Behavioral Health and Opioid Addiction

Profile of an Opioid Addict

- Male or Female
- Young or Old
- College Degree, H.S. or Non-Grad

Wealthy, Middle Class or Poor
Lives in City, Suburbs or Rural Area
White, Black, Brown, Asian or Other
Needs Help?
**DSM-5 Criteria for Opioid Use Disorder**

1. A problematic pattern of opioid use leading to **clinically significant impairment or distress**, as manifested by at least **two of the following**, occurring within a **12-month period**:
   - Opioids are often taken in **larger amounts** or over a **longer period** than was intended.
   - There is a **persistent desire** or unsuccessful efforts to cut down or control opioid use.
   - A great deal of **time** is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
   - **Craving**, or a strong desire or urge to use opioids.
   - Recurrent opioid use resulting in a **failure to fulfill major role obligations** at work, school, or home.
   - Continued opioid use despite having **persistent or recurrent social or interpersonal problems** caused or exacerbated by the effects of opioids.
   - Important social, occupational, or recreational **activities are given up or reduced** because of opioid use.
   - Recurrent opioid use in situations in which it is **physically hazardous**.
   - Continued opioid use despite **knowledge** of having a persistent or recurrent physical or psychological **problem** that is likely to have been **caused or exacerbated** by the substance.

**Specify if**:
- In early remission (3 months of no criteria being met (with the exception of cravings) or sustained remission (12 months or longer (with the exception of cravings).
- On maintenance therapy
- In a controlled environment (where access to opioids is restricted).

**See the DSM-5 manual for details on specifications.**

**Specify current severity**:
- 305.50 (F11.10) Mild: Presence of 2–3 symptoms.
- 304.00 (F11.20) Moderate: Presence of 4–5 symptoms.
- 304.00 (F11.20) Severe: Presence of 6 or more symptoms.

See the DSM-5 manual for details on specifications and how to code when there are other disorders.

Psychological Factors in Opioid Addiction

- Opiate Addiction generally has greater devastation than addiction to other drugs due to the severity of mental and physical effects.
- Family History
- Social History

*Shared risk factors between Mental Illness and Opioid Addiction:*
  - Overlapping genetic vulnerabilities
  - Overlapping environmental triggers
  - Involvement of similar brain systems (reward and stress systems)
  - Both are developmental disorders (often begin in adolescence.)

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Psychological Considerations in Opioid Addiction

- **Medical History**
  - Use of opiates with cancer and pain patients increases risk of depression.
  
  - Chronic pain can lead to mental health issues.

- **Legal Involvement** - Due to drug seeking/drug using behavior

- **Prior Mental Health History:**
  
  Moderate to severe mental illness is a substantial predictor of development of opiate addiction.
**Behavioral Considerations in Addiction to Opioids**

- Substances can create mental health symptoms (paranoia, delusions, depression, etc.) when under the influence.

- When these symptoms continue after influence of substances wears off, it can indicate a co-occurring disorder.

- Substance use increases the risk of sexual assault or violent crime. This can lead to development of PTSD, other anxiety disorders, depression, and eating disorders.

- Poor decision-making is common when intoxicated. (ie. Breaking the law, unprotected sex, sharing needles, etc...) This can in turn cause depression and grief over consequences of these behaviors.

**Opioid Addiction and Suicide Risk**

- 13x greater risk of death
- 14X greater risk of suicide
- Normal risk factors apply (gender, MI, family, social factors)
- Required **targeted intervention** with this population:
  - Formal risk assessment
  - Assessing immediate risk of self-injury or overdose
  - Referral to appropriate services/treatment
Risk factors: Use of alcohol
Depression
Stress
Peers
Employment issues
Short treatment duration
Leaving treatment before completion

Opioid Addiction and Co-Morbid Psychiatric Disorders

• Individuals who suffer from addiction are **twice as likely** to also suffer from mood and anxiety disorders.
• Symptoms of one disorder trigger the other.
• Addiction is a **mental health disorder**.
• It fundamentally changes the brain and impacts hierarchy of needs and desires. The drug becomes priority and impulsive, harmful behaviors may result in order to get it. Affects thinking and functioning.
Opioid Addiction and Co-Morbid Psychiatric Disorders

Substance Abuse Secondary to a Mental Health Diagnosis

* Self-medication: using substance to help manage symptoms that are disruptive or uncomfortable

• Connection to Depression:
  - 1 in 10 adults suffer from clinical depression.
  - Opiate abuse has a very strong correlation with clinical depression. This makes recovery even more difficult if not addressed and treated. (Bi-directional relationship)
  - Use of opiates (not necessarily abuse) increases risk of depression.
  - Increased relapse risk.
  - Often occurs after increased stressors, opportunity, and peer pressure

Substance Abuse Secondary to Other Mental Health Diagnoses:

- Anxiety Disorders
  - Generalized Anxiety Disorder (18% of the population)
  - Obsessive Compulsive Disorder
  - Social Anxiety
  - Post-Traumatic Stress Disorder (75% of Veterans)
- Adult Attention Deficit Hyperactivity Disorder
- Bipolar Disorder
- Psychotic Symptoms/Thought Disorders/Schizophrenia
- Eating Disorders
- Personality Disorders
Opioid Addiction and Trauma

- ACES (Adverse Childhood Experiences) Study
  - Brain development is impacted.
  - Development of negative coping strategies
  - The bigger the number, the bigger the risk for long-term negative effects such as addiction.

Warning Signs of a Co-Occurring Disorder

-Signs vary greatly between individuals.
-Depend on the substance abused, as well as the severity

Symptoms of a dual diagnosis include:
- Sudden change in general behavior
- Difficulty managing daily tasks and responsibilities
- Avoiding events or social activities that were once enjoyed
- Neglecting health and hygiene
- Cognitive impairments
- Refusal to seek or comply with treatment
- Mentions of thoughts of suicide or suicidal behaviors
- Erratic and impulsive behaviors
- Issues managing finances
- Poor performance at school or work
Only 1 in 4 individuals with Opioid Use Disorder receive focused treatment.

Non-Medical Treatment Modalities

• Can decrease risk of relapse
• Psychotherapy is best when combined with MAT and substance abuse counseling
• Most effective with those with moderate or severe MI
• Can be very difficult to separate therapy and therapist effects
• Effectiveness strongly associated with perception of the helping relationship
• Increased effectiveness when completely integrated into treatment/recovery
Evidenced-Based Treatment for Opioid Use Disorder includes:

• Personalized diagnosis and treatment planning tailored to the individual and family
• Long-term management – Addiction is a chronic condition with the potential for both recovery and recurrence. Long-term outpatient care is important.
• Access to FDA-approved medications
• Effective behavioral interventions delivered by trained professionals
• Coordinated care for addiction and other conditions
• Recovery support services, such as mutual aid groups, peer support specialists, and community services

*Combine Substance Use and Mental Health Disorder Treatment simultaneously.*

Non-Medical Treatment Modalities

Most effective with:

• new clients with no treatment history
• successful graduates of intensive programs.
• Family therapy aids retention.

**Focus on:**
Coping skills
Past Trauma
Self-care
Motivational Interviewing  (William Miller, 1983)

**Five Principles of Motivational Interviewing:**
- Express empathy through reflective listening.
- Develop discrepancy between clients' goals or values and their current behavior.
- Avoid argument and direct confrontation.
- Adjust to client resistance rather than opposing it directly.
- Support self-efficacy and optimism.

*Readiness to change*
*Shown to be effective with both voluntary and non-voluntary patients*
*May not be enough for those with comorbid psychiatric disorders*

Non-Medical Treatment Modalities

**Contingency Management Interventions:** Tangible reinforcement
- Voucher based reinforcement
- Prize incentives
- Increases retention and abstinence

**Therapeutic Communities:**
- Comprehensive, include recreational, family, social, and vocational components
- Patients are used as the treatment modality

**Group Psychotherapy:** improved outcomes, less use of opiates (at 6 month follow-up)
Non-Medical Treatment Modalities

**CBT** - identify unhealthy, negative thinking and behaviors and replace with healthier more positive ones

**DBT** - type of CBT, teaches behavioral skills to cope with stress, manage emotions, and improve relationships with others
- significantly greater reductions in substance use
- greater gains in functioning and social adjustment

**ACT** - develop awareness and acceptance of thoughts and feelings
- commit to making change
- increases ability to cope and adjust to life situations

**Psychodynamic Therapy**
- increase awareness of unconscious thoughts and behaviors
- gaining new insights into motivations, and resolve conflicts

**Interpersonal Therapy** - addresses issues with current relationships with others to improve interpersonal skills
Future Directions and Needs

• Fostering easy and broad access to treatment.
• Keeping individuals alive so treatment can happen.
• Collaboration of all entities involved, particularly the medical and behavioral health communities.
• EDUCATION!
• RESEARCH!
• Addressing underlying issues such as mental illness, socio-economic disparity, educational/occupational challenges, preventative health care.

References

References


References

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