The Forum

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On Co-Occurring Mental Health and Substance Abuse Disorders

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Co-Occurring Disorders Committee

MEDICAL CONDITIONS: IMPLICATIONS FOR TREATING CO-OCCURRING DISORDERS

By Eric Morse, M.D.

All clinicians who provide counseling services to persons with co-occurring disorders should ensure that patients receive medical treatment. When referring a patient for a medical evaluation, prepare a *referral document* that lists symptoms, previous diagnoses, all laboratory test results, current medication list, and allergies. Most important are specific referral questions.

Central nervous system disorders can affect changes in the mental status of patients in subtle and obvious ways. *Seizures* with a focal neurological finding may be due to a lesion, mass, or malformation in a patient's brain and usually require a brain imaging study (CT or MRI). *Traumatic brain injuries* are more common in our patient population and should be screened for. Even after recovery, emotional and cognitive problems may persist, whereas depression and personality changes, such as rapid mood changes, may look like a bipolar disorder but respond best to anti-convulsant drugs.

Symptoms of *strokes* include sudden onset of numbness, weakness, facial droop, vision changes, speech problems, lack of coordination, and headaches. Patients who have had strokes tend to have cognitive problems, depression, and poor executive functioning. Immediate medical attention to strokes is very important to minimize the consequences of this nervous system insult. *Chronic pain* is best approached by means of relaxation techniques and stress management that affect the individual's "perceived" pain threshold.

Sleep disorders require an assessment of sleep hygiene and instructions. Poor sleep is often associated with mania, depression, anxiety disorders, and psychotic disorders. Prescribing "sleep medications" should be limited because it can prolong the substance-induced sleep disorder, whereas behavioral (rather than medical) interventions are often most effective. *Obstructive sleep apnea* is associated with excessive daytime sleepiness, fatigue, obesity, a crowded throat, snoring with many wakes, depression and morning headaches. Treatments include weight loss, corrective surgery, sleeping on one's side and CPAP machines.

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TREATING CLIENTS WITH CO-OCCURRING DISORDERS AND DIABETES

By Joann Berkson, RN, M.Ed.

In 2002, the American Diabetes Association estimated that more than 18 million people (6.3% of the U.S. population) suffer from diabetes. Seriously mentally ill persons with substance abuse problems are more likely to develop medical complications if they are diabetic. For instance, people who are schizophrenic or have been diagnosed with bipolar disorder are at greater risk for diabetes and heart disease due to lifestyles marked by poor diet, lack of exercise and poor medication compliance. Therefore, clients must become actively involved in self-care and maintain a balance of proper nutrition, abstinence from alcohol, regular exercise and medication control. Client education and professional monitoring and oversight are essential in working with the clients to successfully manage their health.

What is Diabetes?
Glucose is a form of sugar and the main source of energy for our bodies. Diabetes occurs when there is a deregulation or dysfunction of sugar in the blood. For example, Type I diabetes is due to a child's inability to produce any insulin in the pancreas. Insulin is the

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hormone that assists glucose being absorbed into fat and muscle cells. Most diabetics (90-95% of cases) have Type II diabetes which develops in adulthood. This occurs when the body cannot absorb glucose into cells (known as insulin resistance) or when there is a decrease in ability of the pancreas to produce sufficient insulin. Symptoms often include excessive thirst, frequent urination, weight loss, drowsiness, blurry vision and confusion. A coma may occur if high sugar levels become extreme. Another condition, known as "Pre-Diabetes", occurs when glucose levels are slightly elevated but not high enough to be considered diabetes. Pre-diabetes can be easily controlled with weight loss and lifestyle changes.

How Alcohol Affects Diabetes

The American Diabetes Association Guide to Diabetes states "alcohol contains calories…and can contribute to weight gain. Drinking alcohol also increases a person's risk for hypoglycemia/low blood sugar when consumed on an empty stomach." People on diabetes medication must limit their alcohol consumption significantly. Diabetic neuropathy can worsen with a loss of sobriety and contributes to other medical problems.

The Metabolic Syndrome

The Metabolic Syndrome is a cluster of disorders of the body's metabolism occurring simultaneously, such as high cholesterol, high blood pressure and obesity. Scientists believe that insulin resistance is a major factor in the development of the metabolic syndrome. High blood pressure or hypertension has been associated with heart disease, stroke and kidney disease. High cholesterol is associated with heart disease. The problem begins with an increase in "*bad*" low-density lipoprotein (LDL) as compared to "*good*" high-density lipoprotein (HDL). When there are high levels of LDL and low levels of HDL, a condition named dyslipidemia develops. In conjunction with elevated triglycerides levels, there is an accumulation of fatty deposits in the arteries that lead to blockages and heart disease. When a person already has excessive abdominal fat and is obese, there is an additional risk for heart disease. Obviously, smoking tobacco compounds this risk. Diabetics are considered in the same risk group for heart attack as people who have already had a heart attack. Individual goals for glycemic control set by an endocrinologist may vary for clients who abuse alcohol since alcohol can both cause blood sugar levels to rise and fall. Other complications of diabetes include nerve damage, pain in extremities due to neuropathy, eye disease, sexual problems, and other blood circulation disorders.

Goals of Treatment for Diabetes

The goals of a diabetes management are as simple as "A-B-C". "A" is for the A1C test of the long-term (3-month) level of sugar in the blood. "B" is for blood pressure control. "C" is for cholesterol control; that is, low LDL and high HDL with total cholesterol levels under 200. The control of the "A-B-C" is often accomplished by a combination of medications, diet control and exercise. For example, a 10% reduction in body weight can substantially decrease the chances of developing or exacerbating the aforementioned disorders.

Incorporating Client Care

The counselor is not alone in helping the clients address these problems. A collaborative effort of care should be designed with an internist or endocrinologist and a dietician. Also, the psychiatrist plays a critical role in monitoring the client's response to any psychotropic medications that may cause weight gain or affect insulin resistance. As such, communication between these professionals is paramount to reinforce and monitor care instructions and reduce confusion. The counselor, by virtue of role, is already addressing a myriad of issues related to the client's mental illness and addiction problems. In these cases, medical illnesses are not an exclusive domain of client care.

Specific Strategies

The counselor should meet regularly with the client and make specific inquires about treatment compliance. Since knowledge is the key to self-care, continuous inquiry and reinforcement are needed. Active and frequent communication among practitioners involved in the client's care (i.e., the psychiatrist, psychiatric nurse or internist) helps support the client in accomplishing their treatment goals. Ongoing consultations with the medical team can also help the counselor develop advanced skills in the field of integrated treatment.

Conclusion

Prevention is essential to a healthy lifestyle. Weight and blood pressure should be monitored in counseling clinics. It is recommended that diabetics receive medical assessments every 3 to 6 months. The following questions must be addressed in a medial evaluation:

- What are the goals for maintaining glucose levels?
- Is the client properly and regularly monitoring blood sugar?
- What are the clients' food choices?
- Does the client fill all prescriptions and comply with dose recommendations?
- Is there any tobacco and alcohol consumption?

Counselors must educate clients to be alert and attentive for signs of medical, psychiatric and addiction illnesses.

References:

- American Diabetes Association: www.diabetes.org
- National Diabetes Education Program: www.ndep.nih.gov

O P E N F O R U M

My Many Problems

*By Robin F.**

My past years have presented me with many battles to fight. I am dually diagnosed with Schizoaffective Disorder and substance abuse issues. I have also been diagnosed with other mental illnesses such as dissociative identity disorder and eating disorders. These disorders keep me constantly combating at least one of them at all times.

My medical problems began at a very early age. I was two years old when I was diagnosed with asthma. The product of an alcoholic father and co-dependent mother, I was not atypical in being diagnosed with asthma at such a young age. This was the beginning of numerous visits to the emergency room and hospitalizations. As psychological problems and stressful situations became factors in my life, my asthma began to worsen over the years. I've had to be on long-term steroid therapy just to stay alive. This in itself caused problems, such as osteoporosis, diabetes, and weight gain. The steroids also have the side effect of exacerbating my mania.

Medical issues continued to plague me through my youth. My mother, siblings and I suffered from severe allergies. I had to go for shots on a weekly basis until the doctors found out that the allergy shots were triggering my asthma flare-ups.

The most grueling of my medical problems and probably the one most associated to my issues is my eating disorders. My mother took pride in feeding her children nutritious meals. As I look back, I realize that she suffered from an eating disorder. Many things in my life felt seemed out of control. I felt that the only control I had left were the things I put into my mouth and my body. At one time, I had gotten so emaciated that I was not functioning properly mentally or physically. I believed that if I got thin enough, I would just disappear.

This was the beginning of a long battle with anorexia, bulimia, and drug abuse (which included alcohol, marijuana, PCP, cocaine and LSD). In 1986, I had a close call with death due to laxative abuse that caused my colon to rupture. I needed emergency surgery. However, it still took many years before I began to overcome my anorexia and bulimia. I later began compulsive overeating. Due to chronic steroid therapy and weight gain from "psych" meds, I am now morbidly obese. Just like my manic-depression, I have trouble with balance. There appears to be no in between.

I have had approximately twenty to thirty hospital admissions for asthma, more than ten for mental illness, and three for knee surgery. Taken together, this is a mountain of hurt and pain I've been through, yet I feel like I have just started. I know I have a long way to go.

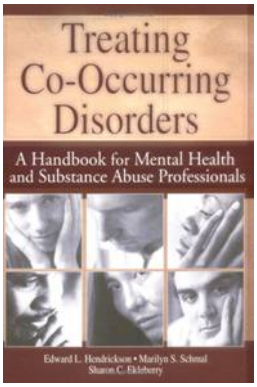
I keep up with all my medical appointments and manage to take the many medications that the doctors constantly adjust. Recently, I celebrated five years of clean and sober time. I'm seeing a bariatric physician; and in the first two weeks under his treatment, I have lost 12½ pounds. I now eat healthy and exercise two to three times a week. Through the cardiopulmonary rehab program at Virginia Hospital Center in Arlington, I have learned how to exercise properly. My asthma no longer keeps me from living an active lifestyle.

My past experiences were tough, but I am glad I had them. The future wouldn't be there for me without them and the present wouldn't be so good.

**The author's name has been changed to protect her privacy.*

NEW RESOURCE FOR THE FIELD: TREATING CO-OCCURRING DISORDERS

The expression that "all politics is local" readily applies to nearly all forms of community empowerment and activism. In the professional field of mental health and substance abuse, this expression also describes the work of the **COG Co-Occurring Disorders Committee** who since 1990 has produced skill development and training opportunities for clinicians in the greater Washington DC metropolitan area. For 12-years this Committee was co-chaired by Ed Hendrickson & Marilyn Schmal, with Sharon Ekleberry a leading member of the committee.



A comprehensive review of their collective leadership ideas is available in the recently published 2004 book entitled **"Treating Co-Occurring Disorders: A Handbook for Mental Health and Substance Abuse Professionals".** This book is described by Haworth Press as a "unique handbook [that] reflects the reality facing professionals in their daily practices, [while] focusing on how to effectively manage caseloads that include vastly differing levels of functioning… When questions arise in the treatment of patients with co-occurring disorders, this book provides clear and useful answers."

This book is useful for the professional and the student alike. In simple language, it provides helpful suggestions for treating this difficult population, especially when a caseload is comprised of individuals of differing diagnostic combinations, functioning capacities, and treatment readiness. Important topics include Frequently Co-occurring Disorders, Assessment, Case Management, Family Interventions, Supervising Staff and Outcome Performance Standards.

Congratulations to the authors for presenting their ideas in a succinct and relevant volume. To obtain a copy of **"Treating Co-Occurring Disorders: A Handbook for Mental Health and Substance Abuse Professionals**", please visit www.amazon.com.

Upcoming Training Opportunity

Passages: Co-Occurring Disorders in the Maturing Adult

Friday, December 3, 2004
8:30am—3:30pm
Metropolitan Washington Council of Governments (COG)
777 North Capitol Street, NE, Suite 300, Washington DC 20002

Featured Speaker: Robin J. Gliboff, LCSW, Greenspring Village

Participants will be able to:

- Describe the indicators of co-occurring disorders and trace their prevalence from mid-life to older adulthood
- Describe the implications of lifestyle on co-occurring disorders as clients age
- Cite the biopsychosocial issues related to co-occurring disorders and late onset
- Differentiate between dementia and depression
- Classify the changing treatment needs of the aging population

CEUs & Contact Hours Available
Registration Fee: $45.00
Continental Breakfast and Lunch included
For more information, please call 202-962-3275

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Many *cardiovascular/respiratory disorders* are preventable and treatable. Risks include obesity, tobacco smoking, lack of exercise, high blood pressure, diabetes, high cholesterol, family history, and stress. *Hypertension* can damage blood vessels, the heart, eyes, and kidneys. One in four Americans have hypertension (as defined above 140/90). Treatment includes increased potassium and lowered sodium intakes, exercise, biofeedback/relaxation techniques, medications, smoking cessation, and weight loss. *Smoking cessation* is imperative and should encouraged. Nicotine replacement therapy (NRT) for one-year has a 10-25% abstinence rate for the patch, gum, spray, lozenge, and inhaler. Ninety-percent of all cases of *pulmonary disorders and emphysema* are related to smoking. Crack-cocaine and marijuana smoking are also antagonists to an efficient respiratory system. Smoking can trigger asthma; and the inhalers used to treat asthma can also induce anxiety and increase heart rate.

Infectious diseases are preventable. Substance abusers are clearly at a higher risk of contracting an infectious disease. For *HIV*, the basic measures of treatment include CD4 counts and viral loads and response to ARVs (anti-retroviral medications), which can interfere with psychiatric medication levels and vice versa, especially methadone. Also, HIV can cause cognitive impairment. Treatment regimens are usually effective. Smoking cessation can actually increase CD4 counts.

Syphilis is called the "great masquerader" of many physical and mental illnesses. It is very treatable with intravenous antibiotics. *Hepatitis B* symptoms include jaundice, fatigue, poor appetite, stomach pain, diarrhea, joint and muscle pain. Many methadone treatment providers offer Hepatitis A and B immunizations as a preventive intervention. For *Hepatitis C (HCV)*, no vaccine is currently available. HCV can cause liver abnormalities without any overt symptoms and remain dormant for many years. Since the liver metabolizes most medications, the doses of certain types of psychotropic medications may need to be adjusted accordingly. *Interferon* is the best treatment for Hepatitis B and C because it can eradicate the virus completely. However, interferon may exacerbate or cause depression.

Substance abuse can affect almost every hormone and compound existing *endocrine disorders*. Mental illness and stress can cause changes with most hormones and mimic medical and psychiatric illnesses. *Hypothyroidism* symptoms include fatigue, weight gain, cold intolerance, dry skin, slow body movements, depression, constipation and thinning hair.

About the Co-Occurring Disorders Committee

The **Co-Occurring Disorders Committee** has been in existence since 1990 and is composed of mental health and substance abuse management and direct service staff from the public and private sector in the metropolitan Washington region. The goals of the committee are as follows:

- To promote effective, evidence-based, and integrated treatment services for individuals with co-occurring mental health and substance use disorders.
- To promote interagency and collegial communication and collaboration among public and private treatment programs and their staff providing these services.
- To provide low cost trainings on dual diagnosis topics for professionals providing treatment for individuals with mental health and substance use disorders.

Conversely, *hyperthyroidism* symptoms include weight loss, "bug eyes," nervousness, sweats, loss of appetite, insomnia, palpitations, and heat intolerance. Hyperthyroidism can be a cause of mania and acute anxiety.

Symptoms of *diabetes* include thirst, frequent urination, weight loss, fatigue, blurred or poor vision, headaches, slow healing cuts or sores, and numbness or tingling in hands and feet. Both types cause small vessel disease whereas medications and a modified diet are essential. Alcohol can cause direct damage to the pancreas and cause blood sugar elevation. Schizophrenia is also a risk factor for diabetes because two of the genes for these disorders are located close together.

Medical emergencies require immediate attention. When in doubt, the client should be sent to the emergency room. *Delirium* is considered a medical emergency with an acute onset and waxing/waning course; it is often due to an underlying medical condition. Symptoms include a disturbance of consciousness or attention, cognitive dysfunctions (such as disorientation), short-term memory loss or language problems. It is important that delirium is not attributed to substance consumption or withdrawal unless all other medical causes have been ruled out. When a patient is experiencing *chest pain*, the major concern is for a heart attack. Grand mal *seizures* can occur during

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withdrawal states and when patients lose consciousness, pupils are fixed and dilated, tongue biting with drooling or frothing of the mouth, and spasms or convulsions occur. There is often a loss of bladder and bowel control. If a client is experiencing a seizure, it is advisable to never restrain the patient (unless they are about to fall); never try to make them stop convulsing; and never put something into their mouths. *Respiratory distress* is significant because oxygen consumption and breathing is a critical biological function. All asthma attacks or allergic reactions must be taken seriously. Symptoms of such attacks include a change in skin color and inability to complete verbal sentences.

For *psychiatric emergencies,* all treatment programs need a plan-of-action for referrals to a Crisis Center or Mobile Crisis Team. If in doubt, always call 9-1-1. Clinicians must be familiar with the emergency petition (EP) process and State Law where physician or psychologist can initiate an EP. For example, *overdoses* on many drugs can be lethal. Psychotropic medication overdoses can also cause serious cardiac arrhythmias, seizures, kidney/liver failures. The newer antidepressants, antipsychotics, and mood stabilizers are relatively safe in overdose.

In summary, it is important to note that medical conditions can complicate many psychological disorders. Therefore, all clinicians should receive basic training on the symptoms, diagnostic tests, and sequelae of medical disorders and the contributing neuropsychiatric effects on mental status and the drug abuse recovery process. Knowledge of symptoms and professional experience will ensure that quality services are in place to address the physical health needs of persons with co-occurring disorders.

The Forum is published twice yearly by the Metropolitan Washington Council of Governments Co-Occurring Disorders Committee.
To become a member of the Co-Occurring Disorders Committee, please contact M. Lynn Smith at (301) 279-8828 ext 106.
To submit articles, resources, or other information on co-occurring disorders, please contact Robert B. Hordan at 301-883-3505.

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