NAADAC'S LIFE-LONG LEARNING SERIES
in partnership with Hazelden

INTEGRATING TREATMENT FOR CO-OCCURRING DISORDERS: AN INTRODUCTION TO WHAT EVERY ADDICTION COUNSELOR NEEDS TO KNOW

Participant's Reference Guide and Workbook

presented by:

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A SPECIAL THANK YOU

NAADAC, the Association for Addiction Professionals, and Hazelden understand the need for continuous education and strive to provide addiction-focused professionals the latest training to remain knowledgeable and pursue best practices for clients. The addiction profession is constantly changing to reflect new research and new understanding of the populations we serve. As a result, NAADAC and Hazelden have partnered to provide addiction professionals comprehensive education on co-occurring disorders.

This manual has been developed as a resource for addiction-focused professionals who work with clients suffering from co-occurring disorders. More and more of the clients who seek out treatment will exhibit this complex condition. The 2005 National Survey on Drug Use and Health produced by SAMHSA, estimates that 2.7 million adults had co-occurring major depressive episode and alcohol use disorder in the past year. Further, it is estimated that less than ten percent of adults who have a co-occurring disorder and alcohol use disorder received treatment for both problems.

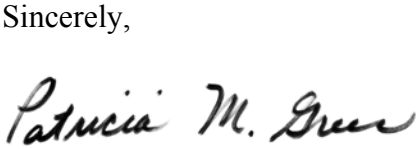
This manual is intended to be a resource for professionals seeking to expand their knowledge of best practices in treating co-occurring disorders. The concept of co-occurring disorders will be defined, along with a chronology of identifying and assessing this and other mental health and addiction related issues. Common mental health disorders will be described and treatment strategies for co-occurring ailments will be introduced.

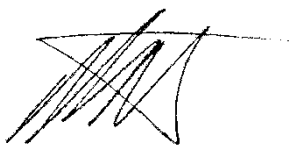
Many writers and consultants volunteered their time and knowledge during the development of the training materials. NAADAC and Hazelden would like to extend its sincerest appreciation to the numerous contributors to this project: Marty Harding, Sue Hoisington, Jim Holder, Donovan Kuehn, Kaylene McElfresh, Richard Solly, Gerry Schmidt, Misti Storie, Cynthia Moreno Tuohy and Mary Woods. This project could not have been completed without the many hours of brainstorming, researching, writing, reviewing and editing so this product could be a significant contribution to the addiction profession.

NAADAC's Life-Long Learning Series *Integrating Treatment for Co-occurring Disorders: What Every Addiction Counselor Needs to Know* is only one of many planned educational projects geared at providing comprehensive and unbiased education to the addiction profession. NAADAC and Hazelden recognize you have a choice in education providers, and we are delighted you have chosen to take part in this educational seminar and build your toolbox of treatment resources. Thank you for your dedication to the addiction profession!

Together, we can and are making a difference!

Sincerely,





Patricia M. Greer, LCDC, AAC
President of NAADAC, the Association for Addiction Professionals

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SECTION ONE:

INTRODUCTION TO CO-OCCURRING DISORDERS

In this chapter, co-occurring disorders are defined, commonly held myths are dispelled and the history of treatment for co-occurring disorders is outlined.

MYTHS AND FACTS

Addiction professionals have varying opinions and beliefs about co-occurring disorders. Some of the beliefs held by the profession are accurate, while, other opinions do not reflect current research, literature or current practice. This section will discuss some of the most commonly held misconceptions concerning co-occurring disorders, as well as some useful facts that will help addiction professionals better understand the co-occurring disorder population.

Please describe three beliefs you currently have about co-occurring disorders.

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MYTHS ABOUT CO-OCCURRING DISORDERS

MYTH: Addiction professionals are not competent to recognize, assess or treat mental health disorders.

It is commonly believed that addiction professionals are only equipped to treat individuals with substance use disorders. However, the majority of addiction professionals today have at least a bachelor's degree and more often than not a master's degree, which means that they have been formally educated with at least some basic level training on mental health disorders as a requirement for licensure, either as a certified addiction counselor (CAC) or licensed professional counselor (LPC). This training may not be as in depth as a licensed social worker (LSW), but most addiction counselors today have received some level of training in mental health during their careers. To achieve the status of Master Addiction Counselor (MAC), advanced training is required. Many states now require addiction counselors to take at least one course on co-occurring disorders to learn how to treat these illnesses.

Given that so many clients with substance use disorders have *co-morbid disorders*,[1] it can be assumed that most addiction professionals have been interacting with clients with mental health disorders since the beginning of their careers. While this on-the-job-training is no replacement for academic or continuing education about co-occurring disorders, it can provide invaluable and significant insight to the treatment team. While early practitioners often had no formal training in addiction intervention and treatment and relied on their own personal background in recovery, today, addiction professionals rely on a foundation of training and education.

Mental health and substance use disorders are categorized as brain diseases because we know that these diseases occur at the neurological level and that by understanding the biology we can develop effective treatment interventions. These interventions can be behavioral, cognitive, spiritual or more effective medications. For people with co-occurring disorders, both illnesses are occurring at the same time and are interrelated. Both are primary disorders and need to be conceptualized as such.

MYTH: Individuals with co-occurring disorders cannot achieve recovery.

This myth is partially perpetuated by differing definitions of "recovery" among the various entities that use the term. For example, addiction professionals may refer to individuals in recovery as those who have changed their substance abusing behavior for the duration of their lives, regardless of whether they have engaged in formalized treatment, Twelve Step programs or either of the two. On the other hand, those individuals who attend Twelve Step programs may define recovery as abstinence from drugs and/or alcohol (or addictive behaviors) and a personal dedication to "work the steps" in the Twelve Step program. Further, mental health professionals may define recovery as "a process in which the client moves toward specific behavioral goals through a series of stages, [and] recovery is assessed by whether or not these goals are achieved."[i] Finally, clients with a mental health and/or substance use disorder may view recovery as "the process of reclaiming a meaningful life beyond [their disorder], with symptom control and positive life activity."[ii] As one can see, the definition of "recovery" varies from one profession and one person to another.

Regardless of the differences, all of these definitions share the common result of changing the individual's unhealthy living that has caused significant distress in his or her life. Undoubtedly, clients with co-occurring disorders are able to successfully change unhealthy behaviors and thoughts and accomplish "recovery" according to the four definitions above, as well as many other common indicators of recovery, such as "improved health, better ability to care for oneself and others, a higher degree of independence, and enhanced self-worth."[iii] In short, the presence of two or more co-occurring mental health and substance use disorders does not prevent a client from achieving recovery, in any sense of the word.

[1] The definition of words or phrases that are underlined and *italicized* can be found in the Glossary beginning on page 162.

MYTH: Individuals with co-occurring disorders do not respond well to treatment.

It is true that clients with co-occurring disorders have less favorable outcomes than those who suffer only from either a substance use disorder or a mental health disorder. However, individuals with co-occurring disorders most certainly respond to and can benefit from effective treatment. Research establishes why people with co-occurring disorders often have unfavorable outcomes, including:

- Leaving treatment early;
- Frequent transfer of the client between clinicians and/or treatment facilities;
- High rates of recidivism and return to treatment;
- No decline in substance use;
- No improvement in psychiatric symptoms;
- High incidence of suicide;
- High incidence of victimization;
- Increased use of medical services (including hospitals and emergency services);
- Legal problems, such as incarceration;
- High incidence of relationship distress;
- Work and school problems; and
- Less satisfaction with treatment.[iv]

Many of these barriers to successful treatment can be addressed through programs designed specifically for clients with co-occurring disorders and the unique needs of this population. By addressing both the mental health disorders and substance use disorders through an integrated treatment approach (discussed in detail later in this educational program) provides clients with co-occurring disorders greater opportunities to succeed in treatment.

MYTH: Individuals with co-occurring disorders will not participate in self-help groups.

The use of self-help programs has traditionally been a cornerstone to addiction treatment and recovery. However, individuals with co-occurring disorders are often regarded as difficult members and unsuitable for participation in addiction-focused, self-help meetings. Some mistakenly think that individuals with co-occurring disorders cannot or should not attend Alcoholics/Narcotics Anonymous groups because their mental health disorder may cause them to exhibit a host of psychiatric and substance-related symptoms that could disrupt meetings for others. This assumption simply is not true. These individuals attending AA or NA meetings act like anyone else. In fact, they often feel stigmatized and rarely mention their mental health disorder for fear of being judged. People with mental health problems can benefit just as others

do from the shared experiences of others and achieve recovery through the mutual support of their peers. In addition, many groups specifically designed for clients with co-occurring disorders have emerged to meet this need, such as Double Trouble in Recovery, Dual Recovery Anonymous, Dual Diagnosis Anonymous and Dual Disorders Anonymous. Contact information for each of these self-help groups can be found in the Resources section of this manual.

MYTH: Clients with substance use disorders should not take medications.

This myth is widely believed due to the strong influence of Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and other Twelve Step programs. To some members of Twelve Step fellowships, the use of what some believe to be mood-altering medications, such as antidepressants, is contradictory to a substance-free lifestyle. Some members may express their outright disapproval; while others may feel suspicious. This belief was more widespread than it is today. However, contrary to popular belief, neither Alcoholics Anonymous/Narcotics Anonymous literature nor either of its founding members spoke or wrote against using medications as a component of a recovery plan. This belief was held by leaders of specific chapters and spread erroneously to be AA/NA doctrine.[v] AA/NA does not endorse encouraging its members to discontinue taking prescribed medications for the treatment of addiction, and these organizations directly address this topic in many locations throughout their literature:

- Alcoholics Anonymous World Services, Inc., the administrative headquarters for AA published a pamphlet, entitled "The AA Member – Medications and Other Drugs," which stated:

  "At the same time that we recognize this dangerous tendency to re-addiction, we also recognize that alcoholics are not immune to other diseases…Because of the difficulties many alcoholics have with drugs, some members have taken the position that no one in AA should be on medication. While this position has undoubtedly prevented relapses for some, it has meant disaster for others…It becomes clear that just as it is wrong to enable or support any alcoholics to become re-addicted to any drug, it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems."[vi]

- *The Big Book*, the primary reference tool written by the founders of AA, states:

  "God has abundantly supplied this world with fine doctors, psychologists, and practitioners of various kinds. Do not hesitate to take your health problems to such persons. Most of them give freely of themselves, that their fellows may enjoy sound minds and bodies. Try to remember that though God has wrought miracles among us, we should never belittle a good doctor or psychiatrist. Their services are often indispensable in treating a newcomer and in following his case afterward."[vii]

- The NA website states the following:

  "In Narcotics Anonymous, members are encouraged to comply with complete abstinence from all drugs including alcohol. It has been the experience of NA members that complete and continuous abstinence provides the best foundation for recovery and personal growth. NA as a whole has no opinion on outside issues, including prescribed medications. Use of psychiatric medication and other medically indicated drugs prescribed by a physician and taken under medical supervision is not seen as compromising a person's recovery in NA."[viii]

This strong stance by AA and NA to not discourage the use of prescribed medications further promotes the concept of co-occurring disorders and legitimizes the simultaneous treatment of any mental health disorders with the treatment of the substance use disorder(s).

Check which medications are nonaddictive and appropriate for use with clients with a substance use disorder:

❑ Prozac® ❑ OxyContin® ❑ Neurontin® ❑ Cymbalta®

❑ Zyban® ❑ Effexor® ❑ Ambien®

FACTS ABOUT CO-OCCURRING DISORDERS

FACT: Many addiction professionals are not comfortable treating clients with co-occurring disorders.

Addiction professionals who are uncomfortable treating clients with co-occurring disorders need not feel ashamed or embarrassed by these feelings because they are not alone. It can be unsettling to treat clients with multiple, interacting diagnoses, especially when the client suffers from severe mental illness. This discomfort could be due to a lack of experience, training or mentoring opportunities with this client population. Some addiction professionals simply may not wish to treat clients outside of the substance use discipline.

Regardless of the reason, it is important to acknowledge these feelings, and like all biases held, one must work to prevent them from interfering with the client's treatment. This can be accomplished by implementing the following three-step model recommended by the American Association for Multicultural Counseling & Development (AAMCD):

1) The addiction professional must gain self-awareness of his or her own assumptions, values and biases.
2) The addiction professional must gain an understanding of the client's worldview.
3) The addiction professional must develop appropriate intervention strategies and techniques to help the client receive the best and most appropriate treatment.[ix]

This three-step model, coupled with further education, experience, training, supervision and mentoring, can often help an addiction professional overcome his or her discomfort in addressing co-occurring disorders. Attending this training is an important step in this process.

FACT: Having co-occurring disorders is stigmatizing for clients.

Even more so than individuals with only one mental health or substance use disorder, clients with co-occurring disorders experience significant stigmatization and discrimination from society-at-large, as well as the treatment community. The lack of understanding about co-occurring disorders leads to stereotyping. The complexity of existing with more than one disorder is sometimes daunting to these clients, often resulting in demoralization, despair, shame and/or guilt. It is important for mental health and addiction professionals to inspire hope within these individuals and dispel the negative messages they might have heard about their illnesses, so they may continue to be motivated in treatment and increase their chances of recovery.

FACT: Many addiction facilities are not prepared to treat individuals with co-occurring disorders.

It is not uncommon for clients with co-occurring disorders to present in treatment facilities that do not have the staff, training or resources available to treat the unique and varying needs of this population. These clients "may be treated for one disorder without consideration of the other disorder, often 'bouncing' from one type of treatment to another as symptoms of one disorder or another become predominant."[x] Even worse, some clients simply "fall through the cracks" and do not receive treatment because the facility is not equipped to screen and assess, let alone treat, co-occurring disorders.

These clients are being underserved and not being afforded equal opportunities to recover from their co-occurring disorders and live healthy, functional lives. As such, the Center for Substance Abuse Treatment (CSAT) introduced the "no wrong door" policy, which stated that every door to in the healthcare system should be a "right" door into treatment. Further, each mental health and addiction provider "has a responsibility to address the range of client needs wherever and whenever a client presents for care."[xi] In the event that the professional or treatment facility is unable to provide the needed services to a client, he or she should "carefully be guided to appropriate, cooperating facilities, with follow-up by staff to ensure that clients receive proper care."[xii] This principle leaves no room for interpretation about the quality of care that should be provided to clients with co-occurring disorders, regardless of the "door" through which they enter.

FACT: Individuals with co-occurring disorders are more likely to seek treatment.

Considering that clients with co-occurring disorders commonly appear at facilities not prepared to treat them, this fact is even more alarming. Research suggests that the presence of two or more co-occurring disorders largely increases the likelihood that the individual will seek treatment. This could partially be due to the fact these clients are more likely to be hospitalized and therefore, be brought to the attention of mental health and addiction professionals. Regardless, individuals with co-occurring disorders are obviously in need of treatment and the profession must make sure they are receiving the services they deserve if and when they seek help.

FACT: Divided funding streams, insurance reimbursement policies and state/federal mandates make it more difficult for clients with co-occurring disorders to receive effective treatment.

Mental health and addiction services are primarily supported through separate funding streams at the state level. This separation reflects what happens at the community level struggling to provide effective treatment for clients with co-occurring disorders. For example, the Substance Abuse Prevention and Treatment (SAPT) block grant is a significant source of funding for state substance abuse treatment, whereas the Community Mental Health Services (CMHS) block grant funds state mental health services. This division leaves the burden of aggregating funds to pay for the treatment of co-occurring disorders on the service providers. Further, the amount of funding provided to each profession is not equal. For example, Medicaid spends approximately $1 billion per year on substance abuse treatment services, yet spends approximately $20 billion per year on mental health services.[xiii]

Insurance reimbursement policies are just as disparate. An individual is more likely to have an insurance carrier pay for some portion of treatment if he or she has a mental health disorder as compared to a substance use disorder. Often, insurance carriers will grant longer treatment periods for mental health disorders than for a substance use disorders, if coverage is provided at all. Policies such as these make it more difficult to for clients with co-occurring disorders to pay for effective treatment that is often extensive and costly.[xiv] The newly passed *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* provides parity for mental health and addiction payments. We are hopeful it will help more clients with co-occurring disorders by reimbursement for effective treatment.

At the federal level, there is an identified lack of coordination between federal agencies responsible for implementing and regulating mental health and addiction services. To make matters worse, there are also conflicting statutory requirements and requirements among these agencies that are impeding the delivery of effective treatment services to clients with co-occurring disorders.[xv]

Please describe what opinions you have, if any, about the mental health profession.

Please describe what opinions you have, if any, about the addiction profession.

How has the discussion of these myths changed or affected how your view mental health disorders and/or the clients who have them?