

**Northwest Frontier
Addiction Technology
Transfer Center**

3414 Cherry Ave NE, Suite 100
Salem OR 97303
Phone: (503) 373-1322
FAX: (503) 373-7348

A project of
Oregon Health &
Science University

**Steve Gallon, Ph.D.,
Project Director**

Mary Anne Bryan, Editor
maryanne.bryan@state.or.us

Be sure to check out
our web page at:
<http://www.open.org/nfatc>

*Unifying research,
education and
practice to
transform lives*

“Co-Occurring Disorders: The Facts”

*“Truth, when not sought after,
rarely comes to light.”*

Oliver Wendell Holmes (1809-1894)

The next three issues of the Addiction Messenger will provide you with information on co-occurring disorders. You may have clients who have a co-occurring disorder and you may have questions about their disorder, their assessment, and best or recommended treatment approaches. This series of articles will address these questions.

The term co-occurring disorders may also be familiar to you by other terms: dual-diagnosis, dual disorders, MICA (mentally ill chemical abusers), MISA (mentally ill substance abusers), CAMI (chemical abuse and mental illness), and SAMI (substance abuse and mental illness). These terms describe the coexistence of a mental health disorder and AOD problems.

The Relationship Between AOD Use & Psychiatric Symptoms/ Disorders

Effective treatment is dependent upon an accurate understanding of the client entering an addiction treatment setting. Your ability to discriminate between symptoms of substance abuse and psychiatric disorders is vital to development of a relevant individualized treat-

ment plan. Consider the following during the screening and assessment process :

- * AOD use can cause psychiatric symptoms and mimic psychiatric syndromes.
- * AOD use can initiate or exacerbate a psychiatric disorder.
- * AOD use can mask psychiatric symptoms and syndromes.
- * AOD withdrawal can cause psychiatric symptoms and mimic psychiatric syndromes.
- * Psychiatric and AOD use disorders can independently coexist.
- * Psychiatric behaviors can mimic AOD use problems.

Clients with psychiatric disorders have an increased risk for AOD disorders, and those with AOD disorders have an increased risk for psychiatric disorders. Compared with clients who have either a psychiatric or AOD use problem, clients with co-occurring disorders may have more severe and chronic medical, social, and emotional problems. These clients are vulnerable to both AOD relapse and a worsening of the psychiatric disorder. They often require longer treatment, have more crises, and may not progress through treatment as quickly as others.

Philosophical & Clinical Approach Issues

A client with a co-occurring disorder will benefit from a treatment plan that is coordinated among services that include AOD, mental health, social, and medical

programs. However, these systems may have philosophical and clinical differences. Historical differences between the Addictions and Mental Health Systems respectively include:

- * Peer counselor vs medical/professional model
- * Spiritual recovery vs scientific treatment
- * Self-help vs medication
- * Confrontation/expectation vs individualized support/flexibility
- * Empowerment vs case management
- * Episodic treatment vs continuity of responsibility
- * Recovery ideology vs deinstitutionalization ideology
- * Psychopathology is secondary to the addiction vs addiction is secondary to the psychopathology

Treatment Models: Sequential, Parallel, & Integrated

As the addictions and mental health systems have each become more aware of the need to provide appropriate services to clients with co-occurring disorders several treatment approaches have emerged.

Sequential Treatment

Sequential Treatment is historically the most common model of treating co-occurring disorders. In this model the client is treated by one system first and then by the other system. There is a serial or non-simultaneous participation between both systems. This approach has often left the patient “ping-ponging” between two systems, with the addiction professionals referring the patient to the mental health agency and the mental health professionals referring the

patient to the addiction treatment agency. In such a situation the patient typically does not receive adequate care.

Parallel Treatment

In the Parallel Treatment model the client is involved with both the addiction and mental health systems simultaneously. The mental health treatment is provided in a mental health setting while the addiction portion of treatment is provided in its setting. The coordination of services for the client can be variable and can lead to key issues not being addressed in either setting.

Integrated Treatment

The Integrated Treatment model is an approach that combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for clients with co-occurring disorders. This is the model currently accepted as having the most potential benefit to the patient.

Integrated treatment programs developed in recent years share a common philosophy and core components. The essential components of an integrated treatment program include:

- ❖ Clinicians who are cross-trained in the treatment of co-occurring disorders; they become certified in both mental health and addiction counseling. Continuity in treatment is important to avoid sending mixed messages to the client.
- ❖ Motivational enhancement techniques to facilitate engagement of client and to encourage progress.
- ❖ Behavioral interventions to address training in social skills, symptom management and behavior change.
- ❖ Case management to coordinate

clinical, housing, and social issues.

- ❖ Treatment that is appropriate and sensitive to culture, ethnicity and gender.
- ❖ Long-term care that is available to the client across stages of treatment, relapse, and recovery. Clients are not discharged but managed over time, much the same way a person with a chronic physical illness would be treated in a medical setting.
- ❖ Interventions that match the patient’s stage of recovery: engagement, persuasion, active treatment, relapse, and recovery.
- ❖ Psychoeducation and group interventions to provide support, address behaviors, and to share coping strategies.
- ❖ Self-help groups that provide encouragement for recovery.
- ❖ Inclusion of client’s social network and family when appropriate to facilitate client’s progress and support resistance to relapse.
- ❖ Treatment based on rehabilitation and recovery concepts and medical interventions.
- ❖ Maintenance of a therapeutic alliance to assist client engagement, consistency in treatment, and a positive outcome.
- ❖ A sense of optimism among staff for client improvement.

CSAT

Center for Substance
Abuse Treatment
SAMHSA

Produced under a grant funded by the
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services
Center for Substance Abuse Treatment
5600 Fishers Lane
Rockwall II, Suite 621
Rockville, Maryland 20857
301.443.5052

Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.
Grant No. 1 UD1 T113424-01

❖ A recognition that although a small percentage of clients will require high levels of intensive treatment, many others will respond to integrated services.

Stages of Treatment & Recovery

A client's progress through treatment and recovery can vary significantly based on individual differences. Progress rarely occurs in an orderly, stepwise fashion. The services needed to facilitate your client's progress at each stage may differ in intensity and content. Both illnesses should be considered primary and it is critical that there be continuity in the delivery of care. Four treatment stages associated with co-occurring disorders have been developed by Osher and Kofoed (1989). They include:

1. Acute Stabilization

Treatment can vary in intensity based on the severity of the psychiatric and substance abuse issues. Treatment may be provided in a variety of contexts: inpatient hospitalization, detoxification program, or crisis unit that is capable of managing both substance use and mental disorders. In each case the appropriate psychotropic medication should be available to address psychiatric symptoms.

2. Engagement/Persuasion

Motivational Interviewing techniques are associated with the Engagement/Persuasion stage. The objective is to prepare the client for treatment. The principles of motivational interviewing are beneficial because they facilitate greater engagement and increased treatment compliance. Other approaches that are more confrontational can be counterproductive for clients with a mental illness. Moti-

vatational interviewing techniques focus on tailoring an intervention to the client's readiness for change. The goal here is to establish or re-establish a therapeutic alliance with the patient. Attending to the patient's concerns and understanding their level of motivation is essential to engaging the person and increasing their willingness to participate in treatment.

3. Active treatment/Relapse prevention

Integrated care blends the most successful practices from both mental health and substance abuse treatment strategies. Listed below are treatment components that may be used depending on the nature of the client's mental illness and substance use:

Substance-related

- ❖ Individual, group and family interventions
- ❖ Behavioral contracting
- ❖ Cognitive/behavioral relapse prevention
- ❖ Social skills training
- ❖ Day treatment
- ❖ Residential support
- ❖ Support group (AA, NA, etc.)
- ❖ Ongoing comprehensive assessment of substance use and mental health issues

Mental Illness-related

- ❖ Pharmacologic treatment of specific disorder
- ❖ Individual, group, or family therapy
- ❖ Outpatient treatment
- ❖ Case management
- ❖ Diagnosis-specific group activities
- ❖ Ongoing comprehensive assessment of substance use and mental health issues

Specialized considerations for integrated treatment

- ❖ Interventions must be specific and

concrete due to dual impairment

- ❖ 12-step activities may require additional preparation due to medication use
- ❖ Treatment progress is likely to be slow and patients should have access to treatment indefinitely to help them manage what can be chronic and recurring symptoms.

4. Recovery/Rehabilitation

The core concepts of recovery and rehabilitation focus on:

- ❖ Continued maintenance
- ❖ Individual/group strategies to enhance empowerment and choice
- ❖ Emphasis on individual strengths
- ❖ 12-step work and psychotherapy
- ❖ Supported housing models and sober houses
- ❖ Peer advocacy and counseling
- ❖ Self-help programs based on dual recovery concepts

Integrated treatment for co-occurring mental and substance use disorders is a relatively new form of care. It requires specialized programming and staff training. In the next two issues of the Addiction Messenger we will be examining the issues of how you can best prepare yourself and your agency to work effectively with this important population of patients.

Source:

Center for Substance Abuse Treatment (1994)
Assessment and Treatment of Patients With Coexisting Mental Health and Alcohol and Other Drug Abuse
 Treatment Improvement Protocol (TIP) Series, Volume 9

Free to download at:
www.samhsa.gov

Next Issue:

“Co-Occurring Disorders: Treatment Issues”

2 Continuing Education hours for \$25

Earn 2 Continuing Education Hours - NAADAC Approved by reading the Addiction Messenger (AM)

If you wish to receive continuing education hours for reading the AM just fill out the registration form below, complete the pre-test on the reverse side of this page, and return both to NFATTC with a fee **payment of \$25** (make checks payable to: NFATTC, please). We will send you a free copy of the main source of material information. You must then read the three monthly issues of the Addiction Messenger and the reference material for the series. The last issue in the series will have a post-test in it. You will need to complete the post-test (*along with a 100 word short essay question regarding your reaction to the material*) and return it to the NFATTC. You will receive, by return mail, a certificate stating that you have completed 2 Continuing Education hours. Four continuing education series are offered each year. Completing a series will earn you 2 CE hours (or a total of 8 if you do all four series in 2002). You may complete as many series as you wish.

Series 1 includes Vol. 4, Issues 1-3	“Evidence-Based Treatment Approaches”
Series 2 includes Vol. 4, Issues 4-6	“What Works for Offenders?”
Series 3 includes Vol. 4, Issues 7-9	“Manual-Based Group Skills”
Series 4 includes Vol. 4, Issues 10-12	“Preparing Clients for Change”, “What Is A Woman Sensitive Program?” and “Naltrexone Facts”
Series 5 includes Vol. 5, Issues 1-3	“Methamphetamine: Myths & Facts”

Registration Form for Series 6 - “Co-Occurring Disorders”

Name _____

Address _____

City/State/Zip _____

Phone _____

What is your highest degree status? (check one)

No high school diploma or equivalent Associate’s degree Master’s degree
 High school diploma or equivalent Bachelor’s degree Doctoral degree/equivalent
 Some college, but no degree Other (specify) _____

What is your discipline or profession? (check all that apply)

Addictions Counseling Other Counseling Education
 Vocational Rehabilitation Criminal Justice Psychology
 Social Work/Human Services Physician Assistant Medicine: Primary Care
 Medicine: Psychiatry Medicine: Other Nurse
 Nurse Practitioner Administration None, unemployed
 None, student Other (please specify) _____

Please indicate your primary work setting. (check one)

Criminal justice Educational institution Inpatient facility Outpatient
 Outreach Private practice Residential facility Student
 Other (please specify) _____

Return your pre-test by mail or FAX at (503) 373-7348

Northwest Frontier ATTC
3414 Cherry Ave. NE, Suite 100, Salem, OR 97303

Pre-Test

Series 6

Circle the correct answer for each question

#1

Clients with psychiatric disorders:

- a. seldom have AOD disorders
- b. are at an increased risk for AOD disorders
- c. progress quickly through AOD treatment
- d. "a" and "c"
- e. All of the above

#2

Clients with co-occurring disorders should never be given psychotropic medications.

True False

#3

Which of the following statements are true?

- a. Psychiatric behaviors can mimic AOD use problems.
- b. Psychiatric and AOD use disorders can independently coexist.
- c. AOD use can exacerbate a psychiatric disorder.
- d. AOD use can mask psychiatric symptoms and syndromes.
- e. All of the above

#4

A client with a co-occurring disorder can benefit from a treatment plan that:

- a. is coordinated among AOD, mental health, social and medical programs.
- b. focuses only on AOD treatment
- c. provides mental health and AOD services separately.
- d. focuses primarily on the severity of the mental health disorder.
- e. All of the above

#5

The Integrated Treatment model is an approach that:

- a. is a unified and comprehensive treatment program
- b. refers clients to AOD treatment and then to mental health system.
- c. combines elements of both AOD and mental health treatment.
- d. "a" and "b"
- e. "a" and "c"

#6

Psychiatric disorders have a very narrow range of severity

True False

#7

Which of the following statements are true?

- a. All clients with co-occurring disorders require the same level of care
- b. The client's level of mental health and substance abuse servery can vary independently on a continuum of low to high for each illness.
- c. All clients with co-occurring disorders should be treated in in-patient settings.
- d. "a" and "b"
- e. "a" and "c"

#8

Among clients with AOD use problems and a mood disorder:

- a. many are users of heroin and methadone rather than other drugs
- b. a significant proportion has major depression
- c. Mood disorder symptoms that accompany withdrawal are often the result of the withdrawal.
- d. "a" and "b"
- e. All of the above

#9

The stages of treatment for co-occurring disorders include:

- a. acute stabilization
- b. engagement and persuasion
- c. active treatment and relapse prevention
- d. recovery and rehabilitation
- e. All of the above

#10

The most common psychiatric diagnoses among clients with AOD disorder are mood and anxiety disorders.

True False

*Mail or FAX your completed test to NFATTC
You can still register for continuing education hours for
Series 1, 2, 3, 4 or 5
Contact Mary Anne Bryan at (503) 373-1322 ext. 224*

**Northwest Frontier ATTC
3414 Cherry Ave. NE, Suite 100, Salem, OR 97303
FAX: (503) 373-7348**



FUNDED BY CENTER FOR SUBSTANCE ABUSE TREATMENT

ADDICTION Messengers

Ideas for Treatment Improvement

MAY 2002 • VOLUME 5, ISSUE 5

PLEASE COPY OR POST

Northwest Frontier
Addiction Technology
Transfer Center

3414 Cherry Ave NE, Suite 100
Salem OR 97303
Phone: (503) 373-1322
FAX: (503) 373-7348

*A project of
Oregon Health &
Science University*

Steve Gallon, Ph.D.,
Project Director

Mary Anne Bryan, Editor
maryanne.bryan@state.or.us

Be sure to check out
our web page at:
<http://www.open.org/nfatc>

*Unifying research,
education and
practice to
transform lives*

“Co-Occurring Disorders: Treatment Issues”

*“Do not let what you cannot
do interfere with
what you can do”*

John Wooden (1910 -)

This issue of the Addiction Messenger will continue the focus on co-occurring disorders by providing you with information on treatment issues. You may have questions about your clients who have a co-occurring disorder and the recommended treatment approaches. This second issue in the series will address these questions.

Persons diagnosed with co-occurring disorders present unique challenges for treatment programs. Having an optimistic attitude can foster a hopeful and empowering clinical relationship with your client to promote recovery.

Attitudes

- * Compassion and empathy for the client’s life, and the loss and disability associated with co-occurring disorders
- * Belief that your client deserves respect and dignity, especially when non-compliant or decompensated.
- * Desire to understand and accept your client’s point of view, values, attitudes, and cultural differences.
- * Provide consistent optimism that the client can improve, learn and grow.
- * Accept that you cannot protect your client from the consequences of their own choices.
- * Belief that family and friends of the client are valuable collaborators.
- * Patience with slow pace of progress and

recognizing that small gains are important.

- * Provide patience and comfort without discouragement, anger, or judgement.
- * Belief that treatment of both the addictive and mental health issues have equal significance.
- * Belief that addictive and mental health disorders are chronic and relapsing disorders in which relapses can be viewed as opportunities for learning.
- * Accept that remission and recovery is only attained through the sustained motivation of your client.
- * Comfort with maintaining the treatment relationship when your client isn’t following recommendations.
- * Belief that your client and their family deserve to feel proud of themselves for their daily courage and determination in surviving co-occurring disorders.

Mental disorders most associated with co-occurrence include: anxiety, mood, psychotic, dissociative, eating, impulse-control, personality, and disorders first diagnosed in infancy, childhood, or adolescence. The following sections will focus on mood, anxiety, personality and psychotic disorders and their respective definitions, treatment and connection with substance abuse.

Mood Disorders

Types of Mood Disorders

Major Depressive Episode is defined as a depression in mood and loss of pleasure or indifference to most activities for at least two weeks.

Dysthymia is defined as a chronic mood disturbance with mild to moderate depression for a duration of two years.

Manic Episode is defined as a persistently elevated, euphoric, irritable or expansive mood for at least one week.

Hypomanic Episode is defined as an elevated mood that resembles but is less severe than a manic episode.

Bipolar Disorder is defined as cycles of both manic and major depressive episodes.

Cyclothymia is defined as a mild form of bipolar disorder with more frequent and chronic mood variability.

Treatments

There are several treatments for depression and mood disorders. They include medications, psychotherapy, and other complementary treatments. Antidepressants are used to treat symptoms of depression. More severe cases may require both medication and psychotherapy. Medications may prevent relapses into depression. Psychotherapy helps clients deal with social, relationship, or work problems and to change patterns of thinking and behavior. Cognitive-behavioral therapy has been effective in treating depression. Other complementary treatments include activities that naturally lift depression in mild cases. Activities include cardiovascular exercise, strength training, and relaxation activities such as yoga. The long-term goals of treatment can include consolidating the AOD-free lifestyle, psychiatric stability, social independence and stability, and enhancing career choices and goals. It can be viewed as a maintenance period with personal growth and development.

Connection with SA

Using alcohol or drugs can cause a person to become depressed. Withdrawal from alcohol or cocaine can cause depression. It is important that your client be abstinent for at least a month to determine if the depression will lift by itself. Another concern is that when a client becomes depressed they may be more likely to have negative thoughts and relapse.

Anxiety Disorders

Types of Anxiety Disorders

Panic Attack is defined as an intense period of fear usually reaching a crescendo within a few minutes.

Panic Disorder consists of episodes of panic attacks followed by a persistent fear of the reoccurrence of another panic attack.

Phobia is defined as a dreaded, feared and avoided person, activity, object or situation.

Social Phobia consists of a persistent irrational fear of embarrassment or humiliation in a social situation.

Agoraphobia is defined as a fear of situations from which an escape would be impossible, difficult or embarrassing.

Generalized Anxiety Disorder consists of excessive anxiety, worry, and apprehension focused on many life circumstances.

Obsessive-Compulsive Disorder involves obsessions or compulsive rituals or both.

Post-Traumatic Stress Disorder involves experiencing a psychologically traumatic stressor such as witnessing a death, being threatened with death or injury, or sexual abuse.

Treatments

Psychotherapy in a group setting is effective in treating anxiety disorders. The gains made from therapy are often long term. Cognitive and behavioral techniques are often as effective as medication. Anti-anxiety medications are effective in reducing symptoms, although one category of medications, benzodiazepines, can have life-threatening side effects when combined with alcohol or other medications. There is a potential for people using benzodiazepines to become addicted to them. Alternative treatments to treating anxiety include exercise, strength training, yoga, meditation and participating in relaxing hobbies. Long-term goals include the avoidance of foods that contain stimulants (caffeine, sugar, etc.), attention to the resolution of

pre-existing trauma issues, and participation in 12-step group meetings.

Connection with SA

Substance use can affect the level of anxiety people experience. Some drugs such as cocaine can worsen anxiety while other drugs reduce anxiety levels. The use or withdrawal from drugs can produce anxiety. Marijuana might reduce anxiety to the point a person loses motivation. Anxiety can be a risk factor in developing an addiction. A person with anxiety may turn to substance use, instead of professional help, in an attempt to reduce anxiety levels and help them “cope”. This could lead to an addiction. Drugs and alcohol don’t treat anxiety but rather they cover up anxiety symptoms.

Personality Disorders

Types of Personality Disorders

Antisocial Personality Disorder involves chronic patterns of irresponsible and antisocial behaviors that appear before age 15.

Borderline Personality Disorder is characterized by unstable mood and self-image, and unstable, intense, interpersonal relationships.

Narcissistic Personality Disorder involves a pervasive pattern of grandiosity, lack of empathy, and hypersensitivity to evaluation by others.

CSAT

Center for Substance Abuse Treatment
SAMHSA

Produced under a grant funded by the
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services
Center for Substance Abuse Treatment
5600 Fishers Lane
Rockwall II, Suite 621
Rockville, Maryland 20857
301.443.5052

Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.
Grant No. 1 UD1 T113424-01

Passive-Aggressive Personality Disorder involves covertly hostile but dependent relationships.

Avoidant Personality Disorders includes social discomfort, hypersensitivity to both criticism and rejection.

Histrionic Personality Disorder is characterized by excessive emotionality and attention seeking behaviors.

Paranoid Personality Disorder involves interpreting the actions of others as threatening or demeaning.

Dependent Personality Disorder includes patterns of dependent and submissive behaviors and fear of abandonment.

Self-Defeating Personality Disorder is characterized by patterns of self-defeating behaviors in work and relationships and the feeling of exploitation by others.

Treatments

Progress with clients who have personality disorders can be slow. Expectations of your clients should be realistic. Treatment of people with personality disorders requires attention to particular issues such as: violence to self or others, transference and countertransference, boundaries, treatment resistance, symptoms substitution, and somatic complaints. The borderline personality may benefit from individual counseling with a focus on skills such as assertiveness and boundary setting. Reading ACOA materials and self-help groups have special concerns for this population. Rather than looking for major changes in behaviors, you may want to focus on the small, measurable improvements you notice. Antisocial personalities can benefit from individual counseling with an emphasis on adaptation of thinking and attention to thinking errors. Group counseling can be helpful in exploring these issues. Counselors working with narcissistic personalities may want to engage the client in treatment through working with rather than against their ego inflation. Gains can be made by

positioning yourself as trying to help the client reach his or her goals. Clients with passive-aggressive personalities may try to avoid commitment and responsibility. Structuring interventions so they focus on the clients needs, wants, and desires can promote compliance. Encouraging these clients to participate in same-sex group therapy can help them identify with peers and prevents relationships mutually established to avoid recovery.

Connection with SA

Several alcohol and other drug-induced states may present as a personality disorder. If a personality disorder does coexist with AOD use, only the personality disorder will remain during abstinence. Substance use may trigger or worsen personality disorders. Clients with personality disorders may use AOD for purposes related to their personality disorder to diminish the symptoms, enhance self-esteem and decrease feelings of guilt.

Psychotic Disorders

Types of Psychotic Disorders

Schizophrenia is a group of disorders including thought disorders, hallucinations, bizarre behavior, delusions, and deterioration of functioning.

Schizophreniform Disorder includes the same symptoms but is marked by a sudden onset with resolution in two weeks to six months.

Schizoaffective Disorder includes many of the same symptoms but accompanied by manic or depressive symptoms.

Delusional Disorders include well-organized delusions with an absence of hallucination and abnormal affect.

Brief Reactive Psychosis involves psychotic symptoms after overwhelming stress usually lasting less than one month.

Induced Psychotic Disorder describes the uncritical acceptance by the client of another person's delusional beliefs.

Treatments

The most important initial step in treatment is to identify high-risk conditions that may require immediate treatment. A long-term approach to this population is vital. Abstinence and control over psychiatric symptoms can be a process that takes years. Intensive short-term treatment often fails with this group. Treatment programs based on a multidisciplinary team approach that uses gentle or indirect confrontation techniques are ideal. Group treatment should be modified and coordinated with a comprehensive service plan. Special attention should be focused on medications used to treat psychotic disorders.

Connection with SA

Clients with psychotic disorders often start taking drugs to reduce their symptoms. This "self-medication" can lead to addiction. Substance abuse can be a risk factor for the onset of psychotic disorders. Side effects of medications used to treat the psychosis should be a primary concern of treatment and attended to aggressively to avoid a client relapsing in an attempt to diminish the unwanted side effects of their medications.

Source:

Center for Substance Abuse
Treatment (1994)

**Assessment and Treatment of Patients With
Coexisting Mental Health and Alcohol and
Other Drug Abuse**

Treatment Improvement Protocol
(TIP) Series, Volume 9

Free to download at:

www.samhsa.gov

&

Department of Mental Health Law & Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida

**Co-Occurring Disorders Treatment Manual
2002**

Next Issue:

**"Co-Occurring Disorders:
Levels of Care"**

**Northwest Frontier
Addiction Technology
Transfer Center**

3414 Cherry Ave NE, Suite 100
Salem OR 97303
Phone: (503) 373-1322
FAX: (503) 373-7348

*A project of
Oregon Health &
Science University*

**Steve Gallon, Ph.D.,
Project Director**

Mary Anne Bryan, Editor
bryanm@ohsu.edu

Be sure to check out
our web page at:
<http://www.open.org/nfatc>

*Unifying research,
education and
practice to
transform lives*

“Co-Occurring Disorders: Levels of Care”

*“Many of life’s failures are
people who did not realize how
close they were to success when
they gave up”*

Thomas A. Edison (1847-1931)

This issue of the Addiction Messenger continues the focus on co-occurring disorders with an emphasis on levels of care. You may have questions about levels of severity for co-occurring disorders and the recommended treatment settings and approaches. This third issue in the series will address these questions.

No single treatment approach can meet the needs of all individuals and there is no one type of co-occurring disorders program. Appropriate client treatment interventions depend on several considerations at the particular time. The most effective treatment course can be determined through considering the client’s:

- * diagnosis and history,
- * level of acuity, severity, and disability of each disease,
- * motivation for treatment for each disease,
- * phase of recovery, and
- * available treatment resources.

CO-OCCURRING DISORDERS BY SEVERITY

Individuals with co-occurring disorders fall

into one of four categories. These categories are based on the severity of their mental health and substance abuse disorders. Your client may flow from one category to another during their various stages of treatment and recovery.

Category I

*Less severe mental health disorder/
Less severe substance abuse disorder*

Some individuals in this category are not severe enough to bring them to the attention of mental health or substance abuse treatment systems and may be largely ignored. This group often includes children and adolescents. Clients who do participate in treatment are usually in outpatient settings with various combinations of psychiatric symptoms and patterns of substance misuse and abuse. Concerns may present as anxiety, depression, or family conflict.

Category II

*More severe mental health disorder/
Less severe substance abuse disorder*

Clients in this group will have a serious and persistent mental illness which is complicated by substance use and abuse. The individual may not recognize the substance abuse as a problem. Diagnosis and histories may include: schizophrenia, major affective disorders with psychosis, or serious post traumatic stress disorder.

Category III

*Less severe mental disorder/
More severe substance abuse disorder*

This group of clients will present with alcoholism or drug addiction and have

significant psychiatric symptoms and/or disability but they do not have a serious or persistent mental illness. Clients will have both substance-induced psychiatric disorders and substance-exacerbated psychiatric disorders. Psychiatric syndromes found in this category include: anxiety/panic disorder, depression/hypomania, psychosis/confusion, PTSD symptoms, suicidality, violence, symptoms secondary to misuse/abuse of psychotropic medications, and personality disorders.

Category IV

More severe mental health disorder/

More severe substance disorder

This group of clients are often found in inappropriate settings (e.g., jails, homeless), use the most community resources, are difficult to serve, and have the worst outcomes. Clients will have a serious and persistent mental illness along with alcoholism and/or drug addiction. They will need treatment for addiction, for the mental illness, or for both. For instance, this group may include a sober individual who may benefit from psychiatric treatment in a setting which also provides sobriety support and twelve-step programs.

PRIMARY LOCUS OF CARE BY SEVERITY

Individuals with various levels of co-occurring disorders tend to receive their care in the following types of settings. These settings are also based on the severity of their mental health and substance abuse disorders.

Setting I

Individuals receive care in primary health care settings,

Severity of Substance Abuse Problems

III
Less Severe Mental Disorder
More Severe Substance Abuse Disorder

I
Less Severe Mental Disorder
Less Severe Substance Abuse Disorder

IV
More Severe Mental Disorder
More Severe Substance Abuse Disorder

II
More Severe Mental Disorder
Less Severe Substance Abuse Disorder

Severity of Mental Health Problems

school-based clinics, and community programs.

Setting II

Clients most often receive care through the mental health system.

Setting III

Clients usually receive care through the substance abuse system.

Setting IV

Individuals receive care through various systems: state hospitals, jails, prisons, forensic units, emergency rooms, homeless service programs, mental health and/or substance abuse systems.

SERVICE COORDINATION BY SEVERITY

The clients severity of disorders and their care setting can influence the level of coordination needed to ensure appropriate services. Coordination among substance abuse, mental health, and primary health care systems can facilitate treatment planning and address the needs of the client.

Level I

Consultation

The informal relationships between both mental health and substance abuse providers that ensure client problems are addressed with regard to identification, engagement, prevention and early intervention.

An example would be a phone call requesting information or advice regarding a particular issue.

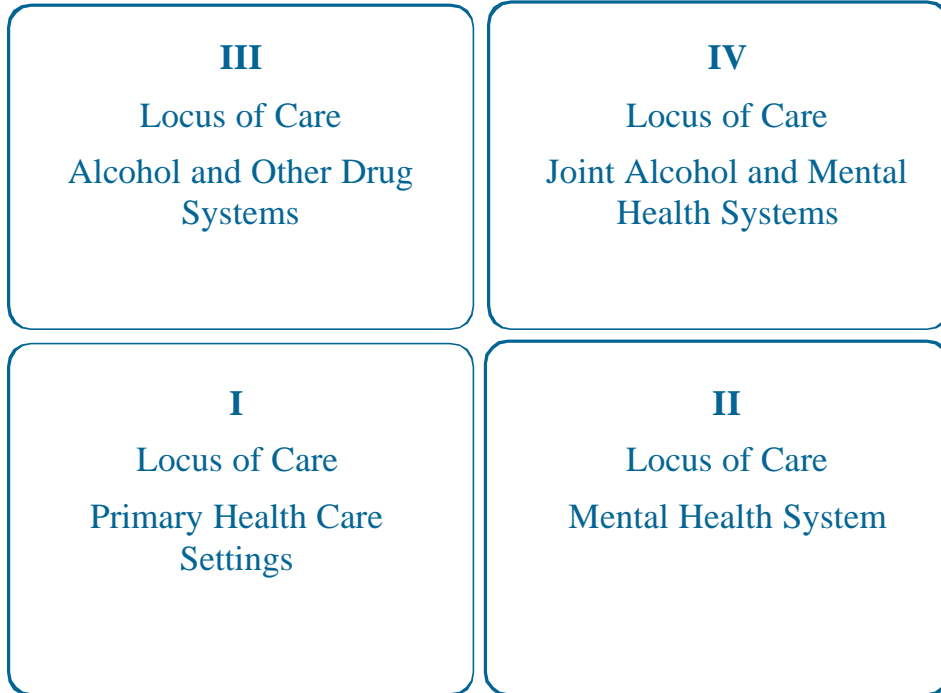
CSAT

Center for Substance Abuse Treatment
SAMHSA

Produced under a grant funded by the Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services
Center for Substance Abuse Treatment
5600 Fishers Lane
Rockwall II, Suite 621
Rockville, Maryland 20857
301.443.5052

Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.
Grant No. 1 UD1 T113424-01

Servery of Substance Abuse Problems



Servery of Mental Health Problems

The main high-risk situations for *mental illness relapse* are:

- * Stopping medications or changing how they are taken without consulting their doctor. Often people stop their medications due to unpleasant side effects.
- * Missing mental health appointments with counselors, doctors, or group therapy. The appointments can be valuable for getting help to keep mental illness symptoms away.
- * Drinking or using drugs can easily destabilize your client’s mental health.
- * Other situations that may contribute to a high-risk situation include: stressful life situations, relationship problems, and experiencing grief or loss due to a death, loss of job, or a health problem.

The best way to prevent a relapse is to avoid high-risk situations along with learning how to cope with the situation if it is unavoidable.

Levels II and III Collaboration

The formal relationships among both mental health and substance abuse providers that ensure both mental health and substance abuse problems are included in the treatment regimen. An example would include interagency staffing conferences for the purpose of designing a treatment program and contributing to service delivery.

Level IV Integrated Services

The relationships among mental health and substance abuse providers in which the contributions of the professionals in both fields are merged into a single treatment setting and treatment regimen.

RELAPSE PREVENTION

Having a mental illness puts a person at a higher risk for an addiction and having an addiction puts a person at a higher risk for worsening mental illness symptoms. Research has shown that untreated mental illness may cause

a relapse into substance abuse, and untreated substance abuse is the main cause of relapse into mental illness. Maintaining recovery and preventing relapse means attending to both of your client’s addictive and mental disorders.

When developing a relapse prevention plan with your client it will be helpful to identify high-risk situations.

The main high-risk situations for relapse *into substance abuse* are:

- * Feeling down, sad, angry, scared, bored, stressed, embarrassed, or guilty, or when having mental illness symptoms such as depression or anxiety.
- * Social pressure when around others that are using. Pressure can be both indirect or direct.
- * Fights, arguments, and after being criticized by someone else.
- * Other situations include: positive emotions, urges/cravings, testing personal control, and feeling bad physically.

Source:

Center for Substance Abuse Treatment (1994)
Assessment and Treatment of Patients With Coexisting Mental Health and Alcohol and Other Drug Abuse
 Treatment Improvement Protocol (TIP) Series, Volume 9

Free to download at:
www.samhsa.gov

&
 Department of Mental Health Law & Policy
 Louis de la Parte Florida Mental Health Institute
 University of South Florida
Co-Occurring Disorders Treatment Manual 2002

Next Issue:

“Trauma”

Name: _____

Post-Test

Series 6

Circle the correct answer for each question

- #1
Clients with psychiatric disorders:
a. seldom have AOD disorders
b. are at an increased risk for AOD disorders
c. progress quickly through AOD treatment
d. “a” and “c”
e. All of the above
- #2
Clients with co-occurring disorders should never be given psychotropic medications.
True False
- #3
Which of the following statements are true?
a. Psychiatric behaviors can mimic AOD use problems.
b. Psychiatric and AOD use disorders can independently coexist.
c. AOD use can exacerbate a psychiatric disorder.
d. AOD use can mask psychiatric symptoms and syndromes.
e. All of the above
- #4
A client with a co-occurring disorder can benefit from a treatment plan that:
a. is coordinated among AOD, mental health, social and medical programs.
b. focuses only on AOD treatment
c. provides mental health and AOD services separately.
d. focuses primarily on the severity of the mental health disorder.
e. All of the above
- #5
The Integrated Treatment model is an approach that:
a. is a unified and comprehensive treatment program
b. refers clients to AOD treatment and then to mental health system.
c. combines elements of both AOD and mental health treatment.
d. “a” and “b”
- #6
Psychiatric disorders have a very narrow range of severity
True False
- #7
Which of the following statements are true?
a. All clients with co-occurring disorders require the same level of care
b. The client’s level of mental health and substance abuse severity can vary independently on a continuum of low to high for each illness.
c. All clients with co-occurring disorders should be treated in in-patient settings.
d. “a” and “b”
e. “a” and “c”
- #8
Among clients with AOD use problems and a mood disorder:
a. many are users of heroin and methadone rather than other drugs
b. a significant proportion has major depression
c. Mood disorder symptoms that accompany withdrawal are often the result of the withdrawal.
d. “a” and “b”
e. All of the above
- #9
The stages of treatment for co-occurring disorders include:
a. acute stabilization
b. engagement and persuasion
c. active treatment and relapse prevention
d. recovery and rehabilitation
e. All of the above
- #10
The most common psychiatric diagnoses among clients with AOD disorder are mood and anxiety disorders.

*Mail or FAX your completed test to NFATTC
You can still register for continuing education hours for Series 1, 2, 3, 4 or 5
Contact Mary Anne Bryan at (503) 373-1322 ext. 224*

**Northwest Frontier ATTC
3414 Cherry Ave. NE, Suite 100, Salem, OR 97303
FAX: (503) 373-7348**

