, p. 126)
PTSD
Trauma
Anxiety
Survivor
Veteran
Memories
Stress
Flashbacks
Injury
Insomnia
Military
Violence
Sexual Assault
Therapy
Support
War
Mental Health
Exposure
Irritability
Danger
ANXIETY DISORDERS: OVERVIEW

• The disorders in this group constitute many of the common complaints that bring people to counseling

• **Fear**: Emotional response to a real or perceived threat

• **Anxiety**: Response/anticipation of future threat

• These feelings can lead to pervasive avoidance behaviors that also cause problems in everyday functioning

• These disorders differ from typical fear, anxiety and avoidance in that they are **excessive** and **persistent**

• Many of these disorders develop in childhood and tend to persist if not treated
PANIC DISORDER: DIAGNOSTIC FEATURES

• Panic attacks are abrupt and intense, with the symptoms often described as like a heart attack
  • Many of the accompanying or secondary symptoms are due to decreased oxygenated blood because the person has hyperventilated during the panic attack
• Panic attacks are often unexpected, with no obvious triggers
• Expected panic attacks often occur because the person is triggered by cues from a previous panic attack
• Frequency and severity can vary
• Many people with panic attacks worry that their symptoms are signs of serious underlying medical problems
GENERALIZED ANXIETY DISORDER: DIAGNOSTIC FEATURES

• Excessive worry and anxiety about nearly everything and nothing seems to alleviate the anxiety
• Females are twice as likely as males to experience symptoms
• People with GAD often develop depressive disorders
• Prevalence peaks at middle age, then declines
• I highly recommend that this diagnosis be used rarely, reserved for people who exhibit nearly all the symptoms for over six months and who are truly disabled by anxiety
• In children, GAD may manifest as a performance anxiety
POST TRAUMATIC STRESS DISORDER & ACUTE STRESS DISORDER: DIAGNOSTIC FEATURES

- The primary difference between PTSD and ASD is the length of time in which symptoms are present
  - ASD can be diagnosed 3 – 30 days following a traumatic event
  - PTSD can be diagnosed 30 days or more from the traumatic event
- Most people who experience a trauma will not develop either ASD or PTSD
  - Likewise, many people who are diagnosed with ASD do not progress to PTSD
- As we saw in the first section, the connection between trauma and SUD is substantial
PTSD & ASD DIAGNOSTIC FEATURES (SAMHSA, 2020, P. 86)

• **Intrusive, persistent re-experiences of the trauma**, including recurrent dreams or nightmares, flashbacks, and distressing memories

• **Persistent avoidance** of people, places, objects, and events that remind the person of the trauma or otherwise trigger distressing memories, thoughts, feelings, and physiological reactions

• **Negative alterations in cognitions and mood**, such as memory loss (particularly regarding details surrounding the event), self-blame, guilt, hopelessness, social withdrawal, and an inability to experience positive emotions

• **Marked alterations in arousal and reactivity**, such as experiencing sleeplessness or feeling “jumpy,” “on edge,” easily startled, irritable, angry, or unable to concentrate
SUBSTANCES THAT CAN MIMIC ANXIETY OR TRAUMA DISORDERS

- Stimulant use, overdose, or withdrawal
- Opioid Withdrawal
- Alcohol Withdrawal
- Benzodiazepine Withdrawal
- Panic during the use of hallucinogens, entactogens, or dissociates
- Adverse reactions to cannabinoids
TREATING CO-OCCURRING SUD & ANXIETY/TRAUMA DISORDERS

• “As a general rule, PTSD [and anxiety disorders] assessment should be conducted after a patient has emerged from acute alcohol or drug intoxication and withdrawal” (Herron & Brennan, 2015, p. 525)

• Group settings may be overwhelming to clients with anxiety and/or trauma disorders

• CBT approaches have proven successful in treating anxiety disorders and SUD

• Medical approaches should address potential abuse of medications, particularly benzodiazepines and drug-drug interactions
TREATING CO-OCCURRING SUD & ANXIETY/TRAUMA DISORDERS

• In the case of trauma-related disorders, trauma-informed care is essential throughout all phases of treatment
• Traumatic memories are often a trigger for the client to use, so establishing safety is imperative...
• ...but trauma and SUD can be treated concurrently
• One option is Seeking Safety: “A 25-session, present-focused, manualized treatment that provides psychoeducation, teaches coping skills, and helps clients gain more control over their lives” (Herron & Brennan, 2015, p. 527)
Eating disorders
EATING DISORDERS: AN OVERVIEW

• Eating disorders, particularly Anorexia Nervosa and Bulimia Nervosa, are some of the most serious mental health disorders
  • Mortality amongst individuals with these disorders is higher than nearly all other mental health disorders
  • This includes a higher risk of suicide
• Clinicians should not treat an individual with an eating disorder unless they have received professional training in treating people with Eating Disorders AND they are working as part of an interdisciplinary team that includes (at the very least) a medical provider trained in treating people with Eating Disorders and a Registered Dietician
ANOREXIA NERVOSA DIAGNOSTIC FEATURES

• “Individuals with anorexia nervosa (AN) are characterized by extremely low body weight for their age and height and are often adamant in their denial of the disorder” (Herron & Brennan, 2015, p. 529)
  • The person’s fear of gaining weight is profound, even when the individual is critically underweight
• There are two sub-types of AN:
  • Binge-Eating/Purging Type: “The weight loss and body image distortions are accompanied by binge eating and purging (vomiting, laxatives, etc.)” (Frances, 2013, p. 145)
  • Restricting Type: Very little energy is consumed
• Elevated suicide risk along with potential medical problems (e.g., emaciation, arrhythmias, hypotension, dehydration, loss of bone mass, growth retardation) are primary concerns
BULIMIA NERVOSA DIAGNOSTIC FEATURES

• Individuals with BN are typically within the normal weight to overweight BMI range
• Excessive concern for body weight, shape and size
• Binging and compensatory behaviors are key components of BN:
  • “Binges are periodic, concentrated, and extraordinary ‘pig-outs’” (Frances, 2013, p. 147)
  • Purging is one subtype of BN, with vomiting the most common way of purging (enemas, laxatives and diuretics are also used)
  • Non-purging behaviors include excessive exercise and fasting
• A higher prevalence of BN than AN in the general population
  • Greater co-morbidity with SUD and BN (Gregorowski et al., 2013)
  • People can vacillate between AN and BN (Frances, 2013)
“Patients with eating disorders who abuse substances demonstrate worse ED symptomatology and poorer outcomes than those with EDs alone, and the presence of an ED in SUD patients leads to greater severity of substance abuse and poorer functional outcomes”

(Gregorowski et al., 2013, p. 7)
"The strongest message conveyed in current literature is the importance of screening and assessment for co-morbid SUDs and EDs in patients presenting with either disorder" (Gregorowski et al., 2013, p. 7)

- The Eating Disorder Examination Questionnaire (EDE-Q 6.0) is a reliable screening tool (Berg et al., 2012)

- Concurrent treatment is highly recommended for co-occurring SUD and EDs (SAMHSA, 2020)
  - But given the lack of programs, SUD may need to be addressed first

- Clients with AN may require medical hospitalization to stabilize and treat medical issues related to their AN
  - This may include re-hydration and refeeding

- Individual and family therapies are often utilized for EDs & SUDs
  - CBT is often utilized as a treatment approach
PERSONALITY DISORDERS

• **Cluster A: Odd or Eccentric (Psychotic)**
  - Paranoid Personality Disorder
  - Schizoid Personality Disorder
  - Schizotypal Personality Disorder

• **Cluster B: Dramatic, Emotional or Erratic (Mood)**
  - Antisocial Personality Disorder
  - Borderline Personality Disorder
  - Histrionic Personality Disorder
  - Narcissistic Personality Disorder

• **Cluster C: Anxious or Fearful (Anxiety)**
  - Avoidant Personality Disorder
  - Dependent Personality Disorder
  - Obsessive-Compulsive Personality Disorder
PERSONALITY DISORDERS

- There is high comorbidity between Cluster B Personality Disorders, and low comorbidity with Cluster A and Cluster C PDs
  - Co-occurring SUD and Antisocial PD is more common in men
  - Co-Occurring SUD and Borderline PD is more common in women
- Cloninger (2000) focuses on four core features that are suggestive of any PD (as cited in Herron & Brennan, 2015, p. 520):
  - Low self-directedness
  - Low cooperativeness
  - Low affective stability
  - Low self-transcendence (unstable self-image, emptiness and erratic world view)
BORDERLINE PERSONALITY DISORDER DIAGNOSTIC FEATURES

• Extreme impulsivity, including self-injurious behaviors that are typically not truly suicidal in nature
  • But because suicidal behaviors are common, death by suicide (sometimes accidental) is between eight and 10% of patients
• Easily bored
• Can be very rude, sarcastic, and demanding
• Typically undermine their own successes
• Symptoms tend to decrease in middle adulthood
• Difficult for many clinicians to develop empathy for people with BPD because of their unstable moods
BORDERLINE PERSONALITY DISORDER DIAGNOSTIC FEATURES

• Diagnosed more often in women than men (3:1 ratio)
• The fear of abandonment is intense—a person with BPD finds being alone intolerable
  • “I hate you, don’t leave me; I love you, get away from me!”
• Dramatic, sudden and intense changes in how the person defines or expresses themselves
• People (including how the individual sees themselves) are seen in black and white, but they can change “sides” quickly
• Stability is elusive
KEYS TO WORKING WITH PEOPLE WITH BORDERLINE PERSONALITY DISORDER

• Set limits at the beginning of treatment: This includes all outside-of-session contacts (unless this is a proscribed treatment modality like Dialectical Behavioral Therapy)

• You will likely be lavishly praised at the start of treatment; do not allow your ego to take control

• You will then be denigrated, often for no discernible reason; do not take it personally

• These individuals are usually in a state of perpetual crisis or near-crisis; you remain calm

• Likewise, their focus on their treatment will likely be all over the place: Set goals and objectives and stick with them; I recommend a CBT or DBT approach
ANTISOCIAL PERSONALITY DISORDER: DIAGNOSTIC FEATURES

• The key aspect with ASPD is a pervasive (some say complete) disregard for the rights of others and a pattern of violating said rights in numerous settings

• The person must have some of the symptoms of Conduct Disorder before the age of 15 (I often ask adults if they have ever been in jail or prison, and why they were incarcerated)

• Be especially aware of aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules
ANTISOCIAL PERSONALITY DISORDER: DIAGNOSTIC FEATURES

- The manipulation and deceitfulness always lead to personal gain
- The person does not appear to learn from the consequences of their previous choices
- The person with APD always seems to have an excuse: “I saw it, I wanted it, so I took it”
- The person can be rude, even abusive, or they can be extremely charming and disarming
- Total lack of empathy; often blames others for their shortcomings
- More common in males; may become less severe as the individual ages
- May be mis-applied to people with lower SES
NARCISSISTIC PERSONALITY DISORDER: DIAGNOSTIC FEATURES

• People with NPD often assume that others feel the same way about themselves as they do
• They are entitled: Often insist on having “the top” doctor, teacher, etc. for them or their family
• Only form relationships with others who “measure up” and who can help them get “to the top”
• Oblivious to the hurtful things they can say
• Envious of others when they succeed
• Self-esteem is incredibly fragile
• Much more common in men
KEYS TO WORKING WITH PEOPLE WITH ANTISOCIAL PD OR NARCISSISTIC PD

• If you directly challenge their “superiority,” they will usually quit treatment; instead, ask a lot questions

• It is okay to allow them to be the “expert…”

• ...But do not allow them to bully you

• Calmly set the expectations for treatment at the beginning, especially if you are working with a couple or a family—and stick to the limits you set

• Remember at the core is a person whose ego is fragile; when “cornered,” they will attack (usually verbally, rarely physically)

• Do not take anything personally

• The individual will usually blame others for their problems: I suggest a Motivational Interviewing approach
TREATING SUD & PERSONALITY DISORDERS

• SUD treatment, both individual and group, is compatible with Dialectical Behavioral Therapy, which is designed to address Borderline Personality Disorder

• Peer-led recovery groups can also be beneficial

• Clients with PD can overwhelm therapeutic groups with their emotional flooding, so facilitators may need to be more active and directive in groups if this occurs

• Likewise, some people with PD can be overwhelming to you as a clinician, so be mindful of transference and counter-transference issues and seek supervision as needed
ATTENTION DEFICIT HYPERACTIVITY DISORDER
ATTENTION-DEFICIT HYPERACTIVITY DISORDER: DIAGNOSTIC FEATURES

• Persistent problems maintaining attention, giving attention to details, and following-through on tasks
• The client does not seem to be listening when spoken to directly
• Disorganized, forgetful and easily distracted
• Avoids things that require sustained attention
• Talks excessively, has a hard time sitting still, or waiting their turn
• “Fidgets” and “always seems to be ‘on the go’”
• Low frustration tolerance, irritability or mood lability are common
ATTENTION-DEFICIT HYPERACTIVITY DISORDER: DIAGNOSTIC FEATURES

• Persistent symptoms in a variety of settings is the key to an accurate diagnosis
• ADHD begins in childhood and several symptoms must be present before age 12 (in DSM IV it was age seven)
• Adult recall of childhood symptoms is unreliable
• The diagnosis should not be made unless information has been obtained from collateral sources (not just what the patient says)
• There are no biological markers for ADHD
ATTENTION-DEFICIT HYPERACTIVITY DISORDER: COURSE

• Prevalence is about 5% of children and 2.5% of adults
• Excessive motor activity can be observed before age four, but it is difficult to distinguish from typical toddler behaviors
• The disorder is relatively stable through adolescence, but hyperactivity tends to decrease
• More frequent in males than females, about a 2:1 ratio
• Consequences are primarily reduced performance and attainment, an increase in substance use and greater likelihood of incarceration
TREATING CO-OCCURRING SUD & ADHD

- Consider using non-stimulant medications to address ADHD symptoms, specifically for clients who are currently misusing drugs.
- Stimulants can be considered for patients who are in sustained recovery:
  - Be aware of possible diversion of prescription medications.
- CBT can be helpful in addressing negative thought-processes.
- Group therapy can be helpful, but people with ADHD may find it challenging to sit through groups.
Here is the link to the Post-Webinar Survey. It should take you less than 5 minutes to complete: https://redcap.vcu.edu/surveys/?s=W4P4ANWYK7

• Your name and contact information will not be linked to your survey responses.
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