



Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know

PRESENTED BY



NAADAC

THE ASSOCIATION FOR
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Seminar Objectives

- 1) Explore common misperceptions and biases regarding co-occurring disorders.
- 2) Recognize and screen for the most frequent co-occurring disorders seen in a substance abuse setting.
- 3) Apply knowledge of evidence-based practices currently utilized in the substance abuse arena to treatment of clients with co-occurring disorders.
- 4) Integrate substance abuse and mental health referral or services within the scope of his or her own practice.



Seminar Objectives

- 5) Identify a client's stage of change and stage of treatment to implement effective interventions.
- 6) Discuss the clinical aspects of medication management for co-occurring disorders.
- 7) Review and discuss case studies and strategies for ensuring successful client outcomes.
- 8) Translate information presented during the educational seminar to clients, families, colleagues and the community.



Section One: Introduction to Co-occurring Disorders



Myths and Facts

Addiction professionals have varying opinions and beliefs about co-occurring disorders.

Some of the beliefs held by the profession are accurate, while, other opinions do not reflect current research, literature or current practice.



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



Myths about Co-occurring Disorders

MYTH: Addiction professionals are not competent to recognize, assess 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).



Myths about Co-occurring Disorders

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.



Myths about Co-occurring Disorders

- 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.



Myths about Co-occurring Disorders

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

It is true that clients with co-occurring disorders have less favorable outcomes than those who suffer only from either a substance use disorder or a mental health disorder.

However, individuals with co-occurring disorders most certainly respond to and can benefit from effective treatment.



Myths about Co-occurring Disorders

Many of these barriers to successful treatment can be addressed through programs designed specifically for clients with co-occurring disorders and the unique needs of this population.

By addressing both the mental health disorders and substance use disorders through an integrated treatment approach (discussed in detail later in this educational program) provides clients with co-occurring disorders greater opportunities to succeed in treatment.



Myths about Co-occurring Disorders

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

The use of self-help programs has traditionally been a cornerstone to addiction treatment and recovery.

However, individuals with co-occurring disorders are often regarded as difficult members and unsuitable for participation in addiction-focused, self-help meetings.



Myths about Co-occurring Disorders

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



Myths about Co-occurring Disorders

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

- This myth is widely believed due to the strong influence of Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and other Twelve Step programs.
- To some members of Twelve Step fellowships, the use of what some believe to be mood-altering medications, such as antidepressants, is contradictory to a substance-free lifestyle.
- Some members may express their outright disapproval; while others may feel suspicious.
- This belief was more widespread than it is today.



Facts about Co-occurring Disorders

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.”¹⁰



Defining Co-occurring Disorders

Co-occurring disorders (COD):

the simultaneous existence of “one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental [health] disorders.”¹⁸



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.¹⁶
- 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.¹⁷



Defining Co-occurring Disorders

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.¹⁹

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.²⁰



Defining Co-occurring Disorders

Common examples include:

- Major depressive disorder and alcohol dependence
- Generalized anxiety disorder, benzodiazepine dependence and alcohol abuse
- Antisocial personality disorder and cocaine dependence



Defining Co-occurring Disorders

- 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.



Common Terminology

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”²²

- Bipolar disorder
- Major depressive disorder
- Schizophrenia
- Obsessive-compulsive disorder
- Social phobia
- Borderline personality disorder
- Posttraumatic stress disorder



Common Terminology

Substance use disorder (SUD):

a behavioral pattern of continual psychoactive substance use that can be diagnosed as either substance abuse or substance dependence



Common Terminology

- In general, substance dependence is more serious than substance abuse.
- Substance dependence is a repetitive and harmful activity that involves behavioral changes, loss of control and continued use in spite of deleterious consequences that would be considered pathological in almost any culture.
- In comparison, substance abuse produces less severe consequences and lacks the components of tolerance and withdrawal that are most commonly associated with addiction.



Common Terminology

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, in the interest of employing a common, accurate language, the term “substance abuse” should only be used in relation to the criteria described above.



Severity of Co-occurring Disorders

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

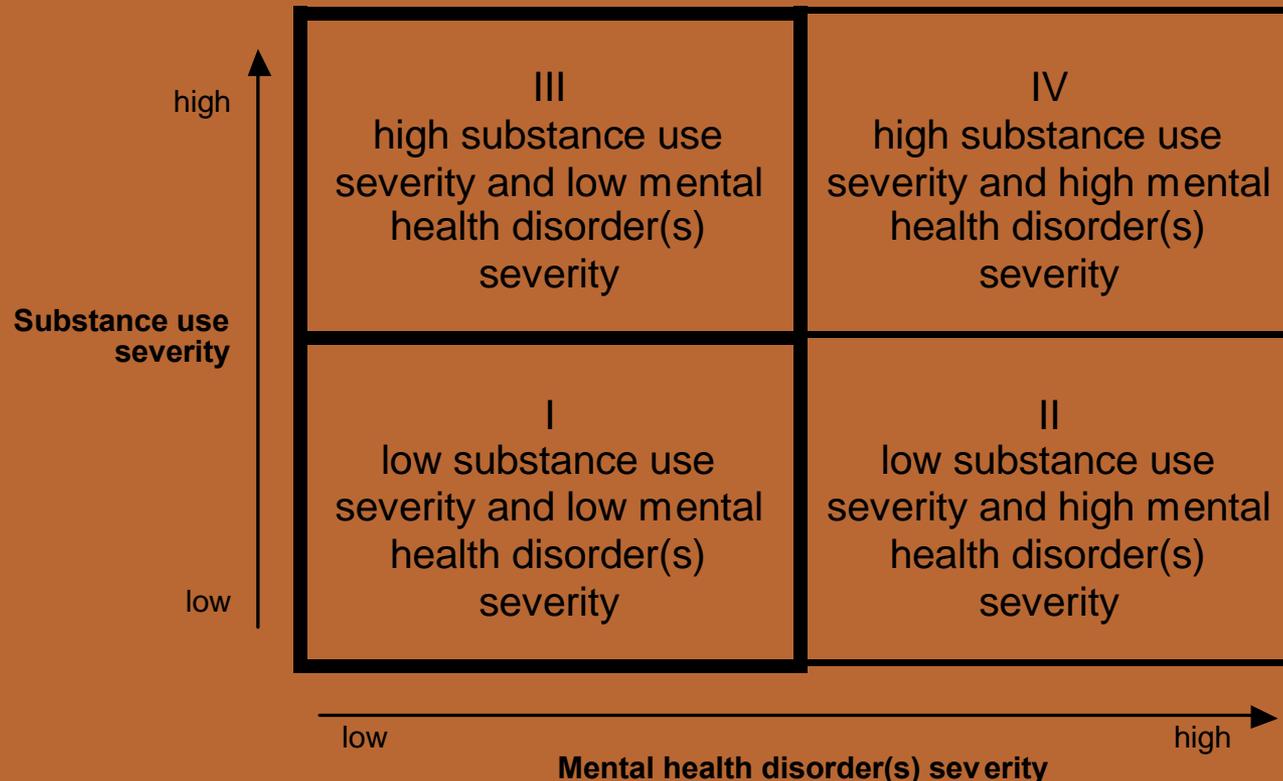
- **Non-severe:** early in the continuum and can include mood disorders, anxiety disorders, adjustment disorders and personality disorders.
- **Severe:** include schizophrenia, bipolar disorder, schizoaffective disorder and major depressive disorder.

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 Care²⁵

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.





Quadrants of Care

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 abuse since he started college. He has difficulty concentrating, has had difficulty getting out of bed and is feeling hopeless about succeeding in school.



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 was treated for alcohol dependence 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.



Quadrants of Care

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 has been dependent on crack cocaine for six years, during which time she has engaged in prostitution, drug dealing and theft to support her addiction. She was also diagnosed with borderline personality disorder at the age of 19.



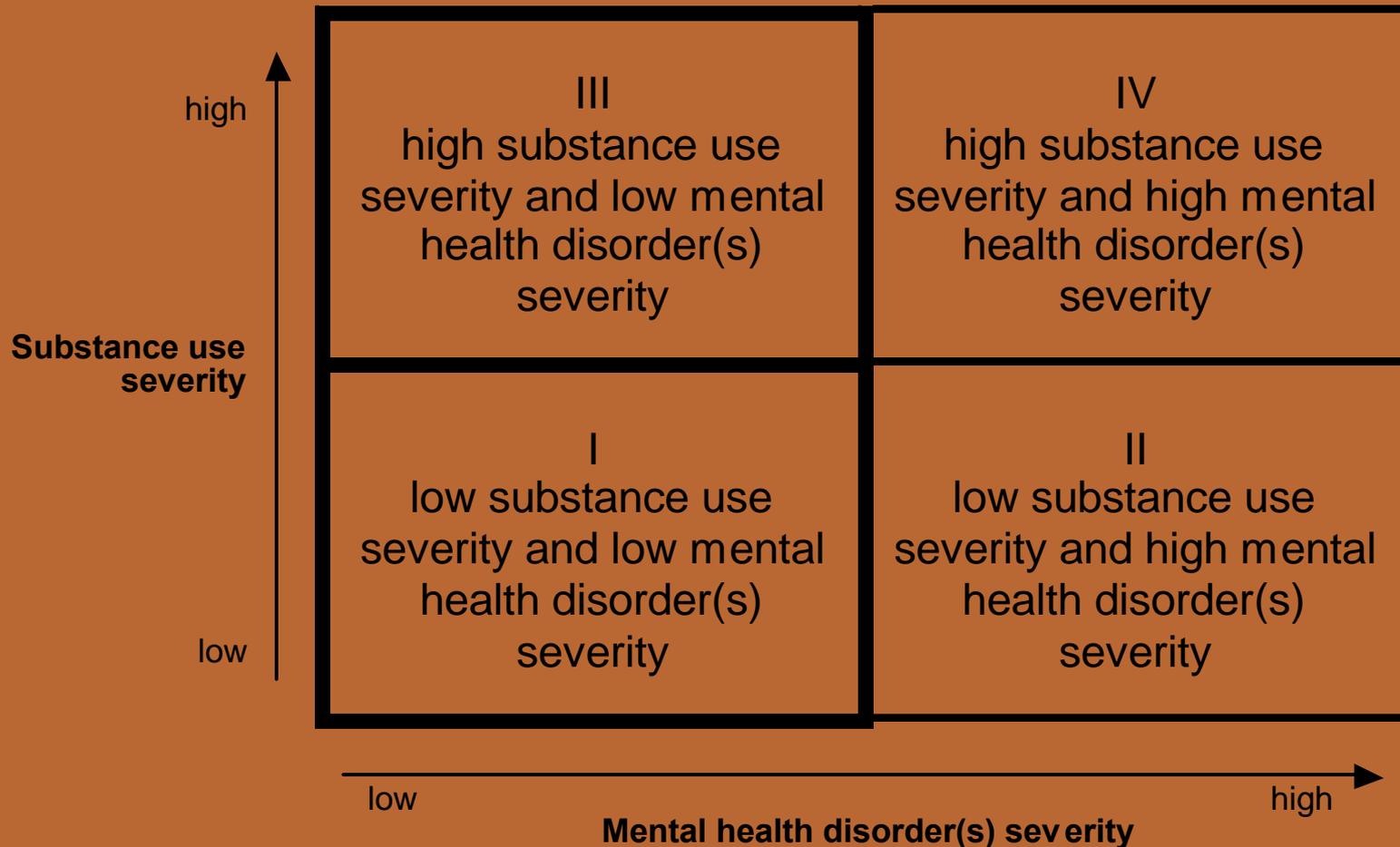
Quadrants of Care

Quadrant IV

- **Diagnosis:** high severity substance use with high severity mental health disorder(s).
- **Likely location of treatment:** specialized residential substance abuse treatment programs; psychiatric hospitals; detoxification programs; jails; or emergency rooms.
- **Client example:** Marcus has schizophrenia and has been dependent on methamphetamine for over 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.



Quadrants of Care²⁵





Co-occurring Disorders Interactions

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 Interactions

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-IV-TR*.
- 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.²⁶
- In general, “the more severe the disability, the lower the amount of substance use that might be harmful.”²⁷
- Chronic substance abuse or dependence usually results in negative consequences for the individual and his or her family.



Historical Perspective on Treatment²⁹

- Clients with co-occurring disorders have historically received substance abuse 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.



Historical Perspective on Treatment²⁹

- 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*²⁹

- **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.



Single Model of Care²⁹

- Historically, mental health professionals regarded substance use problems as a symptom of an underlying mental disorder.
- Believed that once this “*primary disorder*” was treated effectively, the substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope (self-medication model).
- Likewise, addiction professionals often attributed a client’s persistent psychiatric symptoms as manifestations of a substance use disorder that would diminish once he or she completed a quality recovery program.
- The single model of care approach is not applicable to most clients with co-occurring disorders.





Sequential Model of Treatment²⁹

- The sequential model of treatment acknowledges the presence of co-occurring disorders and treats them one at a time.
- Under this model of treatment, it is assumed that the primary disorder can only be treated effectively after any influential underlying disorders are stabilized or resolved.



then





*Sequential Model of Treatment*²⁹

- Once the primary disorder is effectively treated, the client does not often continue to receive further treatment for other co-occurring disorders.
- Maybe due to the treatment professional's failure to refer the client for additional treatment, or if the client is referred, the clinician may fail to ensure that treatment is secured.
- Clients often lack the motivation to obtain additional treatment once one course of treatment is complete.
- This could be due to a lack of awareness of the magnitude of the other disorders, the difficulties associated with initiating new relationships with other treatment providers or a lack of stability or finances to see the treatment through.



Parallel Model of Treatment²⁹

- In a **parallel model of treatment**, also known as parallel care or the concurrent model of care, mental disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.
- The parallel model of treatment is more preferable than sequential treatment, but it still has its own set of drawbacks and limitations.





Parallel Model of Treatment²⁹

- Having separate treatment teams for different co-occurring disorders requires a great deal of communication and coordination among various treatment professionals, which often does not occur with the amount of frequency required to provide effective, unified treatment.
- Often, there is little communication between providers, leaving the client with the burden to shuttle information from one provider to the next.
- Many addiction and mental health professionals have incompatible philosophies on treatment and the steps necessary to achieve recovery.
- This can result in conflicting care, which undermines the potential effectiveness for all disorders being treated.



*Parallel Model of Treatment*²⁹

- Clients are required to bare the burden of seeking out and adhering to separate courses of treatment for each of their co-occurring disorders.
- As with sequential treatment, clients often fail to receive the treatment they require for all of their disorders.
- These clients can easily “fall through the cracks” if they are not monitored by treatment professionals.
- In theory, if treatment professionals from both arenas were committed to regular communication and working in concert to integrate the client’s treatment goals and to increase treatment compliance, a parallel model of treatment is a suitable alternative to integrated care; however, this is rarely achieved in practice as much as one would hope.



Models of Treatment Exercise



A twenty-eight year-old-woman named Anita entered an addiction treatment center where she was assessed as having alcohol dependence. Six months earlier, Anita had been diagnosed with major depressive disorder and was prescribed medication by her family doctor. At the treatment facility, it was recommended that Anita be re-assessed and treated, if necessary, at a mental health clinic, located nearby in town. 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 Treatment²⁹

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.



Integrated Model of Treatment²⁹

The integrated model of treatment can best be defined by following 7 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 Treatment²⁹

1) *Integration* –

Treatment services are designed and provided with the interactive and cyclical nature of co-occurring disorders in mind and in a manner that simultaneously addresses all disorders.

Integration should be apparent at not only the treatment planning level but also within the screening and assessment process and when crisis planning.



Integrated Model of Treatment²⁹

2) *Comprehensiveness* –

Because clients with co-occurring disorders usually experience additional problems beyond their mental and substance use disorders, a comprehensive assessment of other areas that might be contributing to or exacerbated by the co-occurring disorders should be conducted.

Difficulties with housing, finding work or other meaningful activities, improving the quality of family and social relationships, developing a capacity for independent living and developing skills for managing variations in mood are all areas that should be addressed when treating a client with co-occurring disorders.



Integrated Model of Treatment²⁹

3) *Assertiveness* –

Instead of exclusively waiting for clients with co-occurring disorder to present at the door of a treatment facility, integrated treatment programs can be more assertive by delivering most services to them in the community and maintaining constant and consistent contact with each client to continue to engage them in treatment.



Integrated Model of Treatment²⁹

4) Reduction of negative consequences –

Philosophically, the primary goal in treatment for clients with co-occurring disorders is to reduce the numerous harmful effects that often result by the presence of two or more disorders.



Integrated Model of Treatment²⁹

5) Long-term perspective –

Clients with co-occurring disorders often do not produce quick, dramatic changes with only short periods of treatment.

Rather, these clients tend to improve gradually over the course of many months and/or years.

Therefore, time-unlimited services are necessary to allow each client to recover in his or her own pace so the life changes are sustainable and permanent.



Integrated Model of Treatment²⁹

6) Motivation-based treatment –

Clients with co-occurring disorder vary in their motivational states for receiving and engaging in treatment, which directly impacts what goals can be set and what interventions are most likely to be effective.

An integrated model of treatment acknowledges these variances and modifies the course of treatment appropriately to match them.



Integrated Model of Treatment²⁹

7) Multiple psychotherapeutic modalities –

An integrated model of treatment utilizes many different therapeutic approaches to help progress a client in treatment, including individual counseling, integrated group treatment and family interventions.



Integrated Model of Treatment²⁹

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 Treatment²⁹

- 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.



*Integrated Model of Treatment*²⁹



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



Section Two: Mental Health Disorders



Common Mental Health Disorders³⁹

Remember, 50 to 75% of all clients who are receiving treatment for a substance use disorder also have another diagnosable mental health disorder.⁴⁰

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.



Mood Disorders³⁹

In general, mood 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.

According to the *DSM-IV-TR*, mood disturbances can manifest as either:

- major depressive episodes
- manic episodes
- hypomanic episodes
- mixed episodes

Please note, however, these episodes cannot be diagnosed as separate entities but rather, the presence of one or more type of episodes defines which mood disorder diagnosis a client receives.



Mood Disorders³⁹

- Mood disorders are by far the most common co-occurring disorders, with 30 to 40% of individuals with a substance use disorder also having a mood disorder.⁴³
- Conversely, approximately 33% of individuals with a mood disorder also have a substance use disorder.⁴³
- Major depressive disorder, dysthymic disorder and bipolar disorder are the most prevalent mood disorders encountered while treating clients with substance use disorders.



*Anxiety Disorders*³⁹

- 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.



Anxiety Disorders³⁹

- Approximately 25% of Americans will have an anxiety disorder at some point in their lifetimes.
- Women represent most of these cases.⁵⁰
- Generalized anxiety disorder, panic disorder, social phobia disorder, obsessive-compulsive disorder and posttraumatic stress disorder are the most prevalent anxiety disorders encountered while treating clients with substance use disorders.



Personality Disorders³⁹

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.



Personality Disorders³⁹

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)



*Psychotic Disorders*³⁹

- 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 psychotic disorders encountered in a substance abuse treatment setting (provided that integrated treatment is available) are schizophrenia and schizoaffective disorder.



Psychotic Disorders³⁹

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms, such as affective flattening, poverty of speech or general lack of desire, drive or motivation to pursue meaningful goals



Section Three: Co-occurring Disorders Treatment



Stages of Change Model

The stages of change model identifies the varying levels of internal motivation to change one's life.

- **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.⁶¹



Stages of Treatment Model

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.⁶³



Screening and Assessment⁶³

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 Assessment⁶³

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.



Screening and Assessment⁶⁵

- 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.
- There are 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 Assessment⁶⁵

Step 1: Engage the Client

Step 2: Identify and Contact Collaterals

Step 3: Screen for and Detect Co-occurring Disorders



Screening and Assessment⁶⁵

To screen generally for past and present mental 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*
- *Timeline Feedback Form*



Screening and Assessment⁶⁵

To screen for specific past and present mental 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*

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



Screening and Assessment⁶⁵

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

- Posttraumatic stress disorder:
 - *PTSD Checklist**
 - *Modified PTSD Symptom Scale: Self-Report Version*
 - *Clinical Assessment Form for PTSD*



Screening and Assessment⁶⁵

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)*



Screening and Assessment⁶⁵

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*



Screening and Assessment⁶⁵

To aid with categorizing mental and substance use disorders, the *DSM-IV-TR* uses a 5 axial diagnosis framework:

Axis I: Clinical disorders and other conditions that may be a focus of clinical attention

Axis II: Personality disorders and mental retardation

Axis III: General medical conditions

Axis IV: Psychosocial and environmental problems

Axis V: Global Assessment of Functioning score



Screening and Assessment⁶⁵

Step 4: Determine Quadrant and Locus of Responsibility

Step 5: Determine Level of Care



Screening and Assessment⁶⁵

The *American Society of Addiction Medicine Patient Placement Criteria – 2nd Edition Revised (ASAM PPC-2R)* provides six dimensions to assist with determining level of care:

- 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



Screening and Assessment⁶⁵

Dimension 3 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 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.



Screening and Assessment⁶⁵

Step 6: Determine Diagnosis

Step 7: Determine Disability and Functional Impairment

Step 8: Identify Strengths and Supports



Screening and Assessment⁶⁵

Step 9: Identify Cultural and Linguistic Needs and Supports

Step 10: Identify Problem Domains

Step 11: Determine Stage of Change

Step 12: Plan Treatment



Evidence-Based Practices

In most treatment addiction centers, the 3 primary psychosocial treatments are:

- motivational enhancement therapy (MET)
- cognitive-behavioral therapy (CBT)
- twelve step facilitation (TSF)

All of these treatment models are widely used – often without formal training – by addiction professionals around the country and can be easily applied to clients suffering from co-occurring disorders.



Evidence-Based Practices

To summarize the conceptual purpose of ICT:

- motivational enhancement therapy 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*.



Medication Management⁷⁰

Pharmacotherapy = the use of prescription medication to treat co-occurring disorders

Over the past several decades, prescription medication has become a mainstay in the treatment of mental 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 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.



Common Pharmacotherapies⁷⁰

Pharmacotherapies for co-occurring disorders are divided into 6 major classes:

- antidepressants
- anxiolytics
- hypnotics
- mood stabilizers
- antipsychotics
- substance use disorder medications



Common Pharmacotherapies⁷⁰

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.



Medication Compliance⁷⁰

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.

May need help with motivating a client for medication.



Medication Compliance⁷⁰

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.*



Medication Compliance⁷⁰

- ✓ *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 Prescriber⁷⁰

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*⁷¹

- 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,⁷² 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.



*Involving the Client's Family*⁷¹

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 Counseling⁷³

- 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.



Group Counseling⁷³

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 Considerations⁷¹

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 Disorders⁷¹

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 Disorders⁷¹

- ✓ 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.



Clinical Tips for Treating Mental Health Disorders⁷¹

- ✓ 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.
- ✓ Assess the risk of self-harm continually.



Clinical Tips for Treating Mental Health Disorders⁷¹

- ✓ 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 Disorders⁷¹

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 abuse.
- ✓ Expect crises associated with the mental health disorder and have available resources to facilitate stabilization.



Clinical Tips for Treating Mental Health Disorders⁷¹

- ✓ 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!

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