Integrating Treatment for Co-occurring Disorders: Myths, Realities and Effective Approaches to Care

By Thomas Durham, PhD

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44 Canal Center Plaza, Ste. 301, Alexandria, VA 22314
phone: 703.741.7686 / 800.548.0497
fax: 703.741.7698 / 800.377.1136
www.naadac.org • naadac@naadac.org
Seminar 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 treatment of clients with co-occurring disorders.
- Integrate substance use disorder and mental health disorder services within the scope of his or her own practice.
- Identify a client’s stage of change and stage of treatment to implement effective interventions.
- Discuss the clinical aspects of medication management for co-occurring disorders.
- Review and discuss case studies and strategies for ensuring successful client outcomes.
- Translate information presented during the educational seminar to clients, families, colleagues and the community.
Section One:
Introduction to Co-occurring Disorders
Individuals have varying opinions and beliefs about co-occurring disorders. Some of the beliefs held by individuals are accurate, while, other opinions do not reflect current research, literature or current practice.

Please describe three beliefs you currently have about co-occurring disorders.
MYTH: Addiction professionals are not competent to recognize, assess and treat mental health disorders.

- The majority of addiction professionals today have at least a bachelor’s degree and more often than not a master’s degree.

- Meaning, 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).
Given that so many clients with substance use disorders have co-morbid 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.
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.

Undoubtedly, clients with co-occurring disorders are able to successfully change unhealthy behaviors and thoughts and accomplish “recovery” according to:

- previous definitions
- improved health
- better ability to care for oneself and others
- a higher degree of independence
- enhanced self-worth
However, successful recovery is common and is accomplished through outreach and treatment programs designed specifically for clients with co-occurring disorders and their unique needs.

Addressing both the mental health disorders and substance use disorders through an integrated treatment approach (discussed later) provides clients with co-occurring disorders greater opportunities to succeed in treatment and recovery.
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 respond to and can benefit from effective treatment.
Countering the Myth

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
- Homelessness.
Countering the Myth

- For those with co-occurring disorders that are homeless, the ability to attain housing is profoundly affected by their illnesses.

- The impact of co-occurring disorders bears a direct relationship to one’s homeless status.

- It has been estimated that for 70% of homeless individuals, substance use disorder is the primary reason for their homelessness.

- Among those in homeless shelters, over 85% are estimated to have a substance use disorder.
MYTH: Individuals with co-occurring disorders will not participate in mutual support groups.

The use of mutual support 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 mutual support groups such as AA or NA 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.

Those in recovery from co-occurring disorders that attend mutual support groups are no different than those in recovery without a COD.
Countering the Myth

In fact, they often feel stigmatized and may choose not to 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
- Dual Disorders Anonymous
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 in the past 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.

AA/NA does not endorse encouraging its members to discontinue taking prescribed medications for the treatment of addiction.
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 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.

- COD clients can be challenging!
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.
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.
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.
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.

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.
Defining Co-occurring Disorders

Co-occurring disorders (COD):
the simultaneous existence of one or more substance use disorder as well as one or more mental health disorders.
Defining Co-occurring Disorders

- 50 to 75% of all clients who are receiving treatment for a substance use disorder also have another diagnosable mental health disorder.

- Further, of all psychiatric clients with a mental health disorder, 25 to 50% of them also currently have or had a substance use disorder at some point in their lives.
An individual is considered to have co-occurring disorders if he or she has had both a substance use disorder and a mental health disorder at some point in his or her lifetime.

The disorders must not simply be a manifestation of symptoms from a single illness but rather the presence of two or more independently diagnosable disorders.
Common examples include:

- Major depressive disorder and alcohol use disorder
- Generalized anxiety disorder, benzodiazepine use disorder and alcohol use disorder
- Antisocial personality disorder and cocaine use disorder
It is not uncommon for a client with a mental health disorder to use drugs or alcohol.

He or she does not have co-occurring disorders unless the use is problematic.

The same can be said for clients who have a substance use disorder who also experience anxiety or depression from time to time.

In order for a client to have co-occurring disorders, his or her emotional problems and substance use must be elevated and problematic to the degree of warranting independent diagnoses.
Mental health disorder (MHD): significant and chronic disturbances with feelings, thinking, functioning and/or relationships that are not due to drug or alcohol use and are not the result of a medical illness.

- Bipolar disorder
- Major depressive disorder
- Schizophrenia
- Obsessive-compulsive disorder
- Social phobia
- Borderline personality disorder
- Posttraumatic stress disorder
Mental health disorders manifest similarly in most people.

- APA - *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSM-5)*

- WHO - *International Statistical Classification of Diseases and Health Related Problems, Tenth Revision (ICD-10)*

There are small differences between the *DSM-5* and the *ICD-10* (with the *DSM-5, ICD-10 codes are included where applicable*).
Substance use disorders (SUD):

a behavioral pattern of continual psychoactive substance use that falls within a wide range “from mild to a severe state of chronically relapsing, compulsive drug taking” (DSM-5)
In general, substance related disorders encompass 10 separate classes of drugs, each indicating broad diagnostic criteria under either substance use disorders or substance induced disorders.

A substance use disorder would be diagnosed according to the degree of severity by evaluating symptoms against specific criteria for a particular drug.

A substance induced disorder is a diagnosis given when specific criteria is met due to intoxication or withdrawal as a result of the use of a particular drug.
The term “substance abuse” has historically been used by both the mental health and addiction professions to refer to any excessive use of psychoactive substances, regardless if it was diagnosable as abuse or dependence.

However, with the publication of the *DSM-5* in 2013, there is no longer a differentiation between abuse and dependence. Instead an individual is diagnosed with a substance use (or substance induced) disorder with a determination of the severity based on diagnostic criteria.
Severity of Co-occurring Disorders

Co-occurring mental health disorders can be thought of as being on a continuum of severity.

- **Non-severe**: early in the continuum and can include depressive disorders, anxiety disorders, adjustment disorders and personality disorders.
- **Severe**: include schizophrenia, bipolar disorder, schizoaffective disorder and major depressive disorder.

This classification is determined based on a specific diagnosis and by state criteria for Medicaid qualification but can vary significantly based on severity of the disability and the duration of the disorder.
Quadrants of Care

Consider the following two clients:

- a military veteran who has post-traumatic stress disorder and is addicted to benzodiazepine (e.g. Valium®)
- a homeless man who has schizophrenia and alcohol use disorder

Please describe how you would treat each client for his or her co-occurring disorders.
Among the most influential factors determining treatment needs of clients with co-occurring disorders is the severity of the substance use disorder, as well as the mental health disorder.
What quadrant(s) of clients do you think are most often treated within treatment facilities focused on substance use disorders?

What quadrant(s) of clients are you currently providing services?

What quadrant(s) of clients do you feel you are equipped to treat given your education, training and experience?
Quadrant I

- **Diagnosis:** low severity substance use with low severity mental health disorder(s).

- **Likely location of treatment:** may not present for treatment; general healthcare settings; or intermediate outpatient settings of either mental health or addiction treatment programs.

- **Client example:** Eric’s occasional use of marijuana has escalated to misuse and, as a result, he lost his job and cannot afford housing. He is 30 year old, has no source of income, has difficulty concentrating, and is feeling hopeless about his situation.
Quadrants of Care

Quadrant II

- **Diagnosis:** low severity substance use with high severity mental health disorder(s).

- **Likely location of treatment:** continuing care in the mental health system with integrated case management.

- **Client example:** Karina (age 40) was treated for alcohol use disorder two years ago and is now in full remission. However, the rituals associated with her obsessive-compulsive disorder consume over six hours of her daily routine and have significantly contributed to her recent divorce from her husband. She is currently living with a friend as she has no other family, has no other place to live and no current source of income.
Quadrant III

- **Diagnosis:** high severity substance use with low to moderate severity mental health disorder(s).

- **Likely location of treatment:** addiction treatment programs with coordination with mental health professionals, when necessary.

- **Client example:** Denise (age 25), through continued use of narcotic pain medication, has found heroine to be more readily available and has developed an opioid use disorder. She has engaged in prostitution, drug dealing and theft to support her addiction. She was also previously diagnosed with borderline personality disorder at the age of 19.
Quadrant IV

- **Diagnosis:** high severity substance use with high severity mental health disorder(s).

- **Likely location of treatment:** specialized residential substance use disorder treatment programs; psychiatric hospitals; detoxification programs; jails; or emergency rooms.

- **Client example:** Marcus (age 38) is jobless and homeless. He has symptoms of schizophrenia and has developed SUD from frequent methamphetamine use over the last two years. He frequently engages in usage binges lasting three or more days. His mental health disorder, coupled with his lack of sleep, often results in hallucinations and fits of paranoia and delusions.
Psychoactive substances and mental health disorders interact in many different ways.

One does not always precede the other or present as the “primary” disorder.

Not every client with co-occurring disorders will exhibit the same symptoms.
Co-occurring disorders can relate in the following ways:

- A substance use disorder can initiate and/or exacerbate a mental health disorder.
- A mental health disorder can initiate and/or exacerbate a substance use disorder.
- Substance use disorders can cause psychiatric symptoms and mimic mental health disorders. These disorders are referred to as substance-induced mental health disorders in the DSM-5.
- A substance use disorder can mask psychiatric symptoms and/or mental health disorders.
- Psychoactive substance use withdrawal can cause psychiatric symptoms and/or mimic mental health disorders.
Co-occurring Disorders Interactions

- Individuals with mental health disorders are more biologically sensitive to the effects of psychoactive substances and are at a much greater risk of also having a substance use disorder.

- In general, the more severe the disability, the lower the amount of substance use that might be harmful.

- Chronic substance use disorder usually results in negative consequences for the individual and his or her family.
Section Two: Mental Health Disorders
Remember, 50 to 75% of all clients who are receiving treatment for a substance use disorder also have another diagnosable mental health disorder.

It is important for addiction professionals to understand and be able to recognize the mental health disorders in clients seeking treatment for substance use disorders.

To aid in this effort, the most prevalent mental health disorders are described in this section, along with how these disorders influence addiction treatment and recovery.
Common Mental Health Disorders

This information is not intended to equip participants with the skills needed to diagnose these mental health disorders since diagnosis is outside of the scope of practice for many.

Rather, this knowledge will allow participants to recognize and identify possible co-occurring disorders so an appropriate treatment plan can be devised, including outreach and identifying appropriate referrals, to address all the symptoms and pressing needs of the client.
In general, a depressive disorder is an illness that involves the body, one’s emotions, and thinking. It also interferes with daily functioning and causes pain both mentally and physically. Depressive disorders are characterized by a drastic disturbance in an individual’s mood and are among the most prevalent mental health disorders encountered by addiction professionals.

The two most common depressive disorders, as listed in the *DSM-5*, are:

- Major depressive disorder
- Persistent depressive disorder (dysthymia)
Which psychoactive substances can produce depressive symptoms when a client is intoxicated?

- alcohol
- benzodiazepines
- opioids
- barbiturates
- cannabis
- steroids

Which psychoactive substances can produce depressive symptoms when a client is experiencing withdrawal?

- alcohol
- benzodiazepines
- opioids
- barbiturates
- stimulants
- steroids
Depressive disorders are by far the most common co-occurring disorders, with 30 to 40% of individuals with a substance use disorder also having a depressive disorder.

Conversely, approximately 33% of individuals with a depressive disorder also have a substance use disorder.

Major depressive disorder and dysthymic disorder are the most prevalent depressive disorders encountered while treating clients with substance use disorders.
Depressive Disorders

The depressed feelings associated with major depressive disorder must not be due to the loss of a loved one and must exceed the normal “ups and downs” of everyday life.

Of course, everyone experiences periods of sadness and difficulty adjusting to the various challenges in life.

However, clients with major depressive disorder endure severe depressive symptoms that interfere with their ability to function over the course of several weeks or months.

Up to 15% of individuals with this disorder die from suicide.

90% of suicides are attributed to a psychiatric disorder; depressive disorder is the most common.
Major Depressive Disorder:

A.) Five or more of 9 symptoms present during the same 2 week period

B.) Symptoms cause significant impairment in major areas of functioning.

C.) Not attributed to substance use or another medical condition

D.) The major depressive episode is not better accounted for by another disorder.

E.) Client has never had a manic episode, mixed episode or hypomanic episode.
Depressive Disorders

Persistent Depressive Disorder (Dysthymia):

A.) Depressed mood for most of the day, for more days than not, for at least two years.

B.) Two or more of the following symptoms during the period described above:

1.) poor appetite
2.) insomnia or hypersomnia
3.) low energy or fatigue
4.) low self-esteem
5.) poor concentration or difficulty making decisions
6.) feelings of hopelessness
Persistent Depressive Disorder (cont.):

C.) The client has not been without the symptoms in Criterion A and B for more than two months at a time.

D.) Criteria for a major depressive disorder may be continually present for two years.

E.) There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F.) The disturbance is not better explained by schizophrenia or other psychotic disorder.

G.) Symptoms are not due to a substance or general medical condition.

H.) Symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.
Persistent depressive disorder (dysthymia) is a often a less severe form of major depressive disorder, but the symptoms are more constant and last for at least two years.

It is often described as a “low-grade” depression that individuals accept as part of their normal state of being.

Further, individuals who have experienced a major loss during childhood have a greater risk of developing dysthymic disorder later in life.
Case Study #1:
The Case of Jane
Bipolar Disorders

- Bipolar disorder (formerly referred to as manic depression) is characterized by the presence of either manic or hypomanic symptoms.

- Most often, individuals with bipolar disorder experience extreme mood swings that can vary from depression to mania, with some periods in between where few or no symptoms are present.

- Over the course of several days or weeks, these mood swings result in changes in overall outlook, behavior and energy level and can persist for up for weeks or even months.

- Depending on the nature and severity of symptoms present, a diagnosis of bipolar I disorder or bipolar II disorder will be given.
Bipolar I Disorder:

Must meet the criteria for a manic episode. The manic episode *may* be preceded by and *may* be followed by hypomanic or major depressive episode.
**Manic Episode:**

A.) A distinct period of abnormally and persistently elevated, expansive or irritable mood that lasts at least one week.

B.) Three or more of the following symptoms during the period described above:

1.) inflated self-esteem or grandiosity
2.) decreased need for sleep
3.) more talkative than usual or pressure to keep talking
4.) flight of ideas or subjective experience that thoughts are racing
5.) distractibility
6.) increase in goal-directed activity or psychomotor agitation
7.) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. sex, shopping, etc.)
Manic Episode (cont.):

C.) Symptoms cause significant impairment in social or occupational functioning or relationships with others, requires hospitalization or there are psychotic features.

D.) Symptoms are not due to a substance or general medical condition.
Many of these symptoms of a manic episode should look familiar, given that several psychoactive substances produce similar set of effects.

This makes it difficult to ascertain whether the presenting manic episode-like symptoms are due to an underlying bipolar disorder, substance use disorder, or withdrawal.
Which psychoactive substances can produce manic episode-like symptoms when a client is intoxicated?

- stimulants
- alcohol
- hallucinogens
- inhalants
- steroids

Which psychoactive substances can produce manic episode-like symptoms when a client is experiencing withdrawal?

- alcohol
- benzodiazepines
- barbiturates
- opioids
- steroids
Hypomanic Episode:

A.) A distinct period of abnormally and persistently elevated, expansive or irritable mood that lasts at least four days.

B.) Three or more of the following symptoms during the period described above:

1.) inflated self-esteem or grandiosity
2.) decreased need for sleep
3.) more talkative than usual or pressure to keep talking
4.) flight of ideas or subjective experience that thoughts are racing
5.) distractibility
6.) increase in goal-directed activity or psychomotor agitation
7.) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. sex, shopping, etc.)
Hypomanic Episode (cont.):

C.) The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person.

D.) The symptoms are observable by others.

E.) Symptoms are not severe enough to cause significant impairment in social or occupational functioning or relationships with others, or to require hospitalization and there are no psychotic features.

F.) Symptoms are not due to a substance or general medical condition.
Major Depressive Episode:
A.) Five or more symptoms have been present during the same two-week period; criterion one or two must be present.

1.) depressed mood most of the day, nearly everyday
2.) markedly diminished interest or pleasure in all, or almost all, activities
3.) significant weight loss when not dieting, or weight gain or decrease or increase in appetite
4.) insomnia or hypersomnia
5.) psychomotor agitation or retardation
6.) fatigue or loss of energy
7.) feelings of worthlessness or inappropriate guilt
8.) diminished ability to think or concentrate, or indecisiveness
9.) recurrent thoughts of death, suicidal ideation, suicide attempt or specific plan for committing suicide
Bipolar Disorders

Major Depressive Episode (cont.):

B.) Symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.

C.) Symptoms are not due to a substance or general medical condition.
Major depressive episodes are considerably more difficult to accurately recognize with clients who have a substance use disorder because substance intoxication and withdrawal can often produce depressive symptoms.

This makes it difficult to ascertain whether the presenting symptoms are due to a bipolar disorder, depressive disorder, substance use disorder, or withdrawal.

Individuals who are new to recovery often experience depression and even thoughts of suicide; they may relapse in an attempt to alleviate their profound negative mood.
Bipolar II Disorder:

A.) The presence (or history) of at least one hypomanic episode and at least one major depressive episode.

B.) There has never been a manic episode.

C.) The major depressive and hypomanic episodes are not better accounted for by schizoaffective disorder, schizophreniform disorder, delusional disorder or other schizophrenia spectrum or psychotic disorder.

D.) Symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.
In the general population, approximately 1% of individuals have bipolar disorder.

Among these individuals, about 50% also have a co-occurring substance use disorder.

These individuals often experience more intense and frequent mood swings, and as a result, are more often hospitalized than individuals with only bipolar disorder.
Case Study #2: The Case of John
Anxiety disorders manifest as different clusters of signs and symptoms of anxiety that range from sensations of nervousness, tension, apprehension or fear.

They are among the most prevalent mental health disorders encountered by addiction professionals.

Anxiety can also emanate from the anticipation of danger, which can be either internally or externally induced.

Approximately 25% of Americans will have an anxiety disorder at some point in their lifetimes.

Women represent most of these cases.

Generalized anxiety disorder, panic disorder, social anxiety disorder (social phobia), are the most prevalent anxiety disorders encountered while treating clients with substance use disorders and are discussed individually below.
Anxiety Disorders

Generalized Anxiety Disorder:
A.) Excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities.
B.) The client finds it difficult to control the worry.
C.) The anxiety and worry are associated with at least three of the following:
   1.) restlessness or feeling keyed up or on edge
   2.) being easily fatigued
   3.) difficulty concentrating or mind going blank
   4.) irritability
   5.) muscle tension
   6.) sleep disturbance
Generalized Anxiety Disorder (cont.):

D.) Symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.

E.) Symptoms are not due to a substance or general medical condition

F.) Symptoms are not better explained by another psychiatric disorder.
Anxiety Disorders

Panic Disorder:

A.) Is characterized by recurrent and unexpected panic attacks. A panic attack is an abrupt surge of intense discomfort that reaches a peak within minutes and during which time four or more of the following symptoms occur:

1.) palpitations, pounding heart or accelerated heart rate
2.) sweating
3.) trembling or shaking
4.) sensations of shortness of breath or smothering
5.) feeling of choking
6.) chest pain or discomfort
7.) nausea or abdominal distress
8.) feeling dizzy, unsteady, lightheaded or faint
9.) chills or heat sensations
10.) numbness or tingling sensations
11.) feelings of unreality or being detached from oneself
12.) fear of losing control or going crazy
13.) fear of dying
Panic Disorder:

B.) At least one of the attacks has been followed by one month (or more) of one of the following:
   1.) persistent concern about having additional attacks
   2.) a significant change in behavior related to the panic attacks

C.) The disturbance is not attributable to physiological effects of a substance or general medical condition

D.) Panic attacks are not better accounted for by another mental disorder.
Social Anxiety Disorder (Social Phobia):

A.) A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and that he or she will be humiliated or embarrassed.

B.) Fear that one will act in a way or show anxiety symptoms that will be negatively evaluated.

C.) Social situations almost always provoke fear or anxiety.

D.) Social situations are avoided or endured with intense fear or anxiety.
Social Anxiety Disorder: Cont.

E.) The fear or anxiety is out of proportion to the actual threat posed by the social situation.

F.) Symptoms are persistent, typically lasting for 6 months or more.

G.) Symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning.

H.) Symptoms are not due to physiological effects of a substance or other medical condition.

I.) Symptoms are not attributable to another mental disorder.

J.) If another medical condition is present, the symptoms are clearly unrelated or is excessive.
Case Study #3: The Case of Tyrrell.
Obsessive-Compulsive Disorder:

A.) The presence of either obsessions or compulsions.

*Obsessions* are defined as all of the following:

1.) recurrent and persistent thoughts, urges or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

2.) the client attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thoughts or action
Obsessive-Compulsive Disorder (cont.):

Compulsions are defined as all of the following:

1.) repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

2.) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive
Obsessive-Compulsive Disorder (cont.):

B.) The obsessions or compulsions are time consuming or cause clinically significant distress or impairment in social, occupational or other significant areas of functioning.

C.) Symptoms are not due to a substance or general medical condition.

D.) The disturbance is not better explained by the symptoms of another mental disorder.
Posttraumatic Stress Disorder:
A.) The client has been exposed to actual or threatened death, serious injury or sexual violence in one or more of the following ways:

1.) directly experiencing the traumatic event(s)
2.) witnessing in person the event(s) as it occurs to others
3.) learning that the traumatic event(s) occurred to a close family member or close friend.
4.) experiencing repeated or extreme exposure to aversive details to the traumatic event.
Posttraumatic Stress Disorder (cont.):

B.) Presence of one or more of the following intrusion symptoms:

1.) recurrent, involuntarily and intrusive distressing memories of the event,

2.) recurrent distressing dreams of the event

3.) dissociative reactions as if the traumatic event were recurring

4.) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

5.) marked physiological reactivity or exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
Posttraumatic Stress Disorder (cont.):

C.) Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the event(s) occurred as evidenced by one or both of the following:

1.) avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

2.) avoidance of or efforts to avoid external reminders that arouse distressing memories thoughts or feelings about or closely associate with the traumatic event(s)
Posttraumatic Stress Disorder (cont.):

D.) Negative alterations in cognitions and mood associated with the traumatic event(s) as evidenced by two or more of the following:

1.) inability to recall an important aspect of the trauma
2.) persistent and negative exaggerated beliefs or expectations about oneself, others or the world
3.) persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame self or others
4.) persistent negative emotional state
5.) markedly diminished interest or participation in significant activities.
6.) feeling of detachment or estrangement from others
7.) persistent inability to experience positive emotions
Posttraumatic Stress Disorder (cont.):
E.) Marked alterations in arousal and reactivity associated with the traumatic event(s) as evidenced by two or more of the following:
   1.) irritability or outbursts of anger
   2.) reckless or self-destructive behavior
   3.) hypervigilance
   4.) exaggerated startle response
   5.) problems with concentration
   6.) sleep disturbances
F.) Duration of the disturbance is more than one month.
G.) Symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.
H.) The disturbance is not attributable to physiological effects of a substance or other medical condition.
Personality disorders are a group of disorders characterized by rigid, inflexible and maladaptive behavior patterns of sufficient severity to cause significant impairment in functioning and internal distress.

They are enduring and persistent styles of behavior that are integrated into an individual’s way of being that deviate from the expectations of his or her culture.

Personality disorders usually become recognizable during adolescence or early adulthood and usually remain relatively stable during the lifespan.
There are three clusters of personality disorders:

- **Cluster A:** The client appears odd or eccentric. (Examples: paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder)

- **Cluster B:** The client appears dramatic, emotional or erratic. (Examples: histrionic personality disorder, narcissistic personality disorder, antisocial personality disorder and borderline personality disorder)

- **Cluster C:** The client appears anxious or fearful. (Examples: avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder)
Personality Disorders

- Antisocial personality disorder is a pattern of disregard for, and violation of, the rights of others.

- It is the most common co-occurring personality disorder with a substance use disorder.

- 20 to 41% of individuals with a substance use disorder also have antisocial personality disorder.

- 83% of individuals with antisocial personality disorder meet criteria for a substance use disorder.

- Approximately 4% of the general population has antisocial personality disorder, with three-fourths of these being men.
Antisocial Personality Disorder:

A.) There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15, as indicated by at least three of the following:

1.) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
2.) deceitfulness, as indicated by repeated lying, use of aliases or conning others for personal profit or pleasure
3.) impulsivity or failure to plan ahead
4.) irritability and aggressiveness, as indicated by repeated physical fights or assaults
5.) reckless disregard for safety of self or others
6.) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
7.) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another
Antisocial Personality Disorder (cont.):

B.) The client is at least 18 years old.

C.) There is evidence of conduct disorder (aggression to people and animals, destruction of property, deceitfulness or theft or serious violations of rules) with onset before age 15.

D.) The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.
Addiction professionals should take extra care to differentiate true antisocial behavior from substance-related antisocial behavior.

Many of the criterion required for a diagnosis of antisocial personality disorder resemble behavior commonly associated with substance use disorders.

Individuals who have antisocial personality disorder will continue to display these behaviors even after psychoactive substance use has ceased.
**Borderline Personality Disorder:**

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1.) frantic efforts to avoid real or imagined abandonment

2.) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3.) identity disturbance, such as unstable self-image or sense of self
4.) impulsivity in at least two areas that are potentially self-damaging, such as spending, sex, substance use, reckless driving, binge eating, etc.

5.) recurrent suicidal behavior, gestures or threats or self-mutilating behavior

6.) affective instability due to a marked reactivity of mood

7.) chronic feelings of emptiness

8.) inappropriate, intense anger or difficulty controlling anger

9.) transient, stress-related paranoid ideation or severe dissociative symptoms
Which is the most prevalent personality disorder seen by addiction professionals?

- borderline personality disorder
- narcissitic personality disorder
- histrionic personality disorder
- antisocial personality disorder
Schizophrenia spectrum and other psychotic disorders are a group of severe mental health disorders that are characterized by a disintegration of thinking processes, involving the inability to distinguish external reality from internal fantasy.

These disorders all share psychotic symptoms as a prominent component, meaning that the individual experiences delusions, hallucinations, disorganized speech and/or disorganized or catatonic behavior.

The most prevalent disorders from this category encountered in a substance use disorder treatment setting (provided that integrated treatment is available) are schizophrenia and schizoaffective disorder.
Schizophrenia:

A.) The presence of at least two of the following for a significant time during a one-month period:

1.) delusions
2.) hallucinations
3.) disorganized speech
4.) grossly disorganized or catatonic behavior
5.) negative symptoms, such as affective flattening, poverty of speech or general lack of desire, drive or motivation to pursue meaningful goals
Schizophrenia (cont.):

B.) One or more areas of major functioning (work, interpersonal relationships or self-care) are markedly below the level achieved prior to the onset of the disturbance.

C.) Continuous signs of the disturbance persist for at least six months.

D.) The client does not have schizoaffective disorder or a bipolar disorder with psychotic features (no major depressive or manic episodes have occurred concurrently with active phase symptoms).

E.) Symptoms are not due to a substance or general medical condition.

F.) If there is a history of autism spectrum disorder or a communication disorder of childhood onset, prominent delusions or hallucinations must be present for at least one month.
Schizoaffective disorder is easily confused with other mental health disorders, most notably schizophrenia and bipolar disorders.

Schizoaffective disorder and schizophrenia are similar in that both disorders can produce major depressive episodes, manic episodes, or both.

However, with schizophrenia, major depressive or manic episodes do not occur concurrently with active phase symptoms (Criterion A).
Schizoaffective disorder can be differentiated from similarly looking disorders based on the presence or absence of psychotic symptoms.

- Example: If the individual experiences psychotic symptoms only during his or her depressed or manic periods = a bipolar disorder
- Example: If the characteristic psychotic symptoms are present regardless of whether the individual is experiencing depressive or manic symptoms = schizoaffective disorder
Schizoaffective Disorder:

A.) An uninterrupted period of illness during which there is either a major depressive episode or a manic episode concurrent with Criterion A of schizophrenia.

B.) During the same period of illness, there have been delusions or hallucinations for at least two weeks in the absence of prominent mood symptoms.

C.) Symptoms that meet criteria for a depressive episode or manic episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

D.) Symptoms are not due to a substance or general medical condition.
These clients are extremely vulnerable to homelessness, housing instability, victimization, poor nutrition and inadequate financial resources.

If they are receiving treatment at an addiction center, they are often viewed as disruptive, non-responsive and unmotivated, which frequently results in early termination or failure to complete treatment.

These individuals are at particular risk for relapse of psychiatric symptoms and substance use, frequent hospitalizations, emergency room visits and inpatient detoxifications.
Case Study #4: The Case of Thelma
Section Three: Co-occurring Disorders Treatment
Models of Treatment

- Clients with co-occurring disorders have historically received substance use disorder treatment services in isolation from mental health treatment services.

- Until recently, clients could expect their co-occurring disorders to be treated separately from one another, perhaps by different treatment professionals, at different facilities and at different times.

- As more research on co-occurring disorders began to be conducted, the many limitations this approach places on the client and his or her success in treatment began to surface.

- As a result, the need for an integrated treatment model for substance use and mental health disorders became apparent to eliminate these barriers and better serve this population of in-need clients.
Models of Treatment

- **Single model of care** - It was believed that once the "primary disorder" was treated effectively, the client’s substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope.

- **Sequential model of treatment** - acknowledges the presence of co-occurring disorders but treats them one at a time.

- **Parallel model of treatment** - mental health disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.
A twenty-eight year-old-woman named Anita entered an addiction treatment center where she was assessed as having an alcohol use disorder. Six months earlier, Anita had been diagnosed with major depressive disorder and was prescribed medication by her family doctor. At the addiction treatment facility, it was recommended that Anita be re-assessed and be treated simultaneously at a mental health clinic. What model of treatment does this scenario represent?

- single model of treatment
- sequential model of treatment
- parallel model of treatment
- integrated model of treatment
Integrated model of treatment:
an approach to treating co-occurring disorders that utilizes one competent treatment team at the same facility to recognize and address all mental health and substance use disorders at the same time.

- No disorder is identified as being “primary” or “underlying” to another disorder.
- All co-occurring disorders are treated as one unit that is causing dysfunction and despair in the client’s life.
- This is the preferred model of treatment for co-occurring disorders and intuitively makes sense.
The integrated model of treatment can best be defined by following seven components:

1) Integration
2) Comprehensiveness
3) Assertiveness
4) Reduction of negative consequences
5) Long-term perspective
6) Motivation-based treatment
7) Multiple psychotherapeutic modalities
Integrated Model of Treatment

Integrated treatment programs for co-occurring disorders bypass many of the disadvantages of the other three models of treatment.

- Integrated treatment programs reduce the need for coordination with outside service providers since most or all clinicians are in-house and working together.

- Additionally, integrated treatment reduces frustration for the client in that it reduces the burden to seek out and comply with multiple treatment providers and plans.

Decision-making responsibilities related to treatment are shared among the client, his or her family and all involved treatment service providers, which benefit the client and the clinician.
Integrated Model of Treatment

- Clients and their families are better equipped to participate collaboratively in the decision-making process when the clinician provides as much information and education as possible.

- Due to the transparency advocated by integrated treatment, every stakeholder is tasked with helping the client progress in treatment.

- Clients are invited to become responsible for recognizing and managing their own co-occurring disorders.

- The client and the family will have more knowledge, greater choice in treatment options, more ability for self-management and higher satisfaction with care.

- Research has shown that this process results in better treatment outcomes, less severe symptoms, better functioning and a higher quality of life for the client.
Unlike the other three models of treatment, integrated treatment provides superior screening and assessment to determine which disorder, mental health or substance use, is primary.

- [ ] True
- [ ] False
Screening and Assessment

The evaluation process is an essential component to the integrated model of treatment for co-occurring disorders. The evaluation process at a treatment program consists of two equally important phases: screening and assessment.

Screening:
The first phase of evaluation where the potential client is interviewed to determine if he or she is appropriate for that specific treatment facility and to determine the possible presence or absence of a substance use or mental health problem.
Screening and Assessment

Assessment:
The second phase of evaluation where a systematic interview is necessary to verify the potential presence of a mental health or substance use disorder detected during the screening process.

- The assessment phase is more comprehensive and lengthy than the screening phase and more specific information is gathered from the client.

- The main goal of the assessment process is to obtain enough information about the client so the most effective and individualized treatment plan can be developed.
In line with the recommendation of an integrated model of treatment for co-occurring disorders, an integrated assessment process is also necessary to ensure proper attention is given to each co-occurring disorder.

CSAT (in TIP 42) outlined 12 steps in the integrated assessment process, which are discussed in detail below, as well as the various instruments and measures at an addiction professional’s disposal to execute each step.

As each of the 12 steps are described, please note the similarities in the assessment process for clients with co-occurring disorders to those with only substance use disorders.
Screening and Assessment

Step 1: Engage the Client

- An ability to build a rapport with a potential client can assist in gaining information that is more accurate.

- Be cognizant of the fact that the client could be experiencing an array of emotions ranging from guilt, fear, embarrassment and even intoxication.

- Address the potential client with kindness, patience and understanding, taking care to show empathy, acceptance and concern.
Step 2: Identify and Contact Collaterals

- It is not uncommon for clients with co-occurring disorders to be unwilling or unable to report their past or current symptoms accurately.

- Identifying and contacting family members and significant others (collaterals) to the client early in the assessment process can augment information provided by the client.

- However, before any contact is made with a client’s collaterals, he or she must sign a confidentiality release form and explicitly grant permission to speak to each individual family member or significant other.
Screening and Assessment

Step 3: Screen for and Detect Co-occurring Disorders

- All individuals presenting for co-occurring disorder treatment should be screened routinely for past and present substance use disorders, as well as past and present mental health disorders.

- *Unfortunately, there is no single gold-standard assessment instrument to identify co-occurring disorders.*

- Because of the varying characteristics of co-occurring disorders, many instruments targeted to one or more topics are used during the assessment process to paint a comprehensive picture of the client’s current level of functioning and symptoms.
To screen generally for past and present mental health disorders, the following instruments are extremely helpful:

- **Mental Health Screening Form-III (MHSF-III)**
- **Mini-International Neuropsychiatric Interview (M.I.N.I.)**
- **Addiction Severity Index (ASI)**
- **Brief Symptom Inventory-18**
To screen for specific past and present mental health disorders, the following instruments can be used:

- **Major depressive disorder:**
  - *Beck Depression Inventory (BDI)*
  - *Hamilton Rating Scale for Depression*
  - *Clinical Assessment Form for Major Depression*

- **Persistent depressive disorder (Dysthymia):**
  - *Clinical Assessment Form for Dysthymia*

- **Bipolar disorder:**
  - *Clinical Assessment Form for Manic/Hypomanic/Bipolar Disorder*
Screening and Assessment

- Anxiety disorders:
  - Hamilton Anxiety Rating Scale
  - Beck Anxiety Inventory (BAI)
  - Clinical Assessment Form for Anxiety Disorders

- Social anxiety disorder (social phobia):
  - Social Interaction Anxiety Scale (SIAS)
  - Clinical Assessment Form for Social Phobia

- Trauma- and stressor-related disorders (specifically, posttraumatic stress disorder):
  - PTSD Checklist
  - Clinical Assessment Form for PTSD
To screen for specific past and present substance use disorders, the following instruments can be used:

- Alcohol Use Scale (AUS)
- Drug Use Scale (DUS)
- Addiction Severity Index (ASI)
- CAGE Questionnaire
- Drug Abuse Screening Test (DAST)
- Michigan Alcoholism Screen Test (MAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases (SSI-SA)
- Dartmouth Assessment of Lifestyle Inventory (DALI)
Beyond screening for co-occurring disorders, clients should be screened for safety-related issues. This will consist of ascertaining whether the client has any immediate risk to harm him or herself or others.

The following instruments can be helpful in this effort:

- *Violence and Suicide Assessment Scale*
- *Clinical Assessment Form for Suicidality*
Step 4: Determine Quadrant and Locus of Responsibility

- As discussed earlier, a client with co-occurring disorders can be placed in one of four quadrants care, depending on his or her severity of substance use disorder(s) and mental health disorder(s).

- Most of the information needed to determine which quadrant a client falls into is obtained during the initial intake and screening process.
Screening and Assessment

Step 5: Determine Level of Care

As determined by ASAM, there are four levels of care that can be utilized to treat co-occurring disorders:

- Level 1: Outpatient services.
- Level 2: Intensive outpatient treatment/partial hospitalization services.
- Level 3: Clinically managed residential/inpatient services.
- Level 4: Medically managed intensive inpatient services.
When evaluating what level of care is most appropriate for a client with co-occurring disorders. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, published by the American Society of Addiction Medicine (2013), provides six dimensions to assist with making this determination:

- **Dimension 1:** Acute Intoxication and/or Withdrawal Potential
- **Dimension 2:** Biomedical Conditions and Complications
- **Dimension 3:** Emotional, Behavioral or Cognitive Conditions and Complications
- **Dimension 4:** Readiness to Change
- **Dimension 5:** Relapse, Continued Use or Continued Problem Potential
- **Dimension 6:** Recovery/Living Environment
Dimension 3 (exploring an individual’s thoughts, emotions, and mental health issues) is the most pertinent to clients with co-occurring disorders, and the following five areas of risk must be considered:

1.) Suicide potential and level of lethality;

2.) The degree the client is experiencing interference with his or her recovery efforts due to active mental health disorders;

3.) Social functioning;

4.) Ability for self-care; and

5.) The course of his or her illness(es), which is used as a prediction of the client’s likely response to treatment.
Step 6: Determine Diagnosis

- *DSM-5* is the primary resource used to diagnose mental health and substance use disorders. This 5th edition, published in 2013 is helpful guide in determining diagnosis based on listed criteria for each disorder.

- The *Composite International Diagnostic Interview (CIDI)* is a helpful instrument to use when determining a diagnosis.

- Even though diagnosing may be beyond the scope of practice for many addiction professionals, all are encouraged to familiarize themselves with the most prevalent mental health disorders commonly found to co-occur with substance use disorders and be able to recognize the primary symptoms of these disorders.
Screening and Assessment

Step 7: Determine Disability and Functional Impairment

Clients with co-occurring disorders can often have deficits in cognitive capacity, social skills and other functional areas, and the level of impairment must be determined to formulate an effective treatment strategy.

- **Addiction Severity Index (ASI)**
- **Global Appraisal of Individual Needs (GAIN)**
Step 8: Identify Strengths and Supports

Every client coming to treatment has some strengths and support that allow him or her to function and manage their co-occurring disorders. Learning about the following areas during the assessment process will help increase the client’s chances of successful treatment:

- Talents and interests
- Areas of educational interest, such as vocational or social skills
- Motivators to change
- Existing supportive relationships
- Previous mental health or addiction treatment successes
Step 9: Identify Cultural and Linguistic Needs and Supports

- Like clients with only a substance use or mental health disorder, clients with both co-occurring disorders have cultural and linguistic needs during treatment.

- These can range from daily prayer regimens and wardrobe requirements to difficulty in speaking or reading English fluently.

- Identifying these issues in the assessment process can better allow for their accommodation and the increased comfort of the client.
Step 10: Identify Problem Domains

- It is not uncommon for clients with co-occurring disorders to have problems in medical, legal, vocational, family or social domains of their lives.
- Providing comprehensive and integrated treatment for all of these areas will increase treatment efficacy and quality of life for the client.

- *Addiction Severity Index (ASI)*
- *Intake Evaluation*
Screening and Assessment

Step 11: Determine Stage of Change

- Not all clients with co-occurring disorders enter treatment with the same level of motivation and desire to change.
- Clients could be willing and eager to actively treat one mental health disorder but not address a co-occurring substance use disorder.
- Each disorder has an independent stage of change.
- Matching the client’s treatment plan and objectives to his or her stage of change is vital to effective integrated treatment – more on this topic in the next section.

- University of Rhode Island Change Assessment (URICA)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
- The Substance Abuse Treatment Scale (SATS)
Step 12: Plan Treatment

- After all relevant information is gathered from the client, a comprehensive and integrative plan for treatment must be developed.

- Since not all clients with co-occurring disorders are the same, this plan must be individualized to each client and his or her needs.

- Much like treatment planning for substance use disorders, a client’s recovery plan should consist of problem statements, goals, objectives, specific interventions and target dates for completion.
In most treatment addiction centers, the three primary psychosocial treatments are:

- Motivational interviewing (MI)
- Cognitive-behavioral therapy (CBT)
- Mutual support groups

All of these treatment models are widely used by addiction professionals around the country and can be easily applied to clients suffering from co-occurring disorders.
The Dartmouth Psychiatric Research Center at Dartmouth Medical School integrated 3 evidenced-based therapies into a stage-wise treatment model called the Co-Occurring Disorders Program (CDP), published by Hazelden.

In CDP, a specific curriculum called *integrating combined therapies (ICT)* integrates MI, CBT and Mutual Support Groups.

It borrows the idea of integrating evidence-based therapies from combined behavioral intervention (CBI) developed by William Miller et al.

ICT strategically blends MI, CBT and Mutual Support to maximize the potential benefits specifically for clients with more stable, less severe mental illnesses found in addiction centers.
To summarize the conceptual purpose of ICT:

- motivational interviewing is first utilized to initiate change and engage the client in the therapeutic process;
- cognitive-behavioral therapy is then used to help make change within the client; and
- twelve step facilitation is essential to helping maintain and sustain changes.
Motivational interviewing (MI) is a non-directive method of counseling that uses the internal motivation of a client to evoke and sustain rapid change, instead of the addiction professional’s interpretation and discovery.

MI begins with the assumption that the client has the responsibility for and capability to change.

The client’s own internal motivation is the driving force in this treatment process.

Behavior change is motivated by the client’s state of readiness or eagerness to change.
Also known as the stages of change model, the TTM identifies the varying levels of internal motivation one has to change:

- **Precontemplation** – The client has not considered changing his or her problem behavior.
- **Contemplation** – The client is casually considering change but not immediately.
- **Preparation** – The client makes the decision to change and attempts to begin the process.
- **Action** – The client begins to actually change the problem behavior.
- **Maintenance** – The client has a continued commitment to sustain the new, healthy behavior.
- **Relapse** – The client returns to the problematic behavior and re-enters the stages of change at the appropriate location given his or her readiness to change after experiencing the relapse.
Motivational Interviewing (MI)

After the client’s motivation to change is identified for each substance use and mental health disorder, this information is then matched to his or her stage of treatment, which is his or her level of interaction in the process of changing.

- **Engagement** – The client has no contact with a treatment professional, or the client has little contact but no working alliance with the treatment professional.

- **Persuasion** – The client has regular contact with a treatment professional but is not working to change the problematic behaviors and/or thoughts.

- **Active treatment** – The client is working to change his or her problematic behaviors and/or thoughts and has experienced the results for at least one month but no more than six months.

- **Relapse prevention** – The client has successfully changed his or her problematic behaviors and/or thoughts for a period of no less than six months.
Cognitive-behavioral therapy (CBT) is a method of counseling that primarily focuses on correcting thoughts, emotions and behaviors that lead to dysfunction by simultaneously restructuring the client’s automatic thoughts and learning new behaviors.

By simultaneously correcting the faulty cognitions and inappropriate behaviors, the client can learn new skills for coping in his or her life circumstances.
Cognitive Behavioral Therapy (CBT)

- CBT attempts to answer the questions:
  - “What keeps the client doing what they do?”
  - “How do they change?”

- The "what" question addresses the reinforcers that maintain patterns of thought, affect and behavior.

- The "how" question relates to skill-building.

- CBT will help the client to develop a problem-solving approach to the various inevitable struggles in their lives.
Mutual Support Programs

- Mutual support programs, such as Twelve Step groups, are designed for people in recovery to meet to discuss similar struggles, independent of formal treatment by addiction professionals.

- Mutual support programs are based on the assumption that change can result from a group of people sharing their common problems, experiences and feelings.

- Participants are encouraged to identify with the emotions of the other members and use this commonality to motivate them to change their behavior.

- Mutual support groups generally do not have limitations on who can attend their meetings, just that one must have a genuine desire to rid their life of the problematic behavior.
Pharmacotherapy = the use of prescription medication to treat co-occurring disorders

Prescription medications are available for all mental health disorders and have demonstrated efficacy for the treatment of many disorders, including:

- Depressive disorders
- Bipolar disorders
- Anxiety disorders
- Schizophrenia
- Bulimia nervosa
- Substance use disorders
Over the past several decades, prescription medication has become a mainstay in the treatment of mental health disorders, with some clients with co-occurring disorders invariably required to manage a regimen of multiple medications each day.

Recognizing this new reality, it is imperative that addiction professionals working with clients with co-occurring disorders be familiar with the various medications that are most often prescribed, how they can potentially impact the treatment process and how to encourage clients to comply with the recommended dosing schedules.
Pharmacotherapies for co-occurring disorders are divided into 6 major classes:

- antidepressants
- anxiolytics
- hypnotics
- mood stabilizers
- antipsychotics
- substance use disorder medications
1.) Antidepressants are medications used to treat depressive disorders, and many have been shown to be effective at reducing anxiety, as well.

- Selective serotonin reuptake inhibitors (SSRIs)
- Selective serotonin-norepinephrine reuptake inhibitors (SNRIs)
- Serotonin 5-HT2 receptor antagonists
- Combined noradrenergic-dopaminergic agents
- Noradrenergic and serotonergic agents
- Tricyclics and tetracyclics (TCAs)
- Monoamine oxidase inhibitors (MAOIs)
Common Pharmacotherapies

Most antidepressants do not interact negatively with psychoactive substances, making them ideal for clients with co-occurring disorders who are not abstinent yet.

However, many antidepressants can produce some uncomfortable side effects.
2.) Anxiolytics are medications used to reduce anxiety and symptoms of anxiety disorders.

- Benzodiazepines – can be addictive and have a high potential for misuse
- Barbiturates – can be addictive and have a high potential for misuse
- Anticonvulsants
- Antihistamines

Some anxiolytics can take days to weeks to have a full effect, while others can produce immediate effects, making them useful on an as needed basis.
3.) Hypnotics are medications used to induce and maintain sleep. These medications are often prescribed to clients with co-occurring disorders because of the common occurrence of sleep disturbances.

- Melatonin and melatonin receptor agonists
- Non-benzodiazepines that act only on the benzodiazepine 1 receptors
- Benzodiazepines – can be addictive and have a high potential for misuse
- Trazodone – Desyrel®
- Antihistamines
4.) Mood stabilizers are used in the treatment of bipolar disorder and to prevent future episodes of acute mania and depression. Many clients with bipolar disorder tend to use psychoactive substances when in a manic episode, so pharmacotherapy with a mood stabilizer can help clients with co-occurring disorders prevent relapse and stay engaged in treatment.

- Antipsychotics
- Lithium
- Valproic acid and divalproex products
- Anticonvulsants

Unfortunately, all of the mood stabilizers are known for unpleasant and sometimes dangerous side effects that require regular monitoring.
5.) Antipsychotics are used to alleviate, reduce and prevent symptoms of acute psychosis, such as hallucinations, delusions and disorganized speech.

- Typical = the first 14 medications created to address psychotic symptoms and work in very similar ways, with similar efficacy.

- Atypical = named so because they are thought to have a different mechanism of action than the typical antipsychotics.

Unfortunately, antipsychotics can produce many side effects, such as sedation, weight gain, seizures, abnormal movement patterns and in rare cases, sudden death.
6.) Clients with co-occurring disorders also sometimes require medications to assist with their substance use disorder(s).

At this time, the Food and Drug Administration (FDA) has approved pharmacotherapies only for alcohol dependence and opioid dependence.

All of these medications have demonstrated efficacy and can be valuable in helping reduce or eliminate psychoactive substance use.
Pharmacotherapy can only work if they are taken as prescribed.

Clients often have difficulty strictly adhering to a dosing schedule, making them more prone to relapse and hospitalization.
Medication Compliance

Treatment approach techniques for increasing adherence to a medication regimen:

- Make the medication regimen as simple as possible.
- Develop strategies for incorporating the dosing regimen into the client’s daily routine.
- Outline the benefits of taking medications as prescribed.
- Dispel inaccurate beliefs about the medication.
- Review the side effects of prescribed medication and discuss options for managing those.
- Identify the client’s personal goals and explore how taking his or her medication as prescribed will help achieve them.
- Evaluate the level of support the client is receiving from family and peer groups concerning taking prescribed medication.
Collaboration with Prescriber

Even though the prescriber is ultimately responsible for ensuring safety and effectiveness of pharmacotherapies, addiction professionals can also help in this effort.

Since addiction professionals tend to see the client more often, they are well-positioned to:

- recognize danger signs (including recent psychoactive substance use)
- recognize abnormal side effects
- monitor and support compliance
Involving the Client’s Family

- Research has shown that outcomes for substance use and mental health disorders are improved, including fewer relapses, when families are actively engaged in the treatment process.

- Since they see the client most often, and between 25 to 50% of clients with co-occurring disorders live with a family member, they can more closely monitor the client’s progress and adherence and report any changes that could lead to relapse or impact treatment success.

- Encouraging family member involvement and developing a collaborative relationship as early as possible in the treatment process will result in more beneficial treatment for the client and an easier counseling experience for the addiction professional.
Unfortunately, family members of a client with co-occurring disorders often experience considerable stress, heartbreak and frustration.

- As a result, family members can neglect their own basic needs, as well as the needs of others who depend on them and can even develop their own symptoms of depression or anxiety.

- By engaging in the treatment process with the client, and by participating in self-help groups such as Al-Anon or NAMI, family members can receive support from trained professionals and alleviate the high level of stress they are most likely experiencing.
Group counseling has been the cornerstone of addiction treatment for decades because it is a highly effective and cost-efficient way to provide education and facilitate growth for many clients at a time.

Those clients receiving treatment for co-occurring disorders will most likely participate in some form of group counseling for the same reasons.
Just like with all groups with varying topics and diverse clients, the:

- group size,
- timing and frequency of meetings,
- duration of meetings,
- admission and attendance policies and
- group rules

must all be carefully considered and adapted to fit the needs of the group population. Groups for clients with co-occurring disorders are no exception.
Cultural Considerations

These special considerations may affect the treatment approach that should be implemented and how it will progress and can vary depending on culture, race, ethnicity, age, sex, gender, sexual orientation, religion, socioeconomic status and housing status, to name a few.

Addiction professionals must be aware of the individualized needs of a client and be prepared to respond to each diverse client appropriately.

To be most effective, professionals must be able to recognize the social, political, economic and cultural context within which addiction and mental health disorders exist, including risk and resiliency factors that characterize individuals and groups and their living environments.
Clinical Tips for Treating Mental Health Disorders

When treating clients with personality disorders, addiction professionals should apply the following principles:

- Build a therapeutic alliance with the client.
- Avoid power struggles.
- Do not personalize the client’s behavior.
- Clinicians should take a more active approach in treatment.
- Set agreed upon goals with the client.
- Do not be afraid to assess personal feelings/reaction and teach appropriate affective expressions.
Clinical Tips for Treating Mental Health Disorders

- Assist the client in developing skills, such as deep breathing, meditation and cognitive restructuring, to manage negative memories and emotions.

- Understand that denial may be present and be willing and patient to work through it with the client.

- Use blood/urine screens to verify abstinence claims, when appropriate.

- Use referral information from external sources as leverage when setting goals and moving through treatment.

- Do not allow the client to divide staff members against each other.

- Anticipate that these clients will most likely progress slowly and unevenly, and improvement may mean going from moderately severe to modest impairment.
Clinical Tips for Treating Mental Health Disorders

- Assess the risk of self-harm continually.

- Set clear boundaries and expectations regarding limits and requirements in roles and behaviors.

- Maintain a positive but neutral professional relationship, avoid overinvolvement in the client’s perceptions and monitor the counseling process frequently with supervisors and colleagues.

- Anticipate “crisis” events, such as the need for immediate attention, flattery or manipulation.

- Anticipate separation issues and increased anxiety around termination.
Clinical Tips for Treating Mental Health Disorders

When treating clients with psychotic disorders, addiction professionals should apply the following principles:

- Work closely with a psychiatrist or mental health professional if not trained/educated appropriately to treat severe mental health disorders.

- Teach the client skills for detecting early signs of relapse for both mental illness and substance use disorder.

- Expect crises associated with the mental health disorder and have available resources to facilitate stabilization.
Clinical Tips for Treating Mental Health Disorders

- Assist the client in obtaining entitlements and other social services.
- Monitor medication and promote medication adherence.
- Provide frequent breaks and shorter sessions or meetings.
- Present material in simple, concrete terms with examples, using multimedia methods, if available.
- Encourage participation in social clubs with recreational activities.
Thank You for Participating!

44 Canal Center Plaza, Ste. 301, Alexandria, VA 22314
phone: 703.741.7686 / 800.548.0497
fax: 703.741.7698 / 800.377.1136
www.naadac.org • naadac@naadac.org