Identifying Co-occurring Conditions Among Adult Populations

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OVERRIDING PRINCIPLES

- Clinicians make diagnoses – instruments don’t
- Instruments are tools to be used by clinicians
- Clinicians are not servants to tools
- Clinicians make decisions – tools don’t
Co-occurring Prevalences

- Many adults presenting for services have co-occurring conditions requiring treatment for both
- Some with substance use disorders have substance induced MH problems
- Some with MH conditions self-medicate and experience substance related problems
- Some have independently occurring conditions
- Exact rates will vary with setting and population
NIMH Epidemiologic Catchment Area Study Lifetime Prevalence

N = 18,571 ADULTS

Primary Psychiatric Disorders

Drug or Alcohol Abuse

28% have both

Goodwin, F.K., J.A.M.A., 1989; 261:3517
NIMH Epidemiologic Catchment Area Study Lifetime Prevalence

N=18,571 ADULTS

71% have both Primary Alcohol or Drug Abuse and Psychiatric Disorders

Goodwin, F.K., J.A.M.A., 1989; 261:3517
Screening vs.
Diagnostic Assessment

- Screens provide probability estimates.
- Screens should be fast, cheap, and easy to use by those who are not necessarily experts in the area under consideration.
- Diagnostic assessment should be as complete and definitive as possible.
- Professionals with expertise in the area in question determined diagnoses.
WHEN TO SCREEN?
WHEN TO ASSESS?

- Screen for what is NOT the presenting complaint or problem area.
- Screen for common problems other than the presenting complaint
  - Addiction programs screen for MH
  - MH clinics screen for addictions
- Do an assessment for the presenting complaint or problem area and for positive screen results.
The UNCOPE

U – Have you spent more time drinking/using than intended? (Unintended Use)

N – Have you ever neglected usual responsibilities because of using?

C – Have you ever wanted to cut down on drinking/using?

O – Has anyone objected to your drinking/use?

P – Have you found yourself thinking a lot about drinking/use? (Preoccupied)

E – Have you ever used to relieve emotional distress, such as sadness, anger, or boredom?
UNCOPE: A Brief Screen for Substance Use Disorders

- Six items used in screening adults and adolescents for any substance use disorder
- Free – from Evince Clinical Assessments [research tab at www.evienceassessment.com]
- Three or more positive responses indicate risk for dependence
- Sensitivity for dependence = 86% to 90%
- Specificity = 82% to 87%
SCREENING FOR MENTAL HEALTH CONDITIONS

- More complicated due to diversity of conditions and symptoms involved
- Routine screening for the most common conditions associated with addictions
- Screening or an initial assessment of rarer conditions only if there is some suspicion of a problem
COMMON CO-OCCURRING MENTAL HEALTH CONDITIONS

- Affective disorders – depression & mania
- Anxiety disorders – PTSD, generalized anxiety, phobias, panic attacks
- Personality disorders – antisocial, obsessive-compulsive, borderline
STRATEGIES FOR MENTAL HEALTH SCREENING

- No simple universal screens due to scope and diversity of conditions
- Cover key symptoms of common conditions (e.g., depressed mode for a week or more, experienced a traumatic event, etc.) in psychosocial interview
- Use a structured interview covering common problems – more than a screen, but time efficient
Common Errors in Diagnostic Interviewing for Addictions

- Preoccupation with quantity of use
- Use of vague/poorly defined terms
- Asking clients to make value judgments
- Overemphasis on family history
- Getting into other treatment issues
PRIORITIES FOR DIAGNOSTIC / PROBLEM ASSESSMENT

- Focus on DSM-5 diagnostic criteria
- Document nature and extent of problems and conditions
- Determine if additional assessments or consultations are required
- Determine initial appropriateness of the client for the program options available.
ASSESSMENT vs. THERAPY

- Assessment goal: Objective data collection
- Assessment is NOT therapy
- Complete assessment first
- Buy in is not initially expected or required
- Engagement can develop based on assessment feedback, that is assessment can be therapeutic
ASSESSMENT PRINCIPLES

- Simple, direct, concrete questions
- Logical, natural flow
- Friendly, neutral tone
- Matter-of-fact presumptive wording
- Minimal probing on initial interview
INITIAL INTERVIEW

REQUIREMENTS

- Cover all 11 criteria substance use disorders
- For MH cover sufficient content to meet minimal diagnostic criteria for common conditions
- Use concrete, specific, and unambiguous questions
- Document, document, & document
WHY A STRUCTURED INTERVIEW?

- Eliminates problems caused by illiteracy
- Guarantees systematic content coverage
- Get more information in less time
- Measure for judging respondents consistency of reporting
- Documents specific responses
- Facilitates outside verification
- Foundation for standard communication
INITIAL INTERVIEW OPTIONS

- Develop your own structured interview tailored to your population
- Use a good commercially available interview that has sound clinical properties and is practical for your use
- Some combination of a standard tool plus questions to address unique issues for your population
- Tools and procedures for adults may not be appropriate for adolescents
ADULTS VS. ADOLESCENTS

- Adults are often more willing to talk about substance use than mental health issues.
- Adolescents are typically least willing to talk about substance use but more willing to talk about emotional discomforts and issues other than substances.
- The strategy is to begin with what the typical individual is most open to discussing and move to more sensitive issues during the interview.
CAAPE: Comprehensive Addiction and Psychological Evaluation

- Used in this presentation as an example of a structured interview

- Characteristics include:
  - Logical order of inquiry
  - Ability to be administered in 45-50 minutes
  - Can be used by people not credentialed in both MH and SUD for initial information gathering
CAAPE Order of Inquiry

- Substance use disorders
- Axis I (all but psychosis)
- Axis II
- Psychosis indications
Axis I Mental Health Conditions Covered by the CAAPE

- Depression
- Mania
- Panic disorders
- Anxiety and phobias
- Posttraumatic stress disorder
- Obsessive-compulsive disorder
Axis II Personality Disorders
Covered by the CAAPE

- Antisocial – thoroughly covered

Screening for the following:

- Paranoid
- Schizoid
- Borderline
- Dependent
- Obsessive-compulsive – different from Axis I condition with similar name
SUDDS-IV Prevalence of Substance Dependence Among US Inmates

- Any dependence
- Alcohol
- Marijuana
- Cocaine
- Stimulants
- Heroin

N = 7682
CAAPE Prevalence of Substance Dependence Among UK Inmates

N = 155
CAAPE PREVALENCE OF SUBSTANCE DEPENDENCE AMONG EVALUATION CASES

40 Individuals Evaluated at a Treatment Program

- Any dependence
- Alcohol
- Cocaine
- Heroin
- Marijuana
- Stimulants

80%
60%
40%
20%
0%
PREVALENCE OF PROBABLE AXIS I CONDITIONS AMONG UK INMATES

N = 155
AXIS I CONDITIONS AMONG SUBSTANCE DEPENDENT US JAIL INMATES

N = 176
PROBABLE AXIS I CONDITIONS AMONG TREATMENT CASES

N = 40
PRESENCE OF PROBABLE AXIS II CONDITIONS AMONG UK INMATES

N = 155
PROBABLE AXIS II CONDITIONS AMONG DEPENDENT US INMATES

N = 155
PROBABLE AXIS II CONDITIONS IN TREATMENT SAMPLE

N = 40
CAAPE Findings for Probable Conditions Among Inmates

N = 155
CAAPE Findings for Probable Conditions in Treatment Sample

N = 40
<table>
<thead>
<tr>
<th>Condition</th>
<th>UK</th>
<th>US</th>
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<tr>
<td>Alcohol Dependence</td>
<td>.96</td>
<td>.92</td>
</tr>
<tr>
<td>Cocaine Dependence</td>
<td>.95</td>
<td>.96</td>
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<tr>
<td>Major Depression</td>
<td>.91</td>
<td>.94</td>
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<tr>
<td>Manic Episodes</td>
<td>.89</td>
<td>.87</td>
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<tr>
<td>Panic Attacks</td>
<td>.87</td>
<td>.93</td>
</tr>
<tr>
<td>PTSD</td>
<td>.78</td>
<td>.87</td>
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</table>
IMPLICATIONS OF STATISTICS

- Prevalence for conditions vary from population, but similar patterns emerge.
- Prevalence rates of common conditions provide rationale for routine preliminary assessment.
- Internal consistence reliability is a function of how uniform or consistent a syndrome a condition presents.
CATEGORICAL VS. DIMENSIONAL VIEW OF DISORDERS

- Dimensional – symptoms and problems fall on a continuum – usually in a normal distribution.
- Categorical – distinct syndromes emerge such that those with a condition are distinct from those without it.
- Can have categorical syndromes with varying levels of severity within each.
Examples of Categorical vs. Dimensional Indications

- **Dimensional distribution:** conduct disorder and generalized anxiety and phobic disorders.

- **Categorical distribution:** major depression, manic episodes, and substance dependence.
Positive Dependence Criteria For Dependent Cases – SUDDS-IV

- Cocaine: N=854
- Marijuana: N=1389
- Alcohol: N=2265
- Heroin: N=183
Positive Abuse Criteria For Abuse Cases – SUDDS-IV

% of Cases

Positive Abuse Criteria

Cocaine N=303
Marijuana N=936
Alcohol N=1193
Heroin N=32
Positive Dependence Criteria For Alcohol Dependent Cases

The graph illustrates the percentage of cases with positive dependence criteria across different dependence criteria levels for CAAPE UK, CAAPE WI, and SUDDS MN. Each line represents a different region or study, showing the trend of cases increasing with higher dependence criteria levels.
Clinical Implications and Treatment Planning
Dependence vs. Abuse
Mild vs. Severe

- Dependence and abuse are distinct conditions—not just variations in severity.

- The same will be true for mild vs. severe designations of the DSM-5.

- Dependence has different prognoses and treatment goals as compared to abuse.

- Dependence is a requirement for residential placement according to ASAM PPC-2R.
Importance of Documenting Repeated/Multiple Problems

- The DSM criteria require a pattern of use plus repeated problems related to the substance in question.

- The same problem may occur repeatedly or different problems may be associated with a given substance.

- To qualify for a diagnosis, problems cannot all be associated with a single incident.
A Word on Blackouts

- The word “blackout” should not be used in the context of an interview because it is likely to be confused with passing out.

- Blackouts may fit one criteria for dependence.

- Amnesic periods during or immediately after use are relatively common.

- The blackout defined by prolonged functioning without later recall are rare and late-stage symptoms.
Mental Health Conditions

- Prevalent co-occurring conditions should be considered on a routine basis.

- Conditions likely to complicate treatment (e.g., bipolar, PTSD, antisocial personality, borderline personality) should be considered.

- A clinician does not have to be a mental health expert to identify risk indications.
Axis I Conditions

- May require treatment independent of or in concert with addictions treatment
- Some conditions may require medications for appropriate stabilization (e.g., bipolar disorder)
- The nature and severity indicated from the interview may suggest the type of professional to whom a referral is indicated
Certain conditions may pose behavioral issues beyond those related to addictions (e.g., antisocial personality disorder).

Some conditions may be related to manipulation or instigation of conflicts (e.g., obsessive-compulsive personality disorder or borderline personality disorder).

Individuals with certain conditions may have difficulty with group situations (e.g., paranoid or schizoid personality disorders).
Use of Findings Within One’s Area of Expertise

- Integrate results from the assessment with other available information
- Reconcile any contradictory information if possible
- Use specific findings to support diagnostic conclusions
- Utilize information relevant to treatment planning and placement
Use of Findings Outside One’s Area of Expertise

- Integrate results from the assessment with other available information
- Reconcile any contradictory information
- Determine potential referral issues and the professional best suited to address them
- Utilize specific findings to support the referral and to inform the professional to whom the referral is made