VIRGINIA MEDICAID: 29—
CO-OCCURRING DISORDERS, PART ONE
PAUL BRASLER, LCSW, CAIP
MARCH 1 & 3, 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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• Last revision: January 17, 2022
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/](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=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&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.
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.
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If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at [Lori.keysermarcus@vcuhealth.org](mailto:Lori.keysermarcus@vcuhealth.org) or (804) 828-4164. Thank you for helping us with this effort!
WINTER 2022 WEBINARS

• Co-occurring Disorders, Part 1: 3-1, 10 – 11 AM & 3-3, 1 – 2 PM
• 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:

- Schizophrenia
- Bipolar Disorders
- Major Depressive 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)
SCHIZOPHRENIA
• Schizophrenia is one of the most variable mental health disorders
  • Its symptoms overlap many other disorders, and none of the symptoms that define schizophrenia are specific to schizophrenia alone—they occur with many other disorders as well
  • At the same time, two people can have schizophrenia with completely different symptom-sets
• Despite older views that schizophrenia only starts in late adolescence or early adulthood, more contemporary views agree that schizophrenia can occur any time during and after adolescence
• “About 50% of clients with schizophrenia abuse substances; 75% have tobacco use disorder” (Herron & Brennan, 2015, p. 505)
Delusions

Hallucinations

Disorganized Thinking or Speech

Grossly Disorganized Behaviors

Negative Symptoms
DELUSIONS

• **Fixed false beliefs** that involve a misinterpretation of perceptions or experiences
• May involve a variety of themes, with persecutory being the most common
• **Ideas of reference** are also common, in which the person believes that certain gestures, television shows, song lyrics or environmental cues are specifically for them
• **Bizarre** delusions are clearly implausible
• “The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity” (APA, 2013, p. 87)
HALLUCINATIONS

• Occur with any sense, but the most common with organic psychotic disorders are **auditory hallucinations**
• Not under voluntary control
• Usually experienced as voices that are distinctly outside of the person’s thoughts
• Certain types of auditory hallucinations, especially command hallucinations or voices making a running commentary on the person’s thoughts or actions, are indicative of schizophrenia
• Not all strange perceptual experiences are psychotic
  • Illusions are misconceptions of actual sensory stimuli—these happen all the time
• Hallucinations are generated in the brain in the absence of any external stimuli
DISORGANIZED THINKING/SPEECH

• The person may move from one topic to another (tangential thinking, loose associations)
• Answers to questions may be partially or completely unrelated to the question
• May be so severe that the person does not make any sense at all (word salad)
GROSSLY DISORGANIZED BEHAVIOR

• A variety of behaviors from childlike actions to unpredictable agitation

• Problems may be noted in any goal-directed behavior, leading to problems with performing activities of daily living (e.g., maintaining hygiene)

• The person may appear to be disheveled, dressed inappropriately for the weather, or act bizarre
NEGATIVE SYMPTOMS

Affective flattening: The person’s face appears flat and unmoving, with poor eye contact and body language.

Alogia: Brief, empty replies, decreased productivity of speech.

Avolition: The person may sit for long periods of time, showing little interest in work or social activities.
SCHIZOPHRENIA: DEVELOPMENT & COURSE

• Psychotic symptoms typically emerge between late teens and early 30’s
  • Onset before adolescence is extremely rare
  • Later-onset cases are more likely to be female
• There is usually a slow and gradual onset of symptoms
  • Depression is often present
  • Some cognitive impairment may also be present
• Effective, sustainable treatment options remain limited
  • Some people can improve, but the majority require some level of assistance
• We are still unable to determine what specifically causes schizophrenia
SUBSTANCES THAT CAN MIMIC PSYCHOTIC DISORDERS

• Stimulants (some more than others) at either regular levels or overdose
• Anabolic steroids
• Inhalants
• Cannabis (in some individuals); synthetic cannabinoids are more likely to cause psychosis
• Hallucinogens, Dissociates, Entactogens
• Alcohol: Wernicke-Korsakoff syndrome
• Depressant withdrawal syndrome
TREATING CO-OCCURRING SUD & SCHIZOPHRENIA

• Case management (or care coordination) is important to ensure that services are delivered consistently (especially when provided by separate agencies) to ensure treatment continuity

• Medication adherence is often necessary for people with psychotic disorders

• Some programs have case managers who visit clients daily to ensure they are safe, have enough to eat, are taking their medication, assess transportation needs, etc.

• Even outside such intensive services, CM can help with housing issues, along with food resources, medical concerns

• It is important to help the client create structure (e.g., a daily routine/structure) while also protecting the client’s rights
CASE STUDY: GERALD

Gerald is a 20-year-old male who is brought to you by his family, with whom he lives. He has not slept in four days but says there is nothing wrong with him. The patient’s family states Gerald spends most evenings pacing around the house. Gerald has not been caring for his personal hygiene, and this is not typical for him. The family notes that for the past six months, Gerald has become increasingly paranoid. He spends most nights peering between the drawn shades in the front windows of their house. One year ago, his best friend was shot and killed as he stood next to Gerald on a street corner. Gerald has been smoking cannabis three to four times a day for the past two years.
MOOD DISORDERS: MAJOR DEPRESSIVE & BIPOLAR DISORDERS
Major Depressive Disorder

Diagnostic Features

• Can present with either increased or decreased appetite, and increased or decreased sleep
• Increased agitation and anger outbursts are not uncommon
• Sense of worthlessness or guilt is often present
• Individuals may misinterpret normal daily incidents as evidence to support their negative self-concept
• Difficulty concentrating and/or making even simple decisions is a common symptom
• Thoughts of death and suicidal ideation are common
MAJOR DEPRESSIVE DISORDER

DIAGNOSTIC FEATURES

• Affective symptoms include tearfulness, irritability, brooding
• Excessive worry, even anxiety can be common
• Phobias, somatic complaints, and chronic pain symptoms can also occur
• Suicide is one of the possible mortality outcomes of depression (about 10%)
  • Untreated depression, even if it does not result in suicide, leads to higher mortality due to medical illness
• Fatigue or insomnia are usually presenting symptoms
• For some people with mild depression, they may appear to be functioning normally but doing so causes them to expend a lot of energy
MAJOR DEPRESSIVE DISORDER: PREVALENCE, DEVELOPMENT & COURSE

• 7% of people in the US suffer a Major depressive disorder each year (2 – 3% of children experience a MDD)
• Females are diagnosed with depression twice as much as males
• However, studies note no gender differences in phenomenology, course or treatment response
• Likeliness of onset is with or after puberty
• Variable course, and variable severity among individuals
• Many bipolar disorders begin with a depressive episode
• Depression increases in frequency with age
SUBSTANCES THAT CAN MIMIC DEPRESSIVE DISORDERS

• Chronic or excessive alcohol use, including alcohol intoxication and withdrawal syndromes
• Stimulant withdrawal
• Cannabis withdrawal
• Resolution phase of entactogens and hallucinogens
BIPOLAR I DIAGNOSTIC FEATURES (MANIC EPISODE)

• An abnormally, persistently elevated, expansive or irritable mood and persistently increased activity and energy that is present for most of the day, nearly every day, for a period of at least one week
• Mood is often described as “feeling on top of the world,” or “feeling high without drugs”
• Rapid shifts in mood may occur (happy, sad, angry, repeat...)—this is called lability
• May engage in multiple, overlapping projects, generally using goal-directed behaviors
• Inflated self-confidence to supreme grandiosity can occur
BIPOLAR I DIAGNOSTIC FEATURES
(MANIC EPISODE)

• Engaging in risky or dangerous behaviors may be present
• Decreased need for sleep is a major indicator
• Speech is often loud and pressured—another person cannot get a word in edgewise
  • The speech itself may make no sense, and include singing; lots of drama
• If the person is irritable, their speech is often hostile, threatening and abusive, leading people close to the patient saying, “this is not at all like him; he never says things like that”
• Racing thoughts are often present
• Following the end of a manic episode, the patient may transition into a hypomanic episode, a depressive episode, or may return to a sense of normalcy (euthymia)

• Many people go from mania to severe depression

• The use of substances can co-occur with Bipolar I disorder, and the clinician needs to be careful to not label the effects of a stimulant or another inebriant as a manic episode

• Individuals experiencing a full-blown manic episode often require hospitalization for stabilization
BIPOLAR I: PREVALENCE, DEVELOPMENT & COURSE

• Roughly 0.6% of the US population meets criteria for Bipolar disorder each year
• Mean age of onset is 18 years of age
• More than 90% of people who have a single manic episode will go on to experience another mood episode
• Individuals with Bipolar I disorder who have four or more mood episodes in a single year (separated by periods of remission) are referred to as “rapid cycling”
• 10 – 15% of people with Bipolar I complete suicide
SUBSTANCES THAT CAN MIMIC A MANIC EPISODE/BIPOLAR DISORDER

- Stimulants (any kind)
- Cannabis (in some individuals)
- Hallucinogens
- Dissociates
- Depressant paradoxical stimulant reactions in some individuals
TREATING CO-OCCURRING SUD & MOOD DISORDERS

• Current practice is to treat the SUD and then evaluate mood disorder symptoms when the client is not intoxicated or in acute withdrawal
  • If the symptoms persist beyond acute withdrawal, then evaluate for possible medical treatment of the mood disorder
• Psychotherapy (group and/or individual), in addition to appropriate medication therapy, is often the most helpful
• Case management can help clients determine what additional needs they may have and help the client connect with resources
• Help the client navigate peer groups that have outdated or biased views against the use of medication and treatment to address mood disorder symptoms
CASE STUDY: DEE

Dee is a 28-year-old female who states that she has bipolar disorder and feels out of control. She has never heard the term “manic episode” before but admits that “I get like that when I smoke cocaine,” which she used last night. She is prescribed Prozac and Xanax by her psychiatrist. Dee describes her symptoms as “being happy one minute and sad or angry the next.” Dee also states, “I have an anger management problem!” She receives disability payments for her bipolar disorder. Further discussion reveals that she was molested for much of her childhood by her step-father. When she reported this to her mother, her mother beat her and threw her out of the home.
Post-Webinar Survey

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