Co Occurring Disorders

- Dually diagnosed?
- Dually disordered?
- Co morbid disorders?
- Co-Occurring Disorders

Refers to co-occurring substance use (abuse or dependency) and mental disorders. Clients may have one or more mental disorders as well as one or more substance use disorders.

Examples of Dual Disorders:

- **MENTAL DISORDERS**
  - Schizophrenia
  - Bi-polar
  - Schizoaffective
  - Major Depression
  - Borderline Personality
  - Post Traumatic Stress
  - Social Phobia
  - others

- **ADDITION DISORDERS**
  - Alcohol Abuse/Depen.
  - Cocaine/ Amphet
  - Opiates
  - Marijuana
  - Polysubstance combinations
  - Prescription drugs
**Trauma and Substance Abuse**

- More than 50% of individuals in treatment report having significant trauma related symptoms prior to entering treatment.

---

**Prevalence of Co in Treatment**

- Studies in substance abuse settings have found that from 50% to 75% of consumers had some type of mental disorder.
- Studies in mental health settings have found that between 20% to 50% of their consumers had a co-occurring substance use disorder.

---

**Likelihood of a Suicide Attempt**

**Risk Factor**

- Cocaine use
- Major Depression
- Alcohol use
- Separation or Divorce

**Increased Odds Of Attempting Suicide**

- 62 times more likely
- 41 times more likely
- 8 times more likely
- 11 times more likely

**ECA EVALUATION**
Systems Problems
- Different Laws...commitment/confid.
- Different funding...audits etc
- Different personnel
- Different training
- Different certification
- Different sites
- Different Norms

Issues
- Numerous health and social problems requiring costly care
- Risk for homelessness and incarceration
- Women are at risk of being victims of sexual abuse and domestic violence
- Parents with co-occurring problems risk encounters with child welfare

Issues
- More rapid progression from initial use to substance dependence
- Poor adherence to medication
- Decreased likelihood of treatment completion
- Greater rates of hospitalization
- More frequent suicidal behavior
- Difficulties in social functioning
- Shorter time in remission of symptoms
Needs of the Helper

- Desire and willingness to work with people who have Co-Occurring Disorders
- Appreciation of the complexity of COD
- Openness to new information
- Awareness of personal reaction, feelings, & biases

What to Do? Approaches
What have we done?

- Four general approaches have been tried:
  - 1. Not at all
  - referred out to treatment for the other problem or refused care entirely
  - 2. Serial Treatment
  - one type of disorder treated at a time, in separate settings
  - 3. Concurrent or Parallel Treatment
  - treatment for both types of disorder offered at the same time but in separate settings and by separate providers
  - 4. Integrated Treatment
  - both types of disorder assessed and treated together in specialized settings by providers possessing competency in the treatment of both types of disorder and integrated treatment
Problems with approaches

- No Treatment At All:
  - Denial of treatment is, of course, ineffective. It is also unethical and could result in legal liability.

Problems with approaches – Serial Treatment

- Serial Treatment can worsen problems or create new ones:
  - Confusion due to conflicting treatment philosophies held by different providers
  - Confusion due to conflicting treatment recommendations or priorities
  - Treatment gaps arising due to communication problems between/among providers
  - Practical considerations such as scheduling, transportation, ...

Problems with approaches – Concurrent or Parallel Treatment:

- As with serial treatment, this approach can worsen problems or create new ones:
  - Confusion due to conflicting treatment philosophies held by different providers
  - Confusion due to conflicting treatment recommendations or priorities
Problems with approaches

- Treatment gaps arising due to communication problems between/among providers
- Practical considerations such as scheduling,
- transportation, etc.
- High drop-out rates
- Less than 10% get both services

Integrated Dual Disorder Treatment ...

- Treatment of substance use disorder and mental illness together
  - Same team
  - Same location
  - Same time
  - More on that later ....

Needs of the Helper

- Patience, perseverance, & optimism
- Flexibility of approach
- Belief that all individuals have strengths and are capable of growth and development
Needs of the Helper
- Having a recovery perspective
- Adopt and maintain a multi-problem viewpoint
- Recognize “Phases”... engagement, stabilization, treatment, continuing care
- Address specific real life problems early
- Plan for the client’s functional and cognitive impairments
- Use/access positive support systems for the client to extend the effectiveness of interventions

Medications
- Essential to Treatment of Severely Mentally Ill
  - Substance Use and Not-Taking Meds are the 2 top reasons for De-Comp
  - Should be part of court orders
  - Monitored by Case managers, nurses, doctors
- For Dep/Anx, less clear
  - Personal experience shows maximizing 12 step AND use of meds is best rx

Medications: counselor’s role
- Ask the pt about:
  - Compliance...
  - “Sometimes people forget their medications... how often does this happen to you?...% not taking
  - Effectiveness...
  - “How well do you think the meds are working?... what do you notice...
  - Side Effects...
  - “Are you having any side effects to the medication?... what are they...
  - Have you told the prescriber?
  - Do you need help with talking to the prescriber?
Various reasons Meds don’t work

- The patient stopped the med
- The patient stopped the med AND used drugs and/or alcohol.....
- OR lowered the med and used...
- OR used on top of the med....
- OR used twice the dose on one day and nothing the next....
- Stimulants (cocaine/amphets) are destructive

How to use AA as a treatment partner

1. Know something about AA, its history, presence in your community, structure and content

2. Helpful Readings:
   - Brown: A psychological view of the 12 steps
   - AA: AA for the medical practitioner; and
   - The AA member and medications
   - Twelve Step Facilitation Therapy Manual-
     - Project Match, NIAAA web site
   - Forman: “One AA Meeting doesn’t fit all”

Examples of Evidence-Based Practices

- Integrated Treatment for Co-Occurring Disorders
- Supported Employment
- Assertive Community Treatment
- Family Psychoeducation
- Illness Management and Recovery
EBTS – Evidence Based

- Services that have consistently demonstrated their effectiveness in helping people with mental illnesses achieve their desired goals

- Effectiveness was established by different people who conducted rigorous studies and obtained similar outcomes

View Co-occurring as a stage process = Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- "Relapse"

Precomtemplation

- Not thinking about change
- Does not believe ______ applies to self
- Consequences are not that serious (their perception)
- The individual might be labeled as being in "denial" or "resistant"
- The individual may be unaware or "under-aware" of problem
- "Ignorance is bliss"
Precontemplation Goals of Helper

- Problem identification
- The client and helper may not identify the same thing
- Primary tools are providing information and raising doubt
- Engaging the client

Contemplation

- Aware that a problem exists
- Thinking about changing
- No commitment to take any action
- May be ambivalent about changing
- Weighing out the benefits vs. the costs of making the proposed changes
- "sitting on the fence"

Contemplation – and helper

- Benefit analysis – Pro’s and Con’s
- Explore options client has considered
- Inquire about other attempts to make changes and look to frame it with some positive about the attempt
- Tell me about other challenges you have dealt with in the past
- How will you know when…….
Preparation
- Combination of intention and behavior
- May be experimenting with small changes
- If not currently making changes, has a realistic plan to begin within the next month
  - “Testing the water”

Preparation
- Reinforce commitment toward taking action
- Note and highlight small steps toward change
- Examine potential barriers and client solutions
- Build coping skills
  - “What’s the next step?”
  - “What do you think you will do?”

Action
- Taking definite action to make changes
- Modifying behavior to overcome the problem
- Modifying environment to overcome the problem
- Commitment is clear and effort is put toward change
- Usually last 1-6 months
Action and the Helper

- Reaffirming commitment
- Focus on successful activity
- Evaluate the client's change plan where is it working and areas that may need revised
- Skill building
- Problem solving
- Contingency management

Maintenance

- Working to consolidate gains
- A new pattern of behavior has replace the old
- Consistently engaged in changed behaviors for more than 6 months

Maintenance and the Helper

- Typically active work is not involved while a client is in maintenance, but rather when the client experiences a crisis and "slips" or begins to experience fear of slipping
- Explore the triggers or events that led to the crisis or what is maintaining the crisis
- Provide feedback, information, & review plans
Relapse

- Not really a stage but can occur during later stages and return an individual to a previous stage
- Resuming "old" behaviors
- "a fall from grace"

Moving a Client MI

- Interpersonal form of communication
- Client-centered
- Directive method enhancing intrinsic motivation
- Exploring and resolving ambivalence

Source: Miller, Rollnick, 2002

Motivational Interviewing

- Client centered—focuses on perspective of the individual—"Rogerian". Not focused on skill building, cognitive reframing, past nuclear family issues, etc.
- Consciously directive—intentionally focused on resolving ambivalence by selectively reinforcing "change talk"
Motivational Interviewing

- Method of communicating, rather than set of techniques
- Focus is to elicit an individual's intrinsic motivation for change, rather than using extrinsic forces, i.e., legal sanctions or mandates
- Exploring and resolving ambivalence as a primary avenue for change

Source: Miller, Rollnick, 2002

Principles of Motivational Interviewing

1. Express Empathy: by seeking to understand client's feelings and perspectives, without judgment. Accepting them where they are, allows them the freedom to change, building therapeutic alliance. Ambivalence is normal.

Principles of Motivational Interviewing

- Develop Discrepancy: Help client to identify his/her own discrepancy between present behavior and his/her own values and goals. Want to help to amplify the discrepancy in order to override the status quo. Change is more likely if client can voice concerns, reasons for change, belief in ability to change and intention for change.

- Source: Miller, Rollnick, 2002
Principles of MI

- **Roll with Resistance**: Don’t oppose resistance, or argue for change. The automatic response to feeling pushed is to push back. Actively involve the client in problem-solving. Resistance may be a signal (from client) for “helper” to respond differently.

- **Support Self-Efficacy**: Key element in changing is the belief that one can & is a chief predictor of treatment outcome. Counselor’s belief in person’s ability to change becomes self-fulfilling prophecy.

- “If you wish to change, perhaps I can help.”

MI and OARS

**O - OPEN ENDED**
- reduce defensiveness,
- Increasing trust and acceptance,
- encouraging client to speak

**A - Affirm**
- client using compliments,
- statements of appreciation and understanding,
- Notice client strengths and efforts

**R - Reflective listening**, one of the most important skills required in MI

**S - Summarizing**
- can be done throughout session,
- when transitioning to new topic, emphasizing change talk
  - influence
Traps to avoid during MI
- Question and Answer trap
- Taking sides—arguing FOR, the client argues AGAINST
- Expert Trap—having all the answers
- Labeling Trap—diagnostic labeling
- Premature Focus Trap—trying to get client to see the problem you perceive
- Blaming Trap—counseling has a “no fault” policy

What Is Integrated Treatment for Co-Occurring Disorders?
- Integrated Treatment is a research-proven model of treatment for people with serious mental illnesses and co-occurring substance use disorders
- Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team.
- They receive one consistent message about treatment and recovery

Why Integrated ...
- The focus is on preventing anxiety rather than breaking through denial
- Emphasis is placed on trust, understanding, and learning
- Treatment is characterized by a slow pace and a long-term perspective
- Providers offer stage-wise treatment
Integrated Treatment Recovery Model

- Hope is critical
- Services and treatment goals are consumer-driven
- Unconditional respect and compassion for consumers is essential
- Integrated treatment specialists are responsible for engaging consumers and supporting their recovery

Integrated Treatment Recovery Model (continued)

- Focus on consumers' goals and functioning, not on adhering to treatment
- Consumer choice, shared decisionmaking, and consumer/family education are important

Practice Principles for Integrated Treatment for Co-Occurring Disorders

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders
- Integrated treatment specialists are trained to treat both substance use and serious mental illnesses
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage
Practice Principles for Integrated Treatment for Co-Occurring Disorders

- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages
- Multiple formats for services are available, including individual, group, self-help, and family
- Medication services are integrated and coordinated with psychosocial services

Treatment is Integrated

- Mental health and substance abuse treatment are evaluated and addressed
  - Same team
  - Same location
  - Same time
- Treatment targets the individual needs of people with co-occurring disorders and is integrated on organizational and clinical levels

Treatment is in a Stage-Wise Fashion

- Precontemplation — Engagement
  - Assertive outreach, practical help (housing, entitlements, etc.), and an introduction to individual, family, group, and self-help treatment formats
- Contemplation and Preparation — Persuasion
  - Education, goal setting, and building awareness of problem through motivational counseling
- Action — Active treatment
  - Counseling and treatment based on cognitive-behavioral techniques, skills training, and support from families and self-help groups
- Maintenance — Relapse prevention
  - Continued counseling and treatment based on relapse prevention techniques, skill building, and ongoing support to promote recovery
Integrated Treatment Recovery Model (continued)
- Integrated treatment is associated with the following positive outcomes:
  - Reduced substance use
  - Improvement in psychiatric symptoms and functioning;
  - Decreased hospitalization
  - Increased housing stability
  - Fewer arrests and
  - Improved quality of life

- (Drake et al., 2001)

Summary
- Integrated Treatment for Co-Occurring Disorders is effective in the recovery process for consumers with co-occurring disorders
- The goal of this evidence-based practice is to support consumers in their recovery process
- In Integrated Treatment programs, the same practitioners, working in one setting, provide mental health and substance abuse interventions in a coordinated fashion
- Consumers receive one consistent message about treatment and recovery

Additional Resources
- For more information about Integrated Treatment for Co-Occurring Disorders and other evidence-based practices, visit
  - www.samhsa.gov