Co-Occurring Disorders/Responding to Substance Use Disorder Crises

September 19, 2023

M-TAC

August 15, 2023

DHCS

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Michelle Baass | Director

M-TAC

Medi-Cal Mobile Crisis Training and Technical Assistance Center

Webinar Policies

Participation

We welcome your participation through the methods outlined in the housekeeping introduction. Please note that we do not tolerate disruptive behavior, as it is not aligned with the purpose of this session. We may remove any individuals who disrupt the meeting without warning. In the event of a security incident, this session will end immediately and will not resume. If this occurs, we will send a separate email to all participants with further instructions.

Chat

Participant comments in the chat box do not reflect the views or policies of the presenters, the California Department of Health Care Services (DHCS), or their affiliates or contractors. By using this chat box, you agree to keep your comments relevant to the topic of today's event. While diverse perspectives and opinions are welcome, disruptive comments are not aligned with the purpose of this meeting, and users creating disruption may be removed without warning.

Housekeeping

This event is being recorded: Audio is now broadcasting. 01

Audio is provided through your computer speakers or headphones: Your line is automatically muted. 02

If you have issues with your speakers and would like to connect by phone: Click Join Audio under audio settings. 03

Choose Phone Call tab: Dial the desired phone number, and enter Meeting & Participant ID. 04

Live captioning is available: Click the CC Live Transcription button to show and hide captions during today's event. 05

Need help or have questions for our presenters? Please type in the Q&A box! 06

Mobile Crisis Services

- *Mobile crisis services provide rapid response, individual assessment, and community-based stabilization to Medi-Cal beneficiaries experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.*

Behavioral Health Information Notice 23-025

Conflict of Interest Disclosures

Jennifer Hodgson, Josh Severns, and Arianna Mellinger have certified that they have no relevant relationships with any commercial or nonprofit organizations that represent a conflict of interest.

A New Direction for Mobile Crisis Services

- Change mobile crisis services so that the response is more resolution-focused and works to provide relief to people in crisis in the community.
- Support people in crisis where they are, while using the least restrictive means necessary.

A New Direction for Mobile Crisis Services

» Mobile crisis services should be:

- Person-centered
- Trauma-informed
- Equity-driven
- Brief intervention: de-escalation and resolution focused
- Working from a lens of least restrictive interventions
- Culturally responsive, linguistically appropriate, and accessible

Welcome and Introductions

Introductions

In the chat box, we invite you to share your:

- Name
- Role
- Organization
- One thing you're hoping to learn today

Presenters

Jennifer Hodgson, PhD, LMFT
Principal Consultant
Health Management Associates

Joshua Severns, MSW, LCSW, ACADC
Behavioral Health/SUD Advisor
Kauffman & Associate Inc.

Arianna Mellinger, LCDC-1
Peer with Lived Experience

Agenda

- Introductions
- Triaging and Preparing an Initial Response to Co-Occurring Disorders
- Assessing Need for Medical Intervention
- Overview of Substance Use Disorders (SUD)
  - Criteria, Effects, and Continuum of Use
  - Common Terms to Describe Drugs and Resources for Staying Up to Date
- Understanding SUD and Co-Occurring Disorders
  - Risk Factors
  - Common Symptoms
  - Treatment Modalities
- An Introduction to Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Intervention strategies for adults and youth

Learning Objectives

By the end of this training, participants will be able to…

1. Describe at least three mental health and medical implications of substance use and how they may present in crisis.
2. Articulate trends and language used to describe highly addictive substances that are prone to misuse.
3. Apply the Screening, Brief Intervention, and Referral to Treatment (SBIRT) evidence-based approach when responding to individuals who are misusing alcohol and substances.
4. Identify the Stages of Change and Motivational Interviewing Strategies for developing person-centered action plans.
5. Recognize the signs of opioid overdose and how to initiate an overdose reversal with naloxone.

Audience Poll

What amount of experience do you have providing direct service to individuals with substance use disorders?

a. None
b. Minimal
c. Moderate
d. Significant

Audience Poll

What amount of experience do you have providing direct service to individuals with substance use disorders AND co-occurring mental health disorders?

a. None
b. Minimal
c. Moderate
d. Significant

Audience Poll

Have you ever directly provided mobile crisis services to an individual with a substance use disorder and/or a co-occurring mental health disorder?

a. Never
b. Just a few times
c. A moderate number of times
d. A significant number of times

BHIN 23-025 Requirements

As described in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Best Practice Toolkit, mobile crisis services are a critical component of an effective behavioral health crisis continuum of care. A "behavioral health crisis" refers to any event or situation associated with an actual or potential disruption of stability and safety as a result of behavioral health issues or conditions. A crisis may begin the moment things begin to fall apart (e.g., running out of psychotropic medications or being overwhelmed by the urge to use a substance they are trying to avoid) and may continue until the beneficiary is stabilized and connected or re-connected to ongoing services and supports.[2]

[2] National Council for Mental Wellbeing, "Roadmap to the Ideal Crisis System" (2021) p. 14.

BHIN 23-025 Requirements

Pursuant to Section 14132.57 of the Welfare and Institutions Code (W&I), DHCS intends to seek all necessary federal approvals to provide qualifying community-based mobile crisis intervention services ("mobile crisis services") to eligible Medi-Cal beneficiaries experiencing a mental health and/or substance use disorder (SUD) crisis ("behavioral health crisis"). Accordingly, DHCS submitted to the Centers for Medicare and Medicaid Services (CMS) State Plan Amendment (SPA) 22-0043 that establishes mobile crisis services as a new benefit in the Medi-Cal program. DHCS is not making any changes to the existing crisis intervention services and SUD crisis intervention services benefits covered under the Specialty Mental Health Services (SMHS), DMC and DMC-ODS delivery systems. Medi-Cal behavioral health delivery systems shall continue covering these services in accordance with existing federal and state, and contractual requirements.

UPDATE: DHCS received CMS approval of SPA 22-0043 on July 20, 2023. This SPA adds community-based mobile crisis intervention services to California's Medicaid State Plan as a Specialty Mental Health Services, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System benefit.

BHIN 23-025 Requirements

Mobile crisis services provide rapid response, individual assessment, and community-based stabilization to Medi-Cal beneficiaries who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. While mobile crisis services are intended to support an integrated approach to responding to both mental health and substance use related crises, and mobile crisis teams will be carrying, trained, and able to administer naloxone, this benefit is not intended to replace emergency medical services for medical emergencies.

BHIN 23-025 Requirements

In addition, there may be circumstances where mobile crisis teams are subject to the federal substance use disorder confidentiality regulation, 42 C.F.R. Part 2. Medi-Cal behavioral health delivery systems shall inquire whether any of their mobile crisis teams are subject to 42 C.F.R. Part 2 and, if so, ensure that workflows are in place to ask beneficiaries for their consent when appropriate.[30]

[30] Mobile crisis teams should not attempt to obtain beneficiary consent while the beneficiary is in the midst of the crisis.

BHIN 23-025 Requirements

Beneficiaries experiencing behavioral health crises may have co-occurring needs which require additional considerations in the provision of mobile crisis services. People with I/DD and co-occurring mental health conditions may experience sensory or communication challenges that may complicate de-escalation of a behavioral health crisis. Mobile crisis teams responding to a beneficiary with I/DD shall ensure that natural supports (e.g., familial caregivers, personal attendants) are involved and consulted in the crisis response, if appropriate.35 To the extent possible, mobile crisis teams are encouraged to include a team member with I/DD expertise or have access to an individual with I/DD expertise (e.g., a Board-Certified Behavioral Analyst) via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions.

All members of mobile crisis teams shall participate in training on crisis response for beneficiaries with I/DD, which may include, but is not limited to, general characteristics of people with intellectual disability and autism spectrum disorder, co-occurrence of I/DD, and mental health conditions, and crisis intervention strategies for serving this population (e.g., communication tactics and techniques, strategies to involve caregivers, etc.).

Additionally, county mental health agencies are currently required to develop MOUs with Regional Centers to coordinate services, identify dually diagnosed beneficiaries, and develop procedures for Regional Center staff and county mental health staff to collaborate in responding to beneficiaries with co-occurring I/DD and mental health conditions.[36]

[36] See W&I, § 4696.1, subd. (b).

Lived Experience: Arianna’s Story

Before Recovery

- 4 arrests, each arrest in a crisis state
- Addicted to alcohol, amphetamines, & opioids
- 1 failed attempt at rehab
- 2 car accidents with totaled vehicles
- Feelings of isolation, depression, anxiety, & worthlessness
- Family history of substance use, and mental health challenges

Photo used with permission by Arianna

As a Person in Long Term Recovery

- Sobriety date: 12/02/2017
- 2019 Certified Re-entry Peer
- 2021 Certified Recovery Peer
- 2021 Enrolled in Houston Community College
- Under care of a psychiatrist and therapist since 2019
- Future goal of becoming a Licensed Clinical Social Worker

Photo used with permission by Arianna

Triaging and Preparing an Initial Response to Co-Occurring Disorders

Team Composition Requirements

Table 1. Qualified Mobile Crisis Team Members by Delivery System

Rehabilitative Mental Health Treatment Providers

- Physician
- Psychologist
- Waivered Psychologist
- Licensed Clinical Social Worker
- Waivered/Registered Clinical Social Worker
- Licensed Professional Clinical Counselor
- Waivered/Registered Professional Clinical Counselor
- Marriage and Family Therapist
- Waivered/Registered Marriage and Family Therapist
- Registered Nurse
- Certified Nurse Specialist
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Physician Assistant
- Nurse Practitioner
- Pharmacist
- Occupational Therapist

SUD Treatment Providers

- Licensed Practitioner of the Healing Arts (LPHA) as defined in the "Provider Qualifications" subsection of the "SUD Treatment Services" section of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan
- Alcohol and Other Drug (AOD) Counselor
- Peer Support Specialist

Expanded SUD Treatment Providers

- LPHA as defined in the "Practitioner Qualifications" subsection of the "Expanded SUD Treatment Services" section of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan
- AOD Counselor
- Peer Support Specialist

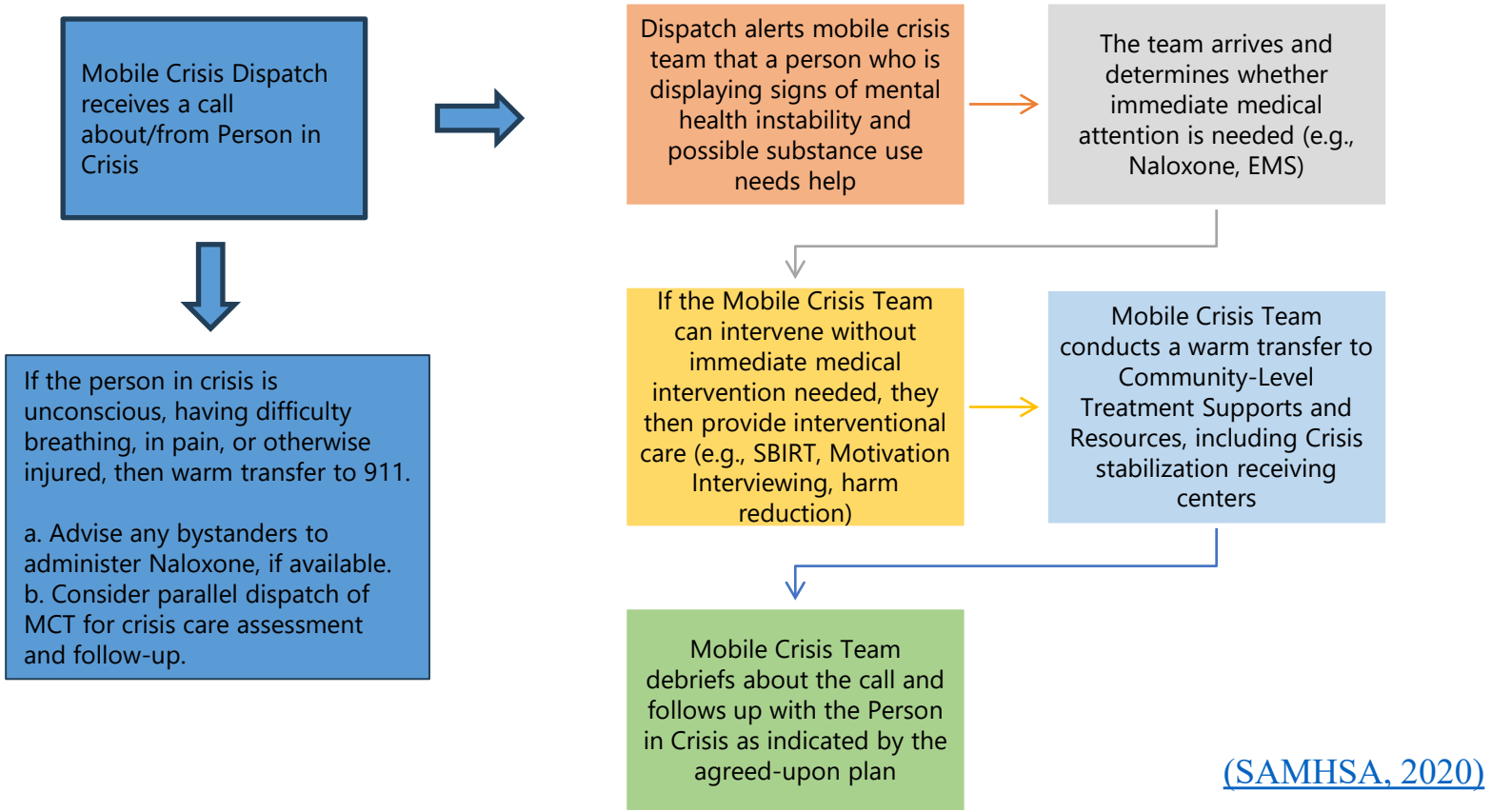
Other Provider Types

- Community Health Workers as defined in the Community Health Worker Services preventive services benefit
- Emergency Medical Technicians Emergency Medical Technicians must be certified in accordance with applicable State of California certification requirements
- Advanced Emergency Medical Technicians. Advanced Emergency Medical Technicians must be certified in accordance with applicable State of California certification requirements
- Paramedics. Paramedics must be licensed in accordance with applicable State

Potential Team Composition Examples

- Two Peer Support Specialists with Telehealth access to Licensed Practitioner of the Healing Arts (LPHA) or another clinician
- Community Health Worker and Peer Support Specialist: With Telehealth Access to LPHA or another clinician
- Peer Support Specialist and EMT
- One Mobile Crisis Team member onsite with telehealth connection to an LPHA or Licensed Mental Health Professional

Steps to Assess and Respond Safely



(SAMHSA, 2020)

Assessment and Management of Overdose

Immediate Medical Attention Required

- Irregular or shallow breathing
- Unconsciousness or unresponsiveness
- Blocked airway and gurgling or snoring sounds
- Blue tint to hands or lips
- Tremors, convulsions, or seizures
- Severe chest pain

Require Assessment for Severity

- Altered mental status (clarify if intoxication or due to medical conditions like low blood sugar)
- Erratic behavior
- Paranoia or disorientation

May Require Medical Evaluation

- Irregular body temperature
- Severe headache
- Vomiting

(SAMHSA Opioid Overdose Prevention TOOLKIT Five Essential Steps for First Responders, 2018)

https://www.gatewayfoundation.org/addiction-blog/drug-overdose-symptoms/#signs

Assessment and Mangement of Overdose: Opioids

Overdoses often develop over a period of ***one to three hours after use***, not always immediately. A mobile crisis team may be dispatched for an unrelated incident, which in turn becomes an opioid emergency.

Immediate Signs

- Slowed breathing
- Unusual sleepiness: Inability to awaken the person using loud voice or physical shaking

Progressing Symptoms

- Choking or gurgling sounds
- Slowed or absent breathing
- Unconscious or unresponsive state

Late Signs

- Blue or purple fingernails and lips
  - Note: In Black and brown individuals, nails/lips may appear grayish or ashen.

(CDC, 2023)

Immediate Actions for Mobile Crisis Teams

- Administer Naloxone (Narcan) in the **left** nostril first
  - Alternate nostrils if you're giving more than one dose
- Call for Emergency Medical Support
- Perform Rescue Breathing
- Place in Recovery Position
  - Laying on their **left** side, with their hand tucked under their face
  - If the desired response is not obtained after 2 or 3 minutes, administer an additional dose of naloxone spray

(SAMHSA, 2018)

Assessment and Management of Intoxication

- Immediate Needs: Is medical detoxification needed? Check for withdrawal symptoms like tremors, seizures, or delirium.
- Provide water, allow space for de-escalation if agitation is present.
- Substance use can elevate the risk of suicide or self-harm. Look for signs and consider a 5150 hold if immediate danger is present.

- Team Questions for Consideration
  - Is medical detoxification necessary?
  - What withdrawal symptoms are present, if any?
  - Is agitation present, necessitating de-escalation?
  - Are there signs indicating an elevated risk for suicide or self-harm?
  - Was the overdose intentional, implying a need for a 5150 evaluation?

Assessment and Management of Intoxication or Withdrawal

General Interaction Tips for Intoxicated Individuals

- **Calm and Non-Confrontational Approach:** Maintain a calm and non-judgmental demeanor to reduce anxiety and aggression.
- **Offer Hydration:** Dehydration is a common risk, so offering water is often beneficial. However, avoid overhydration.
- **Provide Space:** Intoxicated individuals may be overwhelmed by stimuli. Give them space to reduce sensory overload.
- **De-escalation Techniques:** Use de-escalation techniques to defuse tension or agitation.

Assessment and Management of Withdrawal

Withdrawal is the body's response to the abrupt cessation of a substance it has become dependent on. It involves a range of physical and psychological symptoms.

Alcohol Withdrawal

- **Signs**: *Sweating*, Tremors, seizures, delirium tremens, severe anxiety
- **Risks**: Life-threatening, if not managed appropriately. Seizures and delirium tremens require immediate medical attention

Opioid Withdrawal

- **Signs**: Muscle aches, fever, nausea, yawning, lacrimation, insomnia
- **Risks**: Generally not life-threatening but extremely uncomfortable, potentially leading to relapse

Medication-Assisted Treatment (MAT)

- Effective in treating withdrawal from opioids and should be a quick referral option for mobile crisis teams
- Important to know your county 24/7 Access Line

When to Administer Naloxone and What to do Next

(1) NARCAN Nasal Spray - How to use - YouTube

(2) How Naloxone Saves Lives in Opioid Overdose - YouTube

(1)Center for Disease Control and Prevention. (2022, September 22). *How to use naloxone nasal spray (:30)*. YouTube. https://www.youtube.com/watch?v=odlFtGNjmMQ
(2)National Library of Medicine. *How Naloxone Saves Lives in Opioid Overdose*. (n.d.). Www.youtube.com. Retrieved September 20, 2023, from https://www.youtube.com/watch?v=cssRZEI9ujY&t=169s

Complications with Xylazine

- Veterinarian tranquilizer increasingly found in opioids
- Heightens risk of overdose and complications
  - Mixing Xylazine with other drugs can increase the risk of an overdose, especially if the other drugs are opioids or depressants (e.g., alcohol, benzodiazepines [e.g., Valium and Xanax], sedatives, and tranquilizers)
- Slows down heart rate, leading to cardiac issues
- Xylazine does NOT respond to Naloxone
- One of the major signs of xylazine injection use may be necrotic skin lesions

Good Samaritan and Other-Related Laws

- California Code, Civil Code - CIV § 1714.22
  - Legal protections for those authorized by law to prescribe an opioid antagonist
- California Health and Safety Code Section 1799.102
  - Legal protections for those assisting in an overdose situation
- California Health and Safety Code Section 11376.5
  - Legal protections for seeking medical help without fear of arrest for drug possession or intoxication
- Variability in laws across states

Follow-up and Reporting

In accordance with the BHIN-23-025…

- Follow-up Check-In within 72 hours on initial mobile crisis response
- Document the Incident
  - Problems identified during the mobile crisis service encounter (consistent with documentation requirements outlined in BHIN-22-019)
  - Progress note that describes all service components delivered including any follow-up check-ins, referrals, crisis planning, or warm handoffs
- Coordination with Other Delivery Systems
  - Alert individual's Medi-Cal BH delivery system within 48 hours of a mobile crisis response and provide basic information about the encounter
  - Inform individual's care manager (if informed that existing services are in place) and coordinate referrals and follow-up consistent with privacy and confidentiality requirements

Overview of Substance Use Disorders

Substance Use Disorder

At least two of the following symptoms within a 12-month period:

- Substance taken in larger amounts or over a longer period than intended.
- Persistent desire or unsuccessful attempts to cut down.
- A lot of time is spent in activities to obtain, use, or recover from the substance.
- Craving or strong desire to use the substance.
- Failure to fulfill major obligations at work, school, or home due to substance use.
- Continued substance use despite social or interpersonal problems.
- Important activities given up or reduced because of substance use.
- Continued substance use despite knowing it's causing or worsening a physical or psychological issue.
- Situations where use of the substance increases the risk of harm.
- Tolerance, defined by either a need for markedly increased amounts to achieve intoxication or the desired effect or markedly reduced effect when using the same amount.
- Withdrawal, as manifested by the characteristic withdrawal syndrome for that substance or the same (or closely related) substance is taken to relieve withdrawal.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Substance Use Continuum

- **Non-Use**: At the starting point of the continuum, we have individuals who do not use substances at all. Non-use can be a conscious choice or a result of cultural, personal, or health factors.
- **Experimental Use**: May try substances out of curiosity or peer pressure, but it doesn't necessarily indicate a pattern of use.
- **Recreational Use**: This stage involves individuals who use substances in social or recreational settings. They seek relaxation, enjoyment, or to be part of social gatherings. For many, it remains occasional and non-problematic.
- **Regular Use**: It may still be within socially accepted limits, but it can be a sign of increasing involvement with substances.
- **Problem/Risky Use**: This stage signifies that substance use is beginning to have negative consequences on their health, relationships, or responsibilities.
- **Physiologically Dependent Use**: The far end of the continuum is often characterized by an inability to control use, tolerance, withdrawal symptoms, or has a significant impact on daily life (Diagnostic criteria).

(Bennett & Golub, 2012)

Substance Use Disorder

Severity:

- **Mild**: Presence of 2-3 symptoms
- **Moderate**: Presence of 4-5 symptoms
- **Severe**: Presence of 6 or more symptoms

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Why Do People Take Substances?

- To cope with emotional or physical pain
- Explore alternative realities
- Explore substance-induced euphoria
- Social learning
- Cultural/social influences
- Trauma

"No single factor determines whether a person will become addicted to drugs"

(NIDA, 2020)

NIDA. 2020, July 13. Drug Misuse and Addiction. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction
(Golub, Bennett, & Elliott, 2015; Rasmussen, 2008
(Budney, Sigmon, & Higgins, 2003; O'Brien, 2006)

Terms to Describe Drugs

- It is important that we work to connect around language and terms used in reference to substance use.
- Being genuinely wondering and curious is an important approach to building rapport, preventing misunderstanding, and providing effective care and support.
- Ask people to teach you what certain terms mean, as they may have multiple meanings across several substances or may indicate a person is in medical trouble from their use.
  - "You stated that you have taken TNT. Could you please tell me what that is?"
  - "I heard you say that you have the shakes. What do you think is causing that?"

Street Names for Drugs

Adderall Addy, Speed, Thundersticks, Pep Pills,Study Guides	**Cocaine** Coke, Blow, Powder, Snow, Girl, White Lady, Nose Candy, Sniff, Yayo	**Crack** Rocks, Hard, Nuggets, Gravel, Girt, Black Rock	**Ritalin** Vitamin E, Kiddie Coke, Rids, Smarties, Fake Coke	**Meth** Crystal, Crystal Meth, Ice, Crank Glass, Shards, Tina, Tweak	**Bath Salts** Flakka, Ivory Wave, Lunar Wave, Scarface, Bloom	**Phenibut** Anvifen, Fenibut, Pbut, Hoofen, Party Power	
Fentanyl F, Fent, Fenty, Freddy, Fuf, Opes, Blonde, Friend, He-man, Murder 8, Snowflake, Tango and Cash, Apache, Butter, Good Fella, Dragon, Dragon's Breath, White Girl, TNT, Blue Diamond, China Town, China White, Pharmacy, Chinese Food, Lollipop, Jack, Blues, Rainbow Fentanyl	**Heroin** H. Horse, Boy, Dope, Dragon, Smack, Junk, Black Tar, Thunder, China White **Xylazine** Tranq dope	**Morphine** Salt and Sugar, Miss Emmo, M, Emma, Morpho, Deaner, Gods Drug **Iso** Dust, Juice, D, Smack, Footballs	**Desomorphine** Krokodil, Kok, Croc, Kroc, The Zombie Drug, Russian, Magic, Poor Man's Heroin **Carfentanil** Drop dead, Serial Killer, Gray Death, TNT, China Girl, China White	**Hydrocodone** Watsons, 357s, Norco, Tabs, Vicos, Lorris	**Oxycodone** Ozy, O, 512s, Hillbilly Heroin, Rosy, OC 80's; Percs	**Valium** Vis, Drunk Pills, Tranqs, Tranks, Valarie, Old Joes	**Opium** Poppies, Flowers, Dreams, Black Tar, Happiness, Chinese Tobacco, Dopium, Gum, Midnight Oil
Rohypnol Rophies, Roofies, Forget Pill, Forget-Me Pill, Mexican Valium, Roach, Roapies, Ruffies, Wolfies, Roach 2, R2, Pingus		**Klonopin** Kin, Pin, Pinni, Pinner, Chill Pill, Super Valium, Benzo, Bennie	**Ketamine** Special K, K, Ketaset, Green, Kitty Valium	**Xanax** Zany, ZanyBar, Bar, Rounds, Football(1mg), Sticks(2mg), School Bus	**GHB** Georgia Home Boy, Grievous Bodily Harm, Liquid Ecstasy, Soap, G, Liquid	**Alcohol** Booze, Hooch, Juice, Brew, Sauce, Suds, Spirits	**Steroids** Ando, Juice, Gym Candy, Pumpers, Stackers, Tren, D-Bol
Marijuana Pot, Weed, Dope, Kush, Dank, Nufs, Herb, Kind, Mary, Mary Jane, THC, Reefer, Grass, Wax, Honey Oil, Shatter, Pens, Purp, Haze, **Synthetic Cannabinoids** (vaporized or inhaled liquid form)		**LSD** Acid, Lucy, Lucy in the Sky with DIamonds, Doses, Dots, Blotter, Pane Superman, Zen	**MDMA** Ecstasy, Molly, X, XTC, Beans, Asam, Rolls, Scooby Snacks, Skittles, Vitamin E, Vitamin X, Disco Biscuits. Candy, Happy Pills	**Mescaline** Buttons, Cactus Heads, Cactus Buttons, Mesc, Mescal, Mood, Peyote, Topi	**Psilocybin** Shrooms, Booers, Pizza Toppers, Magic Mushrooms, Silly Putty, Fungi	**Phencyclidine** Angel Dust, Super grass, Boat, Tic Tac, Zoom Shermans	

Understanding Substance Use and Co-Occurring Disorders

Introduction to Co-Occurring Disorders (COD)

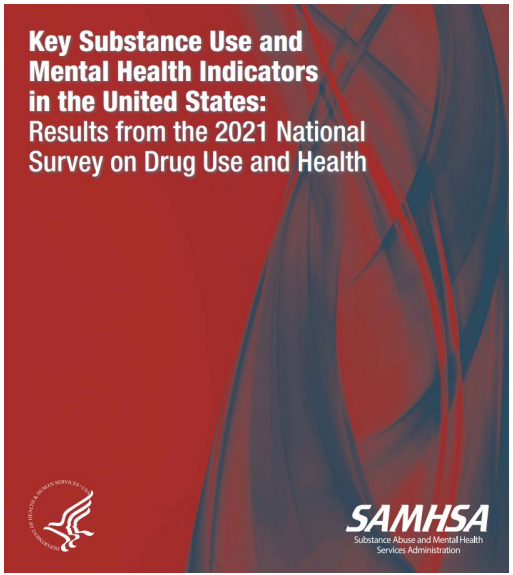
- Explanation of SUD as a chronic pattern of harmful substance use
- Co-occurring disorders may include any combination of two or more substance use disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)
- Use of DSM-5-TR criteria focusing on impact in functional domains such as school, work, and social life
- SUD can be a crisis coping mechanism, leading to serious consequences. Responders must consider biological and psychological factors, offering compassionate interventions.

Adult Case Study

- A referral was made to the mobile crisis team through a collaboration with the VA.
- The referral was for a 45-year-old woman who was having a crisis due to her living conditions and not having access to the medication needed for her Bipolar II Disorder. She used alcohol, cocaine, and Vicodin that she was obtaining on the street.
- Due to her diagnoses and her unsafe living conditions (e.g., no running water or electricity), she accepted a referral from the mobile crisis team to a sober living home and an AA group.
- She contacted the Mobile Crises Services in her County to let them know she was doing well and was grateful for their care. She is in recovery, on disability through the VA, back in her house with all utilities working, and continuing treatment and making progress on her co-occurring disorders.

Common Co-Occurring Mental Disorders with Substance Use Disorders

- Anxiety Disorders (e.g., Generalized Anxiety Disorder)
- Depressive Disorders (e.g., Major Depression Disorder)
- Bipolar and Related Disorders
- Obsessive-Compulsive and Related Disorders
- Sleep Disorders (e.g., Insomnia)
- Psychotic Disorders (e.g., Schizophrenia)
- Conduct Disorder
- Post-traumatic Stress Disorder
- Neurocognitive Disorders (e.g., Attention Deficit Hyperactivity Disorder)
- Eating Disorders (e.g., Body Dysmorphic Disorder, Anorexia Nervosa)
- Personality Disorders (e.g., Borderline Personality Disorder)

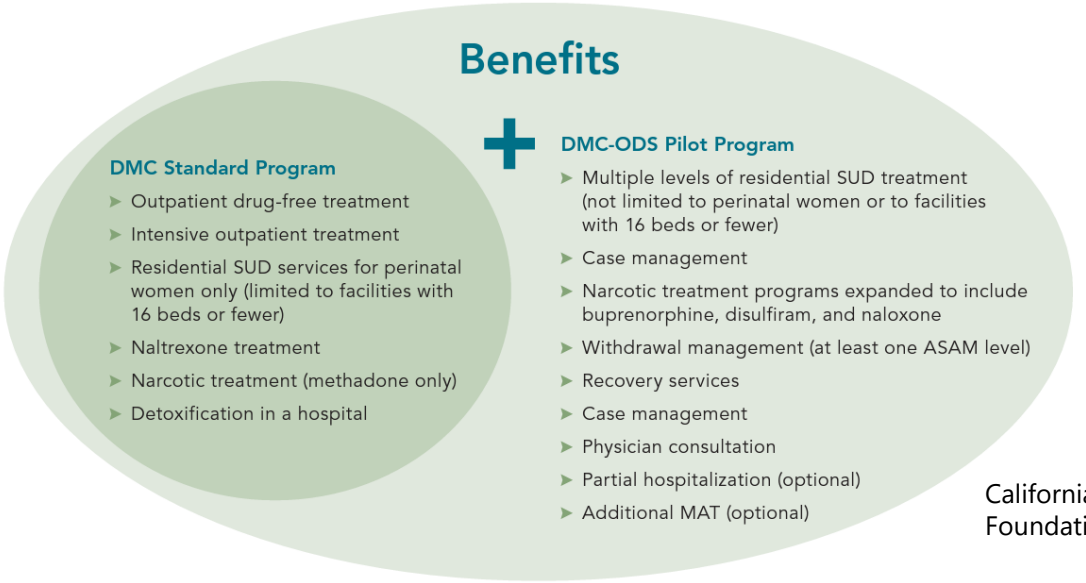


American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

Understanding Drug Medi-Cal

Figure 2. Services Provided Through Drug Medi-Cal Standard and Organized Delivery System Pilot Programs



California Health Care Foundation (2019)

Alignment of DMC-ODS with American Society of Addiction Medicine (ASAM) framework for level of placement

Interactions with DMC-ODS

- Administration of Brief Questionnaire for Initial Placement (BQuIP) for initial recommendations to the level of care
- Importance of warm handoff to SUD services during this process. For access to DMC-ODS, each county has access line for SUD services
- Mobile crisis teams must adhere to specific county policies for administration of services, especially when recommending extended DMC-ODS services

Medical Consequences Related to SUD – From Routes of Use and Direct Impact of Substances

- Liver Diseases
  - Hepatotoxicity & Complications
- Hepatitis C & HIV
  - Risks from Sharing Materials
- Hypertension
  - SUD and Elevated Blood Pressure
- Wernicke-Korsakoff Syndrome
  - Symptoms: Amnesia, Tremor, Coma, Disorientation, Vision Problems
- Diabetes can cause greater risk for health complications of substance use
  - Greater risk for self-medicating with opioids due to nerve pain

National Institute of Neurological Disorders and Stroke, 2023

Adolescent Brain and Substance Use

Adolescent brain development

Adolescence is a period of transformation, where the brain develops in a non-linear fashion, allowing for heightened emotions and reward-seeking behavior. The prefrontal cortex, responsible for self-control and decision-making, grows more slowly than the limbic system which is linked to impulsive behavior. This imbalance can cause teenagers to act without considering the consequences of their actions and pursue thrilling experiences as a result.

Effects of substance use

Substance use during adolescence can disrupt normal brain development and lead to long-term cognitive deficits. It interferes with the brain's reward system and can rewire neural pathways, increasing cravings and risk of addiction.

Early intervention

Identifying problematic substance use early and providing treatment can help prevent progression to severe substance use disorders. Counseling, support groups, and family education are important.

Youth Case Study

- A referral to the mobile crisis team came through 988.
- A peer and a clinician responded to the referral. A 15-year-old reported to her mother during an argument that she was feeling extremely worthless and having thoughts of self-harm. The youth experienced a suicide attempt the year after being sexually assaulted by a boy she briefly dated. She started smoking weed after the assault as a "means to escape." She reported to the MCT that she just wanted the bad feelings to go away and feel like a normal person again. Her mother was unaware of the sexual assault until the mobile crisis team provided services.
- The mobile crisis team provided resources and a warm handoff to a Community-Based Organization's (CBO) Teen Substance Use Disorder (SUD) program.
- During follow-up consultation, the mobile crisis team confirmed that she had received and kept an urgent appointment with the CBO.
- The mobile crisis team debriefed the call and documented the outcome, referral, and follow-up contact call in the beneficiary's file.

Risk Factors

Genetic Predisposition

- Twin Studies: Correlation of SUD and mental health disorders within families
- Genetic Markers: Discussion of DRD2 A1 allele and its implications

Early Life Experiences

- ACEs (Adverse Childhood Experiences): Higher risk for both SUD and mental health disorders.
- Parental Substance Abuse: Implications for child's mental health and risk for SUD

Psychological Factors

- Maladaptive Coping: Substance use as a form of escapism or self-medication
- Personality Disorders: Highlight the comorbidity with disorders such as bipolar disorder and antisocial personality disorder

Cultural and Societal Factors

- Stigmatization: How societal views hinder early diagnosis and treatment
- Cultural Norms: Discussion on societal norms that may inadvertently encourage substance use

Clinical Indications for Further Co-Occurring Assessment

- Multiple Hospitalizations: Elevated risk for comorbidity
- Person does not report success with Monotherapy: Indication for potential comorbidity

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

What is SBIRT?

- SBIRT is an evidence-based, **comprehensive**, **integrated**, **health** approach to the delivery of **early intervention and treatment services.**
  - For persons with or at risk of developing mental health or substance use disorders (SUD)
- SBIRT is designed for use by providers who do not specialize in SUD treatment and **can be offered in any public health, medical, or related setting**.

Babor et al. (2007)

SBIRT Outcomes

SBIRT helps:

- **Stem progression** to severe problems.
- **Improve medical conditions** exacerbated by behavioral health issues.
- **Prevent medical conditions** resulting from behavioral health disorders.
- **Reduce** substance use-related infections and **infectious diseases**.
- **Identify those at higher risk** of misusing prescription drugs.
- Have **positive influence on social function**.

Babor TF, Del Boca F, & Bray JW. (2017)

SBIRT for Adolescents

- Nationwide, 30% of high school students report having used alcohol in the previous month,[1] 14% report illicit drug use[2]
- Five substance groups accounted for 96% of the primary substances reported by the 1,537,025 Treatment Episode Data Set (TEDS) admissions aged 12 and older in 2015: alcohol (34%), opiates (34%), marijuana/hashish (14%), stimulants (9 %), and cocaine (5%)[3]
- 43% of adolescent treatment admissions were referred to treatment by the court/criminal justice system[3]

[1] Centers for Disease Control and Prevention. (2020). Underage Drinking. Retrieved from: www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm

[2] Centers for Disease Control and Prevention, Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. (2018). Youth Risk Behavior Survey Data Summary & Trends Report, 2007–2017.

[3] Substance Abuse and Mental Health Services Administration. (2017). Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS): 2005-2015. National Admissions to Substance Abuse Treatment Services*. BHSIS Series S-91, HHS Publication No. (SMA) 17-5037. Rockville, MD

Co-Occurring Mental Health and SUD Issues in Youth

- Side effects of drug use can appear to be similar to symptoms of behavioral health disorders
- Youth often use substances to cope with behavioral health symptoms, but in the long run, substances can exacerbate it
- Stopping substance use can result in an increase in experience of behavioral health symptoms before they decrease
- Youth strongly believe some substances are the only things that get them through (e.g., cannabis for ADHD or anxiety)
- Ongoing substance use can make it difficult to treat MH disorder with pharmacotherapy

Substance Abuse and Mental Health Services Administration. (2022)

Minor Consent to SUD Services

- California Family **Code § 6929**
  - Minors age 12+ may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol-related problem under this statute.
- Ask the teen for permission to include parents. If the teen's behavior is judged to be putting themselves or others at risk, consider breaching confidentiality and discussing with parents even if permission is not obtained. However, first try to:
  - Encourage teens to take lead in sharing with their parents about their use and what support looks like to them.
  - Support parents on how to use reflective listening skills to engage with their children in conversations about SUD and Co-Occurring Disorders.
  - Guide teens and parents on how to develop an action plan and what each person's role should be.
  - Connect with teens and parents about family or self experiences with use and possible co-occurring disorders/trauma experiences impacting their current response.

SBIRT Core Elements

- **Screening:** Brief screening that identifies behavioral health problems.
  - Completed before or during a mobile crisis team response.
- **Brief Intervention:** Raises awareness, via Motivational Interviewing, of risks and motivates beneficiaries to acknowledge and address problems.
  - 5-8 minutes
- **Brief Treatment:** For example, Motivational Interviewing with CBT strategies with beneficiaries with higher risk or emerging signs/symptoms.
  - 30 minutes
- **Referral:** Referral of those with more serious behavioral health issues to specialized treatment services.

Babor et al. (2007)

SBIRT Goals

- Increase **access to care** for persons with behavioral health disorders and those at risk of behavioral health disorders.
- Foster a **continuum of care** by integrating primary care and behavioral services.
- **Improve linkages** between physical health care services and behavioral health services.

Babor et al. (2007)

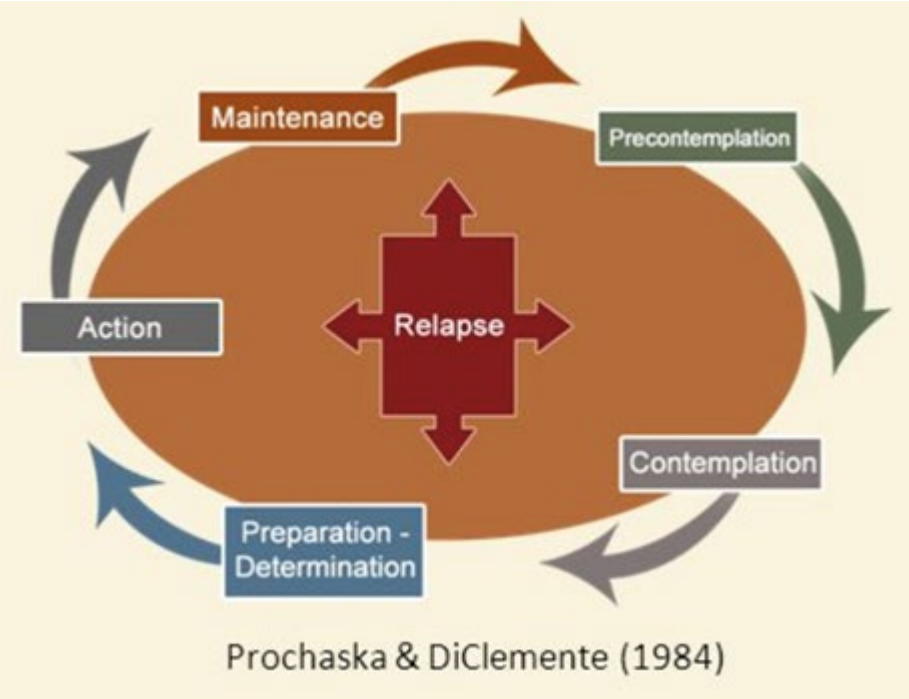
SBIRT Screening Process and Tools

- Introduce the screen
- Be specific in screening questions
- Make sure screening questions reflect the same language as the beneficiary
- Convey a non-judgmental attitude when presenting screen results, no matter what the answers are
- Screening forms and training resources are accessible in multiple languages, multiple versions for age groups and pregnant persons at sites such as: https://www.sbirtoregon.org/screening-forms/ & https://crafft.org/get-the-crafft/#repro & https://oasas.ny.gov/sbirt

- Pre-Screen
- Alcohol Screening Questionnaire (AUDIT)
- Drug Abuse Screen Test (DAST-10)
- Alcohol and Other Drug Screen for Adolescents ages 14-18 (CRAFFT 2.1+N)

Note: *Examples of screening tools, citations, and use permissions are located in an Appendix at the conclusion of this slide deck*

Stages of Change and Motivational Interviewing for developing Person-Centered Action Plans



Four-Step Brief Negotiated Interview

The Brief Negotiated Interview (BNI) is a semi-structured interview process based on Motivational Interviewing (MI) that is evidence-based and **can be completed in 5-15 minutes**.

D'Onofrio, Bernstein, Rollnick (1996)

Motivational Interviewing

"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

Miller & Rollnick, 2013, p. 29

Steps for the BNI

- Build Rapport
- Provide Feedback
- Build Readiness to Change
- Negotiate a Plan for Change

D’Onofrio et al. (2008)

BNI Step 1: Build Rapport

- **Obtain consent**
  - Thanks for filling out/completing the screening forms. Would you mind taking a few minutes to talk to me about your alcohol use and how it might relate to your experience today?
    - "No" means no.
- Start with a **general conversation and ask them open-ended questions**:
  - Tell me about a typical day in your life. Where does your use of _____ fit in?
  - What are the good things about using _____?
  - What are the not-so-good things about using _____?
- Use **reflective listening** to confirm and encourage more conversation.
- **Summarize** to reinforce what has been shared to communicate listening.

D'Onofrio et al. (2008)

BNI Step 2: Provide Feedback

- **Ask permission** to give information.
  - *I have some information on [insert health behavior/condition]. Would you mind if I shared it with you?*
- **Discuss screening findings** and/or link substance use behaviors to any known consequences.
  - *We know that _____ can put you at risk for [consequences: social or legal, illness, and injury]. It can also cause health problems like [insert relevant medical information] and make managing stressful situations more difficult. What are your thoughts on that?*
- **Evoke a response**.
  - Positive reaction-move forward
  - Negative reaction-revisit the pros and cons

D'Onofrio et al. (2008)

BNI Step 3: Build Readiness to Change

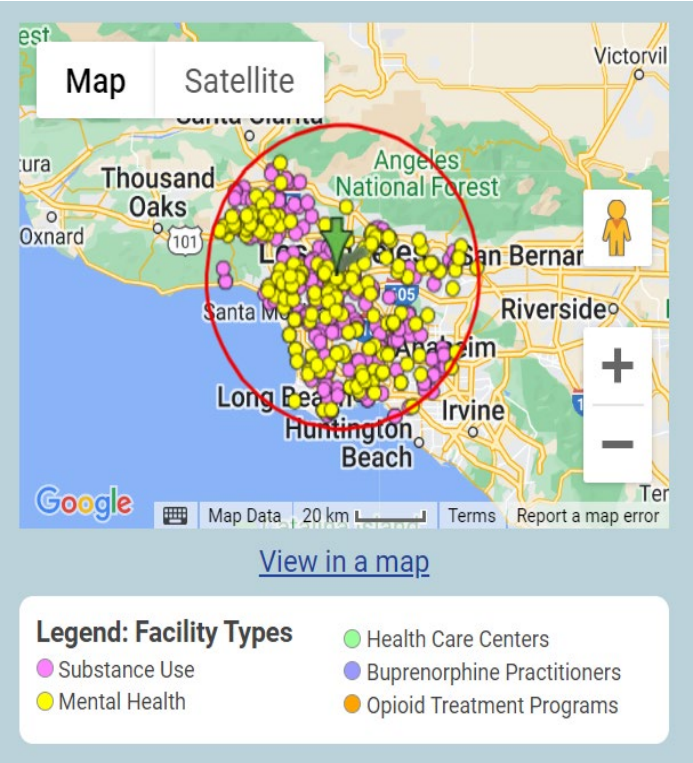
- Ask to talk for a few minutes about their interest in making a change.
- Use the readiness ruler intervention
  - On a scale of 1-10…
    - How important is it for you to change your drinking/use if 10 was most important and 1 was the least?
    - How confident are you that you can change your drinking/use?
    - How ready are you to change your drinking/use?
  - For each ask…
    - Why didn't you give it a lower number?
    - What would it take to raise that number?

BNI Step 4: Negotiate a Plan for Change

- Emphasize **strengths**
  - What are some steps/options that will work for you to stay healthy and safe? What will help you to reduce the things you don't like about _____?
- Identify **supports**
  - What supports do you have for making this change? Tell me about a challenge you overcame in the past. How can you use those supports/resources to help you now?
- Write down **steps**
  - Those are great ideas! Is it okay for me to write down your plan for you to keep as a reminder?
  - Will you summarize the steps you'll take to change your _____?
- Offer appropriate **resources**
  - I have some additional resources that people sometimes find helpful. Would you like to hear about them?
- **Thank** the Person in Crisis/Support Persons present
  - Thank you for talking with me today.

D'Onofrio et al. (2008)

Action: Referral to Treatment



- County-level Referral Sources
  - Substance Use Disorder County Access Lines
- State of California Resource Directories
  - Drug Medi-Cal Organized Delivery System
  - provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery
  - SUD Non-Emergency Treatment Referral Line
  - automated non-emergency substance use disorder (SUD) treatment referral line
  - Narcotic Treatment Programs
  - Provide opioid medication assisted treatment to persons addicted to opiates; interactive locator map
    - Provider Directory (updated 9.13.23)
- SUD Recovery Treatment Facilities- list by county of all non-medical alcoholism and drug abuse recovery or treatment facilities licensed and/or certified by the Department of Health Care Services (DHCS)
- National Resource: Findtreatment.gov- by person's address, city, zip code or facility name

Common Treatment Models

Sequential Treatment

- Considered the least ideal but may be necessary in some cases.
- Untreated psychiatric symptoms can interfere with addiction treatment and vice versa. Therefore, a transition to integrated or parallel treatment is often recommended as soon as medically appropriate.

Parallel Treatment

- Simultaneous but separate treatment for MH and SUD.

Integrated Treatment for Co-occurring Disorders

- Considered the gold standard in treating co-occurring disorders.
- Simultaneous Treatment: MH and SUD are treated concurrently and coordinated with primary medical providers.
- Ruling Out Organic Causes: Importance of assessing for medically complicating conditions, like Wernicke-Korsakoff Syndrome.

Resources to Support Mobile Crisis Teams

- Crisis counselors have access to the FREE! CA Substance Use Line 24/7, clinician to clinician support- **(844) 326-2626.**
- Compile list of local AA, NA, Al-Anon, NAMI, etc. resources or links to lists for your teams to use with People in Crisis.
- Compile a list of any on-demand access resources your County has available to MCTs and Persons in Crisis (e.g., psychiatrists, PCPs, LPHA specialists) and what times services are and are not available.

Summary

- Substance use is associated with an increased risk of developing one or more co-occurring mental illnesses (e.g., depression, anxiety, sleep, additional substance use disorders).
- Some mental illnesses (e.g., generalized anxiety, depression, bipolar disorders, schizophrenia, ADHD, conduct disorder) are risk factors for developing co-occurring substance use disorders.
- It is important to genuinely ask the Person in Crisis to define terms used for specific substances (e.g., TNT) or symptoms (e.g., shakes) to help with building rapport, decreasing misunderstanding, and developing a person-centered safety plan.
- Mobile crisis teams are encouraged to use the evidence-based SBIRT approach and Brief Negotiated Interview (BNI) method when responding to individuals who are misusing alcohol and substances to stem progression, improve and prevent medical conditions exacerbated by behavioral health issues, reduce infections, identify those at higher risk, and lead to positive influence on social functioning.
- Identifying the stage of change (e.g., pre-contemplative, contemplative, preparation, action, maintenance, or relapse) that the Person in Crisis is in helps mobile crisis team responders to better align the individual's readiness to change with their response.
- Opioid overdoses often develop over a period of hours, not always immediately. The initial dispatch reason may be unrelated to an opioid crisis. A mobile crisis team may be dispatched for an unrelated incident, which in turn becomes an opioid emergency. Each mobile crisis team must have someone on it trained to administer Naloxone and to recognize the signs of an opioid overdose.

Appendix: Practice Materials, Resources, SBIRT Screening Tools, and Additional References

Case Studies/Practice Materials

Adult Case Study

- Dax is a 41-year-old father of 4 who served in the military. He was deployed 3 times and was diagnosed with PTSD.
- He fell off a roof last year, hurting his back and badly breaking his leg. He was given Percocet by his doctor, and it led to an addiction.
- He has depleted his family's savings and lost his job for stealing to support his addiction. His wife does not know yet that they are out of money and will lose their home. He has always been the provider and in charge of the financials.
- Dax called mobile crisis because he feels like a failure and thinks his wife and kids would be better off without him.

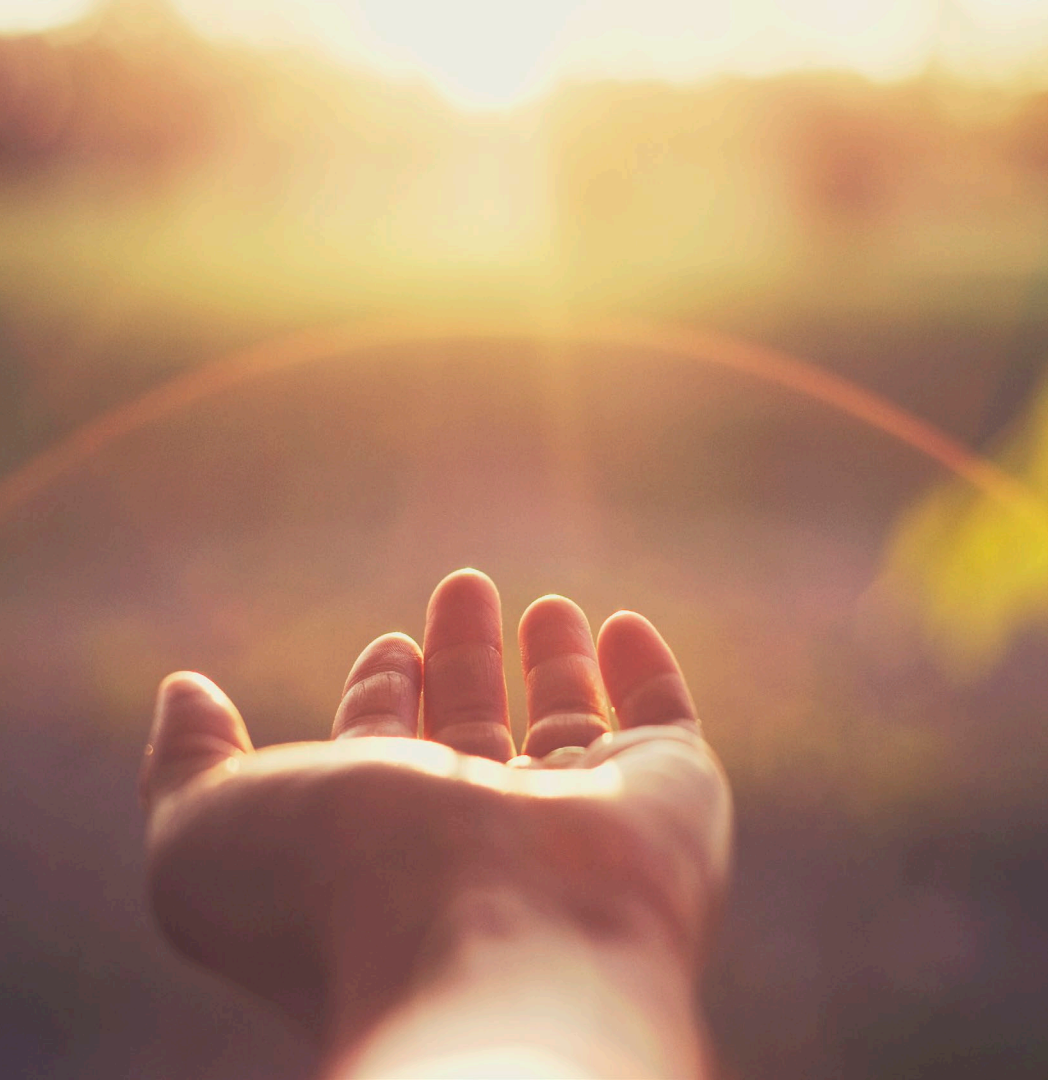
Case Study Practice Questions

What stage of change is the person in currently?

What co-occurring disorders are you going to want to screen for?

What open-ended questions would you want to ask in your continued assessment?

What post-crisis care resources and follow-up would you potentially be considering for this person?



Youth Case Study

Tanasia is a 15-year-old who lives with her grandmother and younger brother (age 12). Their parents are both incarcerated and will not be released for another 5-10 years.

Her brother showed their grandmother that she has been posting pictures to her social media about drinking and using drugs. Last night, she posted about wanting to run away with her boyfriend. Her grandmother called the school for help. She is also suspicious about a possible pregnancy.

Tanasia is crying uncontrollably in her guidance counselor's office. She doesn't want her grandmother to keep her and her boyfriend apart. She is hesitant but willing to talk with a mobile crisis team.

Case Study Practice Questions

What stage of change is the person in currently?

What co-occurring disorders are you going to want to screen for?

What open-ended questions would you want to ask in your continued assessment?

What post-crisis care resources and follow-up would you potentially be considering for this person?

Resources

12 Step Groups

AA (https://www.aa.org/)
NA (https://na.org/)
Marijuana Recovery (https://marijuana-anonymous.org/find-a-meeting/)
Cocaine Anonymous (https://canorcal.org/)
Celebrate Recovery (https://locator.crgroups.info/)
Lifering (https://lifering.org/f2f-meetings/)
Women for Sobriety (https://womenforsobriety.org/meetings/)
Crystal Meth Anonymous (https://www.crystalmeth.org/meetings/)
SMART Recovery (https://meetings.smartrecovery.org/meetings/?reset_search=true)
Sexaholics Anonymous (https://www.sa.org/f2f/United-States-of-America/California/)
Buddhist Recovery Network (https://www.buddhistrecovery.org/meetingslisting/meetings/United+States/California.htm)
Refuge Recovery (https://www.refugerecovery.org/)

Other Meetings

Co-dependent Anonymous (https://coda.org/find-a-meeting/)
Adult Children of Alcoholics and dysfunctional families (https://adultchildren.org/meeting-group/)
Nar-Anon Families and Friends of Addicts (https://www.nar-anon.org/)

Resources

- Fentanyl & Overdose Prevention. (2023). Ca.gov. https://www.cdph.ca.gov/Programs/OPA/Pages/Communications-Toolkits/Fentanyl-Overdose-Prevention.aspx
- Choose Change California- website about Medication Assisted Treatment and "whole-patient" approach to treatment of persons with Opioid Use Disorder https://choosechangeca.org/
- SBIRT Adolescents Learners Guide V1.1: https://www.chcs.org/media/Copy-of-Adolescent-SBIRT-Learners-Guide-V1.1-all-modules-1.pdf
- SBIRT for Pregnant and Postpartum Women: https://amchp.org/wp-content/uploads/2022/01/AMCHP-NASADAD-SBIRT-Issue-Brief-October-2020.pdf

References

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787
- Association of Maternal and Child Health Programs. (2020). *Opportunities for State MCH Programs Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Pregnant and Postpartum Women*. https://amchp.org/wp-content/uploads/2022/01/AMCHP-NASADAD-SBIRT-Issue-Brief-October-2020.pdf
- Babor TF, Del Boca F, & Bray JW. (2017). Screening, Brief Intervention and Referral to Treatment: Implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. Addiction 112(Suppl. 2): 110-117. http://dx.doi.org/10.1111/add.13675
- Babor, T.F., McRee, B.G., Kassebaum, P.A., Grimaldi, P.L., Ahmed, K., & Bray, J. (2007). *Screening, Brief Intervention, and Referral to Treatment (SBIRT) toward a public health approach to the management of substance abuse*. Substance Abuse, 28 (3), 7–30. DOI: 10.1300/J465v28n03_03
- Brief Questionnaire for Initial Placement (BQuIP) User's Manual Beta version. (2020). URL
- Brunette, M. F., Mueser, K. T., Babbin, S. F., Meyer-Kalos, P., Rosenheck, R. A., Correll, C. U., Cather, C., Robinson, D. G., Schooler, N. R., Penn, D. L., Addington, J., Estroff, S. E., Gottlieb, J. D., Glynn, S. M., Marcy, P., Robinson, J. A., & Kane, J. M. (2018). Demographic and clinical correlates of substance use disorders in first episode psychosis. Schizophrenia Research, 194, 4–12. DOI
- California Family Code, § 6929

References

- California Health Care Foundation. (2019). The Drug Medi-Cal Organized Delivery System. The Drug Medi-Cal Organized Delivery System (chcf.org)
- Centers for Disease Control and Prevention. (2020). Underage Drinking. Retrieved from: www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm
- Centers for Disease Control and Prevention, Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. (2018). Youth Risk Behavior Survey Data Summary & Trends Report, 2007–2017.
- D'Onofrio G., Bernstein E., & Rollnick S. (1996). Motivating patients for change: a brief strategy for negotiation. In: Bernstein E, Bernstein J, eds. Case studies in emergency medicine and the health of the public (Unit IV, Chapter 31), Boston, MA: Jones and Bartlett
- D'Onofrio, G., Pantalon, M.V., Degutis, L.C., O'Connor, P.G., Fiellin, D., et al. (2008). Screening, brief intervention and referral to treatment (SBIRT) training manual for alcohol and other drug programs. Yale University School of Medicine
- Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. (2016). URL
- Fentanyl Facts. (2023). URL
- Flentje A, Barger BT, Capriotti MR, Lubensky ME, Tierney M, Obedin-Maliver J, et al. (2020). "Screening Gender Minority People for Harmful Alcohol Use." PLoS ONE. 15(4)

References

- Ghelani, A. (2021). Knowledge and Skills for Social Workers on Mobile Crisis Intervention Teams. Clinical Social Work Journal, 50(4), 414–425. DOI
- Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. (2016). URL
- Fentanyl Facts. (2023). URL
- Gateway Foundation. (2018). Drug Overdose Signs and Symptoms. URL
- He, J., Yan, X., Wang, R., Zhao, J., Li, J., Zhou, C., & Zeng, Y. (2022). Does Childhood Adversity Lead to Drug Addiction in Adulthood? A Study of Serial Mediators Based on Resilience and Depression. Frontiers in Psychiatry, 13. DOI
- Johnson J, Lee A, Vinson D, Seale P. (2013). "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, E253–E259
- Kilaru, A. S., Liu, Y., Gupta, R., Perrone, J., M. Kit Delgado, Meisel, Z. F., & Lowenstein, M. (2021). Naloxone prescriptions following emergency department encounters for opioid use disorder, overdose, or withdrawal. American Journal of Emergency Medicine, 47, 154–157. DOI

References

- Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. (1999). A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med;153(6):591-6
- Luciana, M., Bjork, J. M., Nagel, B. J., Gonzalez, R., Sara Jo Nixon, & Banich, M. T. (2018). Adolescent neurocognitive development and impacts of substance use: Overview of the adolescent brain cognitive development (ABCD) baseline neurocognition battery. Developmental Cognitive Neuroscience, 32, 67–79. DOI
- Management of Suspected Opioid Overdose with Naloxone Guidelines by Emergency Medical Services Personnel | Effective Health Care (EHC) Program. (2016). URL
- McNeely J, Cleland C, Strauss S, Palamar J, Rotrosen J, Saitz R. (2015). Validation of Self-Administered Single-Item Screening Questions (SISQs) for Unhealthy Alcohol and Drug Use in Primary Care Patients. J Gen Intern Med, 30, 1757–1764..
- McNeely J, Strauss SM, Saitz R, Cleland CM, Palamar JJ, Rotrosen J, Gourevitch MN. (2015). A Brief Patient Self-administered Substance Use Screening Tool for Primary Care: Two-site Validation Study of the Substance Use Brief Screen (SUBS). Am J Med. 2015 Jul;128(7):784.e9-19. Epub
- Medications for Opioid Use Disorder For Healthcare and Addiction Professionals, Policymakers, Patients, and Families TREATMENT IMPROVEMENT PROTOCOL TIP 63. (2021). URL

References

- Murthy, V. (2017). Surgeon General's Report on Alcohol, Drugs, and Health. *JAMA, 317 2*, 133-134 .https://store.samhsa.gov/sites/default/files/d7/priv/surgeon-generals-report.pdf
- National Academies of Sciences, Engineering, and Medicine. (2021). Crisis Standards of Care: Ten Years of Successes and Challenges: Proceedings of a Workshop. Washington, DC: The National Academies Press. https://doi.org/10.17226/25767
- Newcomb, M. E., Hill, R., Buehler, K., Ryan, D. T., Whitton, S. W., & Mustanski, B. (2019a). High Burden of Mental Health Problems, Substance Use, Violence, and Related Psychosocial Factors in Transgender, Non-Binary, and Gender Diverse Youth and Young Adults. Archives of Sexual Behavior, 49(2), 645–659. DOI
- Newcomb, M. E., Hill, R., Buehler, K., Ryan, D. T., Whitton, S. W., & Mustanski, B. (2019b). High Burden of Mental Health Problems, Substance Use, Violence, and Related Psychosocial Factors in Transgender, Non-Binary, and Gender Diverse Youth and Young Adults. Archives of Sexual Behavior, 49(2), 645–659. DOI
- NORC at the University of Chicago. (2016). Guide to Adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT). Bethesda, MD: NORC at the University of Chicago. https://www.chcs.org/media/Copy-of-Adolescent-SBIRT-Learners-Guide-V1.1-all-modules-1.pdf
- Office, A. (2021, November 19). Drug Misuse: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. URL

References

- Paquette, C., Daughters, S. B., & Witkiewitz, K. (2022). Expanding the continuum of substance use disorder treatment: Nonabstinence approaches. Clinical Psychology Review, 91, 102110–102110. DOI
- Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin
- Rhoads, J. M. (2022). State naloxone co-prescribing laws show mixed effects on overdose mortality rates - MaryKate Duska, Jared M. Rhoads, Elizabeth C. Saunders, Tracy Onega, 2022. Drug Science, Policy and Law. DOI
- SAMHSA. (2019). Risk and Protective Factors (p. 1). URL
- SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care -A Best Practice Toolkit Knowledge Informing Transformation National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit National Guidelines for Behavioral Health Crisis Care -A Best Practice Toolkit Knowledge Informing Transformation. URL
- SAMHSA. (2020b). Substance Use Disorder Treatment for People With Co-Occurring Disorders UPDATED 2020 TREATMENT IMPROVEMENT PROTOCOL TIP 42. URL
- SAMHSA. (2020c). Substance Use Disorder Treatment for People With Co-Occurring Disorders UPDATED 2020 TREATMENT IMPROVEMENT PROTOCOL TIP 42. URL

References

- SAMHSA Opioid Overdose Prevention TOOLKIT Five Essential Steps for First Responders. (2018). URL
- Skinner,H.A., (1982). The drug abuse screening test. *Addictive Behaviors*, 7(4), 363-372.
- State of California Department of Health Care Services Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications. (2022). URL
- Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
- Substance Abuse and Mental Health Services Administration. (2017). Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS): 2005-2015. National Admissions to Substance Abuse Treatment Services*. BHSIS Series S-91, HHS Publication No. (SMA) 17-5037. Rockville, MD
- The Brief Questionnaire for Initial Placement. (2023). URL
- TIP 63: Medications for Opioid Use Disorder - Full Document | SAMHSA Publications and Digital Products. (2023). URL

Appendix: SBIRT Screening Tools

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

How many times in the past year have you had **4** or more drinks in a day? _____

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

Developed by SBIRT Oregon, Brief-screen-English-pdf.pdf (sbirtoregon.org)

Pre Screen

- Given to adults ages 18 and older.
- One alcohol question and one drug question. Positive responses warrant further screening.
- The alcohol question has been modified, with permission from the author, to be gender inclusive.
- Includes the PHQ-2 screening tool for depression.

Flentje et al., (2020)
McNeely, Cleland, et al. (2015)
McNeely, Strauss et al., (2015)

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

_____

_____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for alcohol use? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W, GM, ≥65:	0-3	4-12	13-19	20+

Alcohol Screening Questionnaire (AUDIT)

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score	Zone	Explanation	Action
0-3	I – Low Risk	"Someone using alcohol at this level is at low risk for health or social complications."	Positive Health Message – describe low risk drinking guidelines
4-9	II – Risky	"Someone using alcohol at this level may develop health problems or existing problems may worsen."	Brief intervention to reduce use
10-13	III – Harmful	"Someone using alcohol at this level has experienced negative effects from alcohol use."	Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available)
14+	IV – Severe	"Someone using alcohol at this level could benefit from more assessment and assistance."	Brief Intervention to accept referral to specialty treatment for a full assessment

* Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

Drug Abuse Screen Test (DAST-10)

To request permission to use the tool, please contact Dr. Harvey Skinner at hskinner@yorku.ca

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

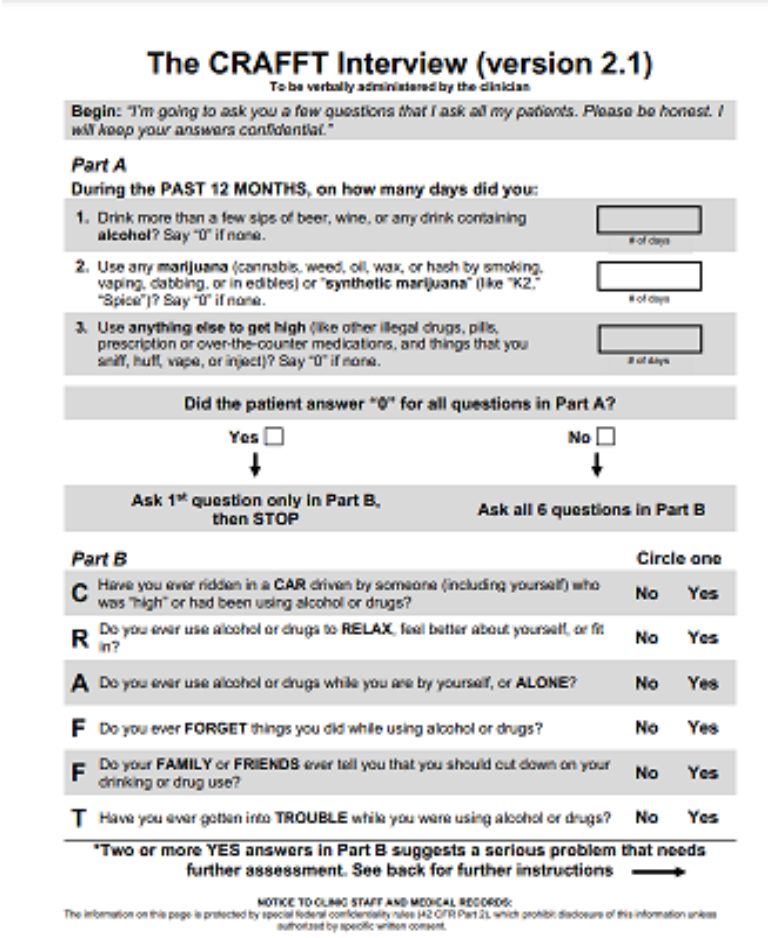
The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		Score:	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Alcohol and Other Drug Screen for Adolescents ages 14-18



The CRAFFT Interview (version 2.1)

To be verbally administered by the clinician

Begin: *"I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."*

Part A

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none. ____ # of days
2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Say "0" if none. ____ # of days
3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Say "0" if none. ____ # of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask 1st question only in Part B, then STOP**

No ☐ → **Ask all 6 questions in Part B**

Part B		Circle one	
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Yes
R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	No	Yes
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	No	Yes
F	Do you ever **FORGET** things you did while using alcohol or drugs?	No	Yes
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	No	Yes
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	No	Yes

***Two or more YES answers in Part B suggests a serious problem that needs further assessment. See back for further instructions →**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.

https://crafft.org/get-the-crafft/

Instructions

The CRAFFT is a 6-item, screening instrument that is used to screen for alcohol and other drug use in the adolescent population ages 14 to 18 years old. The CRAFFT takes approximately 5 minutes to administer and score.

Administration: The CRAFFT is a self-administered screening but it can be read to the adolescent if necessary.

Scoring and Interpretation: Score (1) point for each "YES" answer. A score of (2) or more indicates the need for further assessment.

CRAFFT Score	Degree of Problem Related to Alcohol/Other Drug Abuse	Suggested Action
0 - 1	No problems reported	None at this time.
2 or More	Potential of a significant problem.	Assessment required.

Knight et al., (1999)

Questions?

DHCS

Thank You!

DHCS