

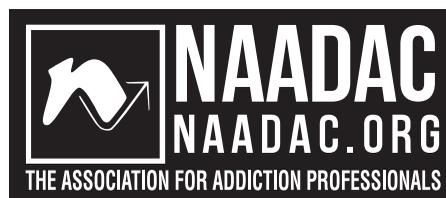
NAADAC'S LIFE-LONG LEARNING SERIES

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

PARTICIPANT'S REFERENCE GUIDE AND WORKBOOK

- SECOND EDITION -

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NAADAC, the Association for Addiction Professionals

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A SPECIAL THANK YOU

NAADAC, the Association for Addiction Professionals, understands 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 is providing 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 2014 National Survey on Drug Use and Health produced by SAMHSA, estimates that 7.9 million adults had co-occurring disorders in the previous year. Further, it is estimated that less than half of adults who have a co-occurring disorders received treatment for both problems (Substance Abuse and Mental Health Services Administration, 2015).

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 would like to extend its sincerest appreciation to the numerous contributors to this project: Thomas Durham, Marty Harding, Sue Hoisington, Jim Holder, Donovan Kuehn, Rose Maire, 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 recognizes 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,



Gerard J. "Gerry" Schmidt, MA, MAC, LPC, CAC

President of NAADAC, the Association for Addiction Professionals

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EXECUTIVE SUMMARY

Co-occurring disorders are not uncommon in clients seeking treatment for substance use disorders. In fact, 50% to 75% of all clients who are receiving treatment for a substance use disorder also have another diagnosable mental health disorder (CSAT, 2013). Further, it has been estimated that, among the general public, 20% to 50% of those with mental disorders currently have or had a co-occurring substance use disorder at some point in their lives (Mueser & Gingerich, 2013; SAMHSA, 2015). These individuals are in need of specialized addiction treatment, as well as mental health services. Recognition of the presence of co-occurring disorders continues to be a significant factor in substance use disorder treatment, as has the need for appropriate education and skill building in this area. This educational program was designed to meet this need.

Historically, there have been several models of treatment that available to clients with co-occurring disorders: single model of care, sequential model of treatment, parallel model of treatment, and integrated model of treatment. However, the preferred model of treatment for co-occurring disorders is the integrated approach because it utilizes one competent treatment team at the a single facility to recognize and address all mental health and substance use disorders at the same time. With an integrated model of treatment, no disorder is identified as being “primary” or “underlying” in relation to another disorder. Instead, all co-occurring disorders are treated as one unit that is causing dysfunction and despair in the client’s life. The integrated model of treatment addresses and/or eliminates many of the barriers to successful treatment inherent in other models of treatment.

Under the integrated model of treatment, the use of the transtheoretical model of behavioral change (also known as the stages of change model) in conjunction with motivational interviewing can be very useful in fostering the client’s level of internal motivation to change his or her life, as well as his or her level of interaction in the process of changing (DiClemente & Velasquez, 2012). While using these approaches, information can be gained during the integrated assessment and screening process. There are many instruments available to addiction professionals to more effectively screen for past and present mental health disorders, substance use disorders and safety-related issues, and these should be used whenever possible to accurately assess the client.

The most comprehensive method of treating co-occurring disorders is the integrated combined therapies (ICT) approach, which integrates motivational interviewing (MI), cognitive-behavioral therapy (CBT) and mutual support groups, such as twelve-step facilitation (TSF). The use of pharmacotherapy, involving the client’s family and group counseling are also helpful in treating co-occurring disorders. Regardless of the approach, addiction professionals should be inclusive of all co-occurring disorders and provide treatment for each at the same time with the goal of holistic recovery in mind (Dartmouth Psychiatric Research Center, 2010).

It is important for addiction professionals to understand and be able to recognize the most frequently encountered mental health disorders in clients seeking treatment for substance use disorders. The most common mental health disorders seen in addiction treatment programs fall under the following classifications: depressive disorders, bipolar disorders, anxiety disorders, trauma and stress-related disorders, personality disorders, and schizophrenia spectrum disorders (CSAT, 2013). These classifications are consistent with the DSM-5 (American Psychiatric Association, 2013).

LEARNING OBJECTIVES

- Explore common misperceptions and biases regarding co-occurring disorders.
- Recognize and screen for the most frequent co-occurring disorders seen in a substance use disorder treatment setting.
- Apply knowledge of evidence-based practices currently utilized in the substance use disorder arena to the treatment of clients with co-occurring disorders.
- Integrate substance use and mental health disorder referral services within the scope of one's own practice.
- Identify a client's stage of change using the transtheoretical model of behavioral change.
- Follow the stages of treatment to implement effective interventions.
- Understand the clinical aspects of medication management for co-occurring disorders.
- Review case studies and strategies for ensuring successful client outcomes.
- Translate information presented to clients, families, colleagues and the community.

**SECTION ONE:
INTRODUCTION TO
CO-OCCURRING DISORDERS**

INTRODUCTION: This section dispels commonly-held myths, defines co-occurring disorders, and outlines the history of treatment for co-occurring disorders.

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 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.

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, more and more addiction professionals are obtaining advanced degrees, and many of these individuals have been formally educated on mental health disorders. Individuals are also obtaining additional training to fulfill requirements for a credentialing, such as a certified addiction counselor (CAC) or licensed professional counselor (LPC). This training may not be as in-depth as the training received by a licensed social worker (LSW), however most addiction counselors today have received some level of training in mental health during their careers. Many state credentialing boards now require addiction counselors to take at least one course on co-occurring disorders to learn how to treat these illnesses. Further, to achieve the Master Addiction Counselor (MAC) credential, additional and advanced training is required.

Given that so many clients with substance use disorders have co-occurring disorders, 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.

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-using behavior for the duration of their lives, regardless of whether they have engaged in formalized treatment, mutual support groups, or a combination of the two. On the other hand, those individuals who attend mutual support groups may define recovery as abstinence from drugs and/or alcohol (or addictive behaviors) and a personal dedication to “work the steps” (in a 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” (Center for Substance Abuse Treatment, 2013, p. 104). 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” (CSAT, 2013, p. 104). As one can see, the definition of “recovery” varies from one profession to another and among those within each profession.

Each of these definitions includes a common result: identifying and eliminating unhealthy behaviors that have caused significant distress in the client’s life. Undoubtedly, clients with co-occurring disorders are able to successfully change unhealthy behaviors and thoughts and accomplish “recovery” according to each of 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.” (CSAT, 2013, p 104). 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.

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 (McGovern, 2008). However, individuals with co-occurring disorders respond to and can benefit from effective treatment. According to McGovern (2008), 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.

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. Addressing both 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 should 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 mutual support meetings. Some mistakenly think that individuals with co-occurring disorders cannot or should not attend Alcoholics/Narcotics Anonymous groups because their mental health disorder(s) 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 have a range of personalities and emotions, just like everyone else, and are no more likely (or less likely) to be disruptive. In fact, they often feel stigmatized and rarely mention their mental health disorder for fear of being judged. People with mental health disorders can benefit just as others do from the shared experiences of other individuals 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, and Dual Diagnosis Anonymous. Contact information for each of these self-help groups can be found in the Resources section of this manual.

MYTH: Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) doctrine dictates that individuals 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 express suspicion about any prescribed medications. 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 (Alcoholics Anonymous World Services, 2011). 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 states:

We 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 take any 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 alcoholic 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 (AA World Services, 2011, p. 6).

- *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 (AA World Services, 2001, p. 133).