Dual Diagnosis: Understanding Co-Occurring Mental Illness and Substance Use Disorders

DUAL DIAGNOSIS: UNDERSTANDING CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Behavioral health professionals have a responsibility to be aware of the complex relationship between mental illness and substance abuse or dependence, known as dual diagnoses or co-occurring disorders. However, many programs that treat mental health issues are not prepared to treat substance abuse, and substance abuse treatment programs are not equipped to help those suffering with mental illness. Experts recognize the importance of effective medical and psychosocial treatments in supporting those with dual diagnosis, so they may experience lasting results, enabling them to lead healthy and productive lives.

Prepared for Quantum Units Education
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July, 2015

Introduction

Dual diagnosis is a term typically used to refer to individuals who are living with a mental illness and substance abuse issue at the same time, and as a result are suffering from a co-morbidity or co-occurring disorder (COD). According to Psychology Today, "Clients with co-occurring disorders (COD) have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders, and a diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder" (Psychology Today, 2014). Most experts believe the initial condition, whether it's a mental disorder or substance use issue, tends to influence a person's path to the second condition. Additionally, mental illness and substance use interact to make each diagnosis worse and to have serious, adverse effects on many areas of functioning, including work, relationships, health, and safety (Mental Illness Fellowship, 2015).

"For people struggling with co-occurring mental health and substance abuse disorders, physical safety and overall health risks are greater; the impairment of life skills is greater; and the chances for successful treatment are much less-all of which contribute to stigma."

Mental Health Disorders, 2014

Prevalence, Characteristics, and Consequences

Recent scientific studies have suggested that nearly one third of people with all mental illnesses and approximately one-half of people with severe mental illnesses (including bipolar disorder and schizophrenia) also experience substance abuse. Conversely, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness (National Alliance on Mental Illness, 2013). Furthermore, According to SAMHSA's 2012 National Survey on Drug Use and Health (NSDUH), an estimated 43.7 million (18.6%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.7 million adults (8.8%) had a substance use disorder. Of these, 8.4 million people had both a mental disorder and substance use disorder (SAMSHA, 2015). In the book, *Co-Occurring Disorders: Integrated Assessment and Treatment of Substance Use and Mental Disorders*, by Charles Atkins, MD, the scope and magnitude of co-occurring disorders are outlined as follows (Atkins, 2014):

- More than 8 million Americans have COD in any given year.
- Mental illness rates in people seeking substance abuse treatment range from 50% to 75%.
- Substance use disorders are found in 50% of people seeking mental health services.
- People with COD are far more likely to require hospitalization than people with either just a mental disorder or a substance use disorder.
- Across mental health diagnoses, people who have co-occurring use disorders have worse outcomes, including more hospitalizations, lower quality of life, more physical health problems and more psychiatric diagnoses.
- Higher rates of suicidal thinking, suicidal plans, and suicide attempts are seen in people with co-occurring disorders.
- Rates of illicit drug use are higher, for all substances, among people with mental illness.

Behaviors associated with dual diagnosis are often difficult to manage and may create numerous problems for the individual, the family, and society. It is quite common for physical and psychological health to be impacted, as well as personal and professional relationships. Additionally, problems with finances, employment, and education may occur, and consequences may include criminal activity or involvement (Mental Illness Fellowship, 2015). Kenneth Minkoff, M.D., a national leading expert on integrated treatment of individuals with co-occurring mental health and substance use disorders and clinical assistant professor, Department of Psychiatry, Harvard Medical School, reports that these individuals are also more likely to (Nami Beginnings 2010):

- Relapse and be re-hospitalized
- Be labeled as "treatment resistant and non-compliant"
- Engage in self-destructive, suicidal or violent behavior
- Have co-occurring health issues of all kinds (including Hepatitis C and HIV)
- Become homeless
- Get in trouble with the law
- Have difficulty with parenting and child welfare
- Have financial issues
- Most painfully, young adults with co-occurring illnesses are more likely to die, and to die prematurely, from overdoses, accidents, violence and a variety of medical issues.

Theories

Various theories have attempted to explain the relationship between mental illness and substance abuse, and why co-existence of these behaviors is prevalent. Although some practitioners accept the basic premise of such theoretical approaches, others question their accuracy. For example, there is some evidence that individuals use drugs in the same way that a person who does not show any signs of mental illness does, or may do so without exposure to multiple risk factors (Clara Myers, 2014). However, having an understanding of these concepts may provide insight to practitioners in the diagnosis and treatment of co-occurring disorders.

Causality Theory-suggests that certain types of substance abuse may causally lead to mental illness. Furthermore, while a dual diagnosis situation might develop in response to some kind of genetic issue, it might also develop when damage caused by addiction comes into contact with a genetic abnormality that could lead to mental illness (Dual Diagnosis, 2015).

Self-Medication Theory-proposes that people begin using drugs in an attempt to alleviate symptoms from a psychiatric condition they already have or to counter the side effects of anti-psychotic medications. Thus, these substances may not be chosen randomly, but rather with a specific purpose.

Alleviation of Dysphoria Theory-theorizes that individuals with characteristics of dysphoria may use substances excessively to lessen feelings associated with depression, anxiety, loneliness, or boredom. However, theorists are unclear which generally appears first, the symptoms or the substance abuse. For example, a depressed person may turn to alcohol or drugs for relief of the discomfort, or an addict or alcoholic whose substance abuse problem is out of control may develop a depressive disorder because of the changes the chemical produces in the brain (Mailinda Miller, 2013).

Multiple Risk Factor/Environmental Triggers Theory-postulates that there may be shared risk factors that can lead to both substance abuse and mental illness, including poverty, lack of structured daily activity, lack of adult role responsibility, living in areas with high drug availability, and association with people who already misuse drugs (Wikipedia, 2015). Painful life experiences such as sexual abuse or other traumatic events can be directly associated with the development of psychiatric problems or the development of post-traumatic stress disorder (PTSD), and may lead to vulnerability to substance abuse and addiction.

Genetics/Supersensitivity Theory-proposes that genetics and early environmental factors may influence certain vulnerabilities to mental health disorders and substance abuse. Stressful life events may trigger a psychiatric disorder or relapse, and self-medicating increases vulnerability so that the individual may become supersensitive to even a small amount of drugs (Myers, 2014).

Improper Diagnosis Theory-suggests that a dual diagnosis label is used inaccurately to describe two conditions, when the symptoms being displayed may actually be the result of the same disease. For example, according to dualdiagnosis.org, people who have bipolar disorder may experience episodes of mania in which they might also use massive doses of drugs and alcohol, without thinking about the consequences of their actions. While it may be appropriate in some cases to diagnose people like this with a substance abuse disorder, as they're clearly harming themselves with the drugs they take, it is also possible that this behavior is part of the symptoms of bipolar disorder, and that the dual diagnosis label is an unlikely fit (Dual Diagnosis, 2015).

Therapeutic difficulties in the treatment of persons with a dual diagnosis stem, not only from two illnesses coexisting in one person, but also from the problem of combining two totally different methods of treatment for people with multiple issues (Sawicka, Osuchowska, Waniek, Kosznik, and Meder, 2009). Although determining the cause of each disorder or the reasons that both may occur will likely never be completely clear, looking at probable theories may help to reflect on ways to best help such individuals.

"Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client."

SAMSHA, 2014

Screening and Assessment

Although screening and assessment are often clustered together, they are actually distinct processes. Screening generally refers to a course of action to identify the presence, or lack thereof, of a potential problem that may require further attention, while assessments are designed to gather more comprehensive and individualized information (Peters, Bartoi, and Sherman, 2008). According to the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, screening is a formal interviewing and/or testing process that identifies areas of a client's life that might need further examination and evaluates for the possible presence of a problem, but does not diagnose or determine the severity of a disorder. Assessment, on the other hand, is a more in-depth evaluation that confirms the presence of a problem, determines its severity, and specifies treatment options for addressing the problem. It also surveys client strengths and resources for addressing life problems, and

examines not only possible diagnoses, but also the context in which a disorder manifests (SAMSHA, 2013).

Clinicians must be aware of factors that may influence the screening and assessment process such as ethnicity and culture, acculturation and language issues, socioeconomic status, sexual orientation, and cognitive and learning disabilities (SAMSHA, 2009). Additionally, while most screening and assessments include researching the client's history, evaluating the current problem or problems, conducting interviews, using assessment instruments, and gathering extensive data, the process should be continuous and must be specific to the individual's goals. There are several reasons for collecting this information, including: (Futures Palm Beach, 2015; Peters and all, 2008):

- To evaluate the client's cognitive skills, such as information processing, working memory and verbal ability
- To assess the client's personality and self-concept
- To evaluate the client's mood and emotional affect
- To assess the client's level of impulse control and attention span
- To determine how the client interacts with others socially
- To identify of the level of motivation and readiness for treatment
- To detect current mental health and substance use symptoms and behaviors, and assess whether current symptoms or behaviors are influenced by co-occurring disorders
- To identify violent tendencies or severe medical problems that may need immediate attention
- To determine eligibility and likely suitability for specialized integrated treatment services
- To determine the level of service needs related to mental and substance abuse problems
- To examine individual strengths, areas of functional impairment, cultural and linguistic needs, and other environmental supports that are needed

Twelve Steps in the Assessment Process

During assessment, a detailed chronological history of past mental symptoms, diagnosis, treatment, and impairment, along with a thorough description of current strengths, supports, limitations, skill deficits, and cultural barriers must be acquired. Such information will help address steps needed to follow the suggested treatment regimen and to determine the stage of change for each problem. SAMSHA recommends 12 specific steps in the assessment process for co-occurring disorders, which are summarized below (SAMSHA, 2006).

Step One: Engage the Client-In order to facilitate open disclosure of information regarding mental health problems, substance use disorders, and related issues, it is critical to engage the client in an empathic, welcoming manner. Rapport is built in a safe and nonjudgmental environment that includes universal access, empathic detachment, person-centered assessment, cultural sensitivity, and trauma sensitivity. Such engagement allows the professional to understand the client's experience and to keep him or her positive and engaged relative to the prospect of better health and recovery.

Step Two: Identify and Contact Collaterals to Gather Additional Information-Clients may be unable or unwilling to report past or present circumstances accurately, so it is recommended that all assessments include routine procedures for identifying and contacting any family and other collaterals who may have useful information to provide. Knowledge from collaterals, sought with permission from the client, is

valuable as a supplement to the client's own report, and can clarify substance use history, clues to the presence of mental health issues, family histories, and potential barriers to treatment.

Step Three: Screen for and Detect Co-Occurring Disorders-Experts recommend that individuals presenting for substance abuse treatment be screened routinely for co-occurring mental disorders, and that all individuals presenting for treatment for a mental disorder be screened routinely for any substance use disorder. Such screenings should include acute safety risk related to serious intoxication or withdrawal or risk associated with mental illness, past and present substance use, substance-related problems, and substance-related disorders. In addition, past and present mental health symptoms and disorders, cognitive and learning deficits, and past and present victimization and trauma should be assessed.

Step Four: Determine Quadrant and Locus of Responsibility- The quadrants of care were developed to categorize individuals with co-occurring disorders based on the severity of the mental and substance use disorders, rather than based on their specific diagnosis. The quadrants include:

- Quadrant I- Less severe mental disorder/less severe substance disorder
- Quadrant II- More severe mental disorder/less severe substance disorder
- Quadrant III- Less severe mental disorder/more severe substance disorder
- Quadrant IV-More severe mental disorder/more severe substance disorder

Although in general the quadrant system as originally developed is not widely used in clinical practice today, it may still be helpful in matching treatment needs and resources for those with dual diagnosis. Specifically, in order to determine where the individual falls in the quadrant system, in addition to assessing substance use, each state mental health system has developed a set of specific criteria for determining consideration as a mental health priority client.

Step Five: Determine Level of Care-During this step, care requirements for individuals with COD are evaluated, and clients are placed in a particular level on a continuum of services ranging from intensive case management for individuals with serious mental disorders who are not motivated to change, to psychiatric inpatient care for others. Additionally, there is the capacity to distinguish, at each level of care, individuals with lower severity of mental symptoms or impairments who require various levels of service intensity.

Step Six: Determine Diagnosis- Determining the diagnosis can be a formidable clinical challenge in the assessment of COD, but spending the time to gather a comprehensive history is one of the best ways to decrease the likelihood of creating harm through misdiagnosis. Clinicians in various treatment settings recognize that it can be impossible to establish a firm diagnosis when confronted with the mixed presentation of mental symptoms and ongoing substance abuse. Also, they understand that substance abuse contributes to the emergence or severity of mental symptoms and therefore confounds the diagnostic picture. During this step, diagnosis is generally established more by history than by prevailing symptom presentation, and it is important to document prior diagnoses and gather information related to the current diagnoses. Furthermore, it is almost always necessary to tie mental symptoms to specific periods of time in the client’s life, particularly those times when active substance use disorder was not occurring.

Step Seven: Determine Disability and Functional Impairment-In order to identify the need for case management and/or higher levels of support and care requirements, current and baseline functional impairment must be evaluated. Assessment of current cognitive capacity, social skills, and other functional abilities is also necessary to determine if there are deficits that may require modification in treatment protocols or recovery programs. In particular, areas that are gauged include whether the client is capable of living independently, if he or she can engage in reasonable social relationships, and the client's level of intelligence. The clinician should also try to establish both the level of intellectual/cognitive functioning in childhood and whether any impairment persists, and if so, at what level, during the periods when substance use is in full or partial remission.

Step Eight: Identify Strengths and Supports- Assessing strengths, healthy attributes, skills, and supports is an important step in providing realistic information. It also provides a positive approach to treatment engagement and an ability to gain knowledge that may be used to help clients when they are struggling through the treatment process. Talents and interests, areas of educational interest and literacy, and areas connected with high levels of motivation to change are addressed. Existing supportive relationships, previous mental health services and addiction treatment successes, current achievements, ways to build treatment plans and interventions based on utilizing and reinforcing strengths, and extending or supporting what has worked previously are also evaluated.

Step Nine: Identify Cultural and Linguistic Needs and Supports-Cultural assessment of individuals with COD is not substantially different from cultural assessment for individuals with substance abuse or mental disorders only. As will all behavioral health professionals, culturally competent clinicians who are assessing those with dual diagnosis need to have the self-awareness, knowledge, skills, and framework to make sound, ethical, and culturally appropriate decisions relating to ethnicity, race, language, gender, faith, identification with certain groups, and so on. Additionally, there are some specific issues that are worth addressing with substance abuse and mental disorders, such as not fitting into the treatment culture, conflict in treatment, cultural and linguistic service barriers, and problems with literacy.

Step Ten: Identify Problem Domains-Individuals with COD may have difficulties in multiple life domains such as medical, legal, vocational, family, or social, but research has indicated that providing assistance in each problem area helps to promote better outcomes. Having an awareness of the client's struggles provides insight into his or her frame of reference and gives the practitioner clues into how these conflicts may impact treatment compliance and the achievement of personal goals. A comprehensive evaluation for individuals with COD requires clarifying how each disorder interacts with the problems in each domain, as well as identifying contingencies that might promote adherence for mental health and/or substance abuse treatment. Information about others who might assist in the implementation of such contingencies also needs to be gathered.

Step Eleven: Determine Stage of Change-A key evidence-based best practice for treatment matching of individuals with COD in both substance abuse treatment and mental health services settings is that for each disorder or problem, interventions have to be matched not only to specific diagnosis, but also to stage of change, and the interventions also should be consistent with the stage of treatment for each disorder. In substance abuse treatment settings, stage of change assessment usually involves determination of precontemplation, contemplation, preparation (or determination), action, maintenance, and relapse. In mental health settings working with individuals with serious mental

illness, stages to be evaluated include pre-engagement, engagement, early persuasion, late persuasion, early active treatment, late active treatment, relapse prevention, and remission. Stage of change assessment ideally will be applied separately to each mental disorder and to each substance use disorder, and motivation and readiness will need to continuously be evaluated throughout the stages of recovery.

Stage Twelve: Plan Treatment-The ultimate purpose of the assessment process is to develop an appropriately individualized integrated treatment plan. Collecting data and information is not enough; it must be organized into a plan that promotes program placements and treatment interventions that match individually to the needs of each client. Treatment planning for individuals with COD and associated problems should be designed according to the principle of mental disorder dual primary treatment, where each disorder or problem has a specific intervention that is matched to a problem or diagnosis, as well as to a stage of change and external contingencies. Additionally, integrated treatment planning involves helping the client to make the best possible treatment choices for each disorder and ensuring consistent adherence to that dual regimen. Only then can goals and objectives that are specific to the individual's needs be addressed.

"Integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders, and effective treatment for individuals with co-occurring mental and substance use disorders requires sharing information across systems and across agencies."

SAMSHA, 2014

Treatment

In order to effectively treat individuals with dual diagnosis, behavioral health professionals need to address the complicated issues that arise from both the substance abuse problem and the mental health disorder. The goal of treatment must be to end the dependence on the substance and to restore the ability to function appropriately in society (Miller, 2013). For many years, experts have realized that to most effectively treat comorbid disorders, services must be integrated so that professionals modify traditional interventions and work together to provide services in a coordinated fashion. Positive outcomes will more likely be achieved if both diagnoses are addressed, if the individual is actively involved in decision-making, setting goals, and developing a plan, if it includes basic education about substance use and mental health disorders and related problems, and if healthy coping skills and strategies are taught (Saisan, Smith, and Segal, 2015). Various treatment formats to engage the client in the therapeutic process are recommended, using a combination of individual, family, and group therapy. Depending on the client needs and program expertise, treatment may also may include the following (American Addiction Centers, 2015):

Recovery-Oriented Challenge Therapy

Centered on activity in which a clinical professional can actively engage with clients to help them identify strengths and skills, build social support, and address basic recovery issues, these groups assist with the development of self-care, boundaries, accountability, and trust. Examples include: group challenges, outdoor activities, ropes courses, equine therapy, games or other skill-building healing activities.

Expressive Therapies in Recovery

This form of group therapy provides clients opportunities to express their creativity and process how their expressions relate to recovery, by participating in activities such as music and art therapy.

Trauma Therapies

Since many clients with dual diagnosis have trauma histories, treatment programs may offer interventions to address these issues, including Eye Movement Desensitization and Reprocessing (EMDR), Seeking Safety Sessions, Dialectical Behavioral Therapy (DBT), and others.

Medical and Psychiatric Sessions

Research by the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute of Drug Abuse (NIDA) and National Institute of Mental Health (NIMH) shows that comprehensive, integrated care significantly increases long-term recovery and quality of life success rates, so medical and psychiatric assessments and follow-ups should be offered throughout treatment.

Psycho-educational and Didactic Groups

Evidence-based groups may be used in dual diagnosis treatment to cover topics such as substance conditions, the physiological effects of substances, co-occurring conditions, medication, cross addictions and relapse prevention, CBT and breathing retraining, cognitive restructuring, social pressures and unhealthy behaviors, and incorporating culture in recovery. In addition, family roles, boundaries strategies, nutrition and wellness, and life skills education may be incorporated.

12-Step Work

12-Step meetings may be participated in several times per week depending on client needs, preferences and level of care. These meetings help strengthen peer support and promote the continued practice of working a recovery program.

In the article, *Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-Occurring Disorders,* Dr. Minkoff and Dr. Christie A. Cline describe evidence-based principles of service delivery for co-occurring disorders. The following assumptions provide a framework for developing clinical practice guidelines for treatment matching and can also be utilized to design a welcoming, accessible, integrated, continuous, and comprehensive system of care, initially within the context of existing resources (Minkoff and Cline, 2004):

1. Co-occurring issues and conditions are an expectation, not an exception. This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency. It must also be incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues.
2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship. Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition.

3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for various populations. Assignment of responsibility for provision of such relationships can be determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the psychiatric and substance disorder.
4. When co-occurring issues and conditions co-exist, each issue or condition is considered to be primary. The best practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time.
5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue. Mental illness and substance dependence (as well as other conditions, such as medical disorders, trauma, and homelessness) are examples of chronic, biopsychosocial conditions that can be understood using a disease and recovery (or condition and recovery) model. Each condition has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.
6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue. For each co-occurring condition or issue, treatment involves getting an accurate set of recommendations for that issue, and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. To promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward is much more effective than negative consequences in promoting learning.
7. Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual diagnosis program or intervention for everyone. For each individual or family, integrated treatment interventions and outcomes must be individualized according to their hopeful goals, their specific diagnoses, conditions, or issues, and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition.
8. All policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring capable. Each program has a different job, and programs partner to help each other to be successful with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships, in which each co-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based community-based learning for each condition, in order to help the individual or family make progress toward achieving their recovery goals.

Furthermore, Minkoff describes the parallels between addiction and major mental illness that include biology, heredity, chronicity, incurability, lack of control of behaviors and emotions, positive and negative symptoms, disease progression without treatment and symptom control with treatment, feelings of guilt and failure, and more (Minkoff, 2006). Over time, experts have recognized these similarities and have realized that sequential treatment in which each issue is addressed separately is less effective than integrated treatment services. Specifically, the Integrated Dual Disorder Treatment

(IDDT) model has been developed to improve the quality of life for people with co-occurring severe mental illness and substance use disorders by helping address both disorders at the same time, in the same service organization, by the same team of treatment providers (NAMI, 2012). See Appendix A for a detailed explanation of the parallel processes of recovery that incorporate the phases of stabilization, engagement/motivational enhancement, prolonged stabilization, and recovery and rehabilitation.

Treatment Modalities Most Commonly Used for Dual Diagnosis

Multidisciplinary treatment may encompass pharmacological, educational, psychological, and social interventions. Medication that has been safely tested in multiple studies to treat substance abuse includes disulfiram (*Antabuse*), acamprosate (*Campral*) and naltrexone (*Revia*) for people with alcoholism. For those with opiate abuse, available medications include naltrexone (*Revia*, *Vivitrol*), methadone and buprenorphine. (NAMI, 2013). Antipsychotics, antidepressants, anti-anxiety medications and mood stabilizers may be used to help manage symptoms of mental illness and to promote recovery. The use of these and all medications should be managed and closely monitored by health care professionals (Dual Diagnosis.org, 2015).

Research-based treatment approaches that are most commonly used in integrated treatment for co-occurring disorders include (American Addiction Centers, 2015):

Motivational Interviewing (MI)

Motivational Interviewing is a collaborative, therapeutic conversation between licensed clinicians and clients that addresses the common problem of ambivalence for change. As defined by William Miller, the creator of MI, its purpose is to strengthen the client's own motivation for and commitment to change in a manner that is consistent with said client's values. Therefore, rather than imposing or forcing particular changes, we "meet the client where the client is" and help her/him move toward his/her goals by drawing out and building his/her readiness to change.

Cognitive Behavioral Therapy (CBT)

Those who suffer from addiction are often driven by destructive thought patterns, and CBT encourages clients to question and examine recurring thoughts in order to phase out those that are negative and unhealthy. Scientific studies have shown that CBT is an effective form of treatment for addiction, mental health conditions, and eating disorders.

Rational Emotive Behavior Therapy (REBT)

Similar to CBT, Rational Emotive Behavior Therapy (REBT) helps clients identify, challenge, and replace their destructive thoughts and convictions with healthier, adaptive thoughts. Empirical studies demonstrate that this process incites emotional well-being and goal achievement.

Dialectical Behavioral Therapy (DBT)

DBT teaches clients how to regulate their emotions to reduce the self-destructive behaviors that derive from extreme, intense feelings and concerns. An effective treatment for substance conditions, eating disorders, anger-related issues, self-injury, and Borderline Personality Disorder, DBT is easily customizable to address a variety of needs. Primarily a skill-building approach, DBT focuses on the development of distress tolerance, emotion regulation, mindfulness, and interpersonal effectiveness.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR helps clients recover from traumatic experiences by utilizing "dual stimulation" exercises to discuss past trauma while simultaneously engaging other parts of the brain through bilateral eye movements, tones, or taps. EMDR helps heal the brain's information processing system and promotes emotional stability and symptom reduction. EMDR's benefits are so empirically effective that it has been approved by the American Psychological Association as a treatment for post-traumatic stress disorder (PTSD) and other trauma conditions, as well as by California's Mental Research Institute, who has found EMDR to be "an important addition to the treatment of substance abuse."

Seeking Safety (And Other Trauma Focused Therapies)

Seeking Safety is a present-focused therapy that helps clients attain safety from trauma (including PTSD) and substance abuse by emphasizing coping skills, grounding techniques and education. The key principles of this highly effective, research-based therapy are helping clients attain safety in their thinking, emotions, behaviors and relationships, integrated treatment of substance conditions and trauma, and focusing on goals to counteract the loss of ideals that is experienced in both trauma and substance abuse.

Locations and Levels of Care for Dual Diagnosis

In behavioral health settings, The Dimensional Rating System is an assessment that determines the level of severity of a client's needs, by looking at the six evaluation parameters of risk of harm, functional status, medical, addictive and psychiatric co-morbidity, recovery environment, treatment and recovery history, and engagement (Sowers and Benacci, 2000). This assists in determining which level of care will be most appropriate based on these factors as well as service availability, financial and personal resources and support, and personal preference. Clients may enter treatment at a particular level of care depending on immediate circumstances, but their status may change and they move to more or less intensive treatment as needed.

The Level of Care Utilization System (LOCUS) was created by the American Association of Community Psychiatrists in order to provide a way to evaluate relevant information and placement decisions that maintained balance between effective care and the appropriate use of services. LOCUS describes the levels of resource intensity using four variables that describe services, intensity, and program characteristics including the care environment, clinical services, supportive services, and crisis resolution and preventative services (DHS/DMH LOCUS Project, 2008). The Levels of Care in LOCUS are unique and distinct from how levels of care are often defined, and are outlined below (Sowers, 2000).

Basic Services-Basic services are those supports that should be available to all members of a community, designed to prevent illness or limit morbidity. They often have a special focus on children, and are provided primarily in community settings but also in primary care environments. There is clinical capability for emergency care, evaluations, brief interventions, and outreach to various portions of the population. This would include outreach to special populations, victim debriefing, high-risk screening, educational programs, mutual support networks, and day care programs. There are a variety of services available to provide support, address crisis situations and offer prevention assistance.

Recovery Maintenance and Health Management-Level One, "Recovery Maintenance and Health Management," is a low-intensity level of care. The clients who participate in this level can live

independently in the community, and are usually stepping down from a more intensive treatment level. This level does not require frequent contact with professionals and it is not an entry point into a system. It is for those who have been in treatment and are now ready for assistance in maintaining health and recovery. These services have minimal requirements, so the care environment can be in a variety of settings. The basic clinical services will be available, and support programs for community living should also be available. Vocational training, rehabilitation, transportation and/or mutual support programs are services that may also be accessible to clients at this level of care.

Low Intensity Community Based Services-Level Two, "Low Intensity Community Based Services," is more intensive than Level 1, and includes clinical services that may be provided on a periodic basis, up to once a week. This can be an entry level for clients presenting with minor disturbances. There is no control over access in this setting, and a full menu of supportive services should be available. Not all clients that are assigned to this level of care are going to use all of the services that are available. However, they will have access to them as needed. Rehabilitation, housing support, and living assistance can all be offered at this level of care.

High Intensity Community Based Services-Level Three, "High Intensity Community Based Services," is the next step. This level is for the client that needs more intensive attention, structure, and contact, usually several days per week, for several hours per day. The requirements for the care environment are not significantly more complex than other outpatient services. However, there will be a greater capacity to provide clinical services, and greater availability of clinicians. Case management is something that is used more extensively at this level of care. Mobile service capability, day care, and rehabilitation services are often part of the treatment plan at this level as well.

Medically Monitored Non-Residential Services-Level Four, "Medically Monitored Non-Residential Services," is for those who need a great deal of structure, support and monitoring, but not so much that they require an onsite living situation for their treatment. Services at this level of care would be similar to traditional day hospital services, or assertive community treatment. It will have 24-hour availability of clinical support. Clients in this level are followed closely. Daily contact with treatment providers, services such as intensive case management, and rehabilitation programs are also available. Involvement will vary to some degree depending on the specific circumstances and needs of the client.

Medically Monitored Residential Services-Level Five, "Medically Monitored Residential Services," is a residential-based service. There is a great deal of structure provided in this setting, and the capability for 24-hour monitoring. There is no capacity for secure care, nor is there the ability to place someone in seclusion or restraints. At this level some chronic custodial care may be provided for those who have little hope of returning to a higher level of functioning. In some cases, it may be similar to a nursing facility; in other cases it may be a subacute or stepdown service. These facilities generally have 24-hour availability of medical personnel, and are capable of providing fairly intensive monitoring. An important aspect of this level of care would be a liaison with community care providers and case management.

Medically Managed Residential Services-Level Six, "Medically Managed Residential Services," is secure care that has traditionally been provided in a hospital setting, although it does not need to be in a hospital. This is a level of care generally used for the most acute and disturbed persons with mental illness. It provides a secure setting with the availability of seclusion and restraints, where admission and treatment can be voluntary or involuntary, and contact between clients and visitors can be restricted.

The clinical attention is generally intense, and medication will be managed and dispensed. A liaison with community care givers is an important component of this treatment modality. Stabilization is the main goal, along with efforts to move clients to less restrictive services as quickly as possible.

Even after level of care needs have been determined, individual paths to recovery will differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit personal needs. For many people, the most effective approach often involves a combination of counseling and medication. Such assistance may now be more accessible as a result of the Affordable Care Act requirement that many health plans cover essential benefits including mental health and substance abuse treatments. Supportive services, such as case or care management, can also play an important role in promoting health and recovery, and effective treatment and support may be provided in a variety of locations, including (SAMSHA, 2014):

- Specialty community behavioral health centers
- Substance use disorder rehabilitation programs
- Independent providers
- Hospitals
- Community health centers
- Mutual support groups and peer-run organizations
- Community-based organizations
- Schools
- Jails and prisons
- At home through tele-behavioral or home-based services
- Inpatient service providers
- Primary care programs with integrated behavioral health services
- A variety of other community settings

Whatever the treatment approach for dual diagnosis, it is imperative that individuals and providers recognize that recovery is a long-term process, since people with severe mental illness and substance abuse do not usually develop stability and functional improvements quickly. Their needs and presentations often change throughout the treatment process, as well as their priorities and goals. Since clients tend to improve over months and years in conjunction with a consistent dual diagnosis program, effective programs must take a long-term, community-based perspective that includes rehabilitation activities to prevent relapses and to enhance gains (Integrated Treatment, SAMSHA, 2009). Additionally, continued recovery calls for learning how to manage stress, recognizing triggers and having an action plan, and staying connected with support systems. Finally, although intervention for people with dual diagnosis is generally more complex than treatment for either issue alone, when such individuals adhere to their treatment plan, they can maintain recovery and lead a healthy and productive life.

Those who suffer from mental health issues like depression or anxiety experience frightening or disturbing symptoms almost every day, such as intrusive thoughts, hopelessness, a lack of motivation or a fear of public situations, that can interfere with basic functions like working or socializing. To quell these negative feelings, many turn to drugs or alcohol."

Dual Diagnosis, 2015

Most Common Dual Diagnoses

Individuals who do not receive adequate treatment for mental illness are more likely to have difficulty with social functioning and are more apt to be unemployed, unstable, homeless, or involved in the criminal justice system. Drugs, alcohol and addictive behaviors like gambling or unsafe sex are often used as dysfunctional coping mechanisms to help individuals live with the painful symptoms of mental illness such as mood disorders, anxiety disorders, schizophrenia and personality disorders (Dual Diagnosis.org, 2015). According to the article, "5 Most Common Disorders with Addictions," the most common mental health/addiction combinations in play today are alcoholism and anti-social personality disorder, marijuana addiction and schizophrenia, cocaine addiction and anxiety disorders, opioid addiction and PTSD, and heroin addiction and depression. Additionally, individuals with the following mental health disorders seem to experience particular vulnerability to substance use:

Depression

Most experts agree that at least 20 percent of those afflicted with serious depression also abuse alcohol or drugs, and approximately the same number of individuals with a substance use disorder also have an anxiety or mood disorder. When it comes to substance abuse and depression, it isn't always clear which one came first, although depression may help predict first-time alcohol dependence, according to a study published in 2013 in the Journal of Clinical Psychology (Thompson, 2015). Both substance abuse and depression may be impacted by genetics, early developmental problems, and environmental risk factors, and may be influenced by chemical changes in the brain. Additionally, depression with co-occurring substance use disorders is associated with more severe depression, multiple co-occurring mental disorders, and more suicide attempts (Atkins, 2014).

Anxiety Disorders

The self-medication theory of co-occurring disorders may be particularly relevant for anxiety disorders. Research has shown that most anxiety disorders, except for Posttraumatic stress disorder **(**PTSD), likely developed years before the substance use disorder. When individuals face social anxiety, panic disorder, generalized anxiety, or other related issues, they may use alcohol or other substances to provide short-term relief that enables them to function in uncomfortable situations. However, in the long run, people may become dependent on the substance and the perpetual cycle of dependency creates increased anxiety, growing shame, and a decrease in individuals' ability to rely on their own inner devices to cope with and manage anxiety (D'Aconti, 2013). Those who are suffering with PTSD can be particularly vulnerable to substance abuse as a way to manage anxiety, intrusive thoughts, and sleep disturbance, although as with other disorders, substance abuse can exacerbate such symptoms. PTSD sufferers who have been in treatment for substance use disorders may be susceptible to relapse as way to cope with reoccurring problems.

Bipolar Disorder

In addition to higher rates of relationship problems, economic instability, accidental injuries and suicide than the general population, people with bipolar disorder are significantly more likely to abuse alcohol or drugs. Between 50-60 percent of those who have symptoms of all-consuming and uncontrollable episodes of sadness, elation, anger or despair may turn to drugs or alcohol out of an unconscious need to stabilize their moods, or as a way to maintain or increase the effects of mania (Dual Diagnosis.org,

2015). As with other co-occurring disorders, treatment and relapse prevention strategies must address both conditions, including assessing strengths, identifying support systems, determining barriers to treatment, and developing coping skills to manage symptoms and substance abuse triggers.

Schizophrenia

Substance use disorders may impact as many as 70 percent of individuals with schizophrenia, and substance use with this population is associated with increased rates of hospitalization, violence, incarceration, homelessness, HIV and hepatitis infections, and poor adherence to treatment (Atkins, 2014). Some people experience a worsening of their schizophrenic symptoms when they are taking such drugs as amphetamines, cocaine, PCP or marijuana. The most common form of substance use disorder in people with schizophrenia is nicotine dependence due to smoking. Although people with schizophrenia may smoke to self-medicate their symptoms, smoking has been found to interfere with the response to antipsychotic drugs, and several studies have found that schizophrenia patients who smoke need higher doses of antipsychotic medication (Psych Central, 2015).

Personality Disorders

According to the National Drug Strategy (NDS), people with comorbid personality disorder and substance use have more problematic symptoms of substance use than those without a personality disorder, are more likely to participate in risky substance-injecting practices that predispose them to blood borne viruses, are more likely to engage in risky sexual practices and other disinhibited behaviors, and may have greater difficulty staying in treatment programs and complying with treatment plans. This is especially true with borderline and antisocial personality disorders, where multiple comorbidity is common. Dialectical behavior therapy is viewed as one of the most effective approaches to helping people with personality disorders lead productive, drug-free lives. While helping to identify connections between the personality disorder and the substance use, DBT teaches the individual how to accept intensely stressful or painful emotions, offers effective coping strategies to deal with these overwhelming feelings, teaches the individual how to live in the moment instead of obsessing over the past or future, and helps the patient be self-accepting of who he or she is while encouraging positive lifestyle changes (Futures of Palm Beach, 2015).

Family Support for Dual Diagnosis

Families, friends, and others can be most helpful in providing empathic and non-judgmental support to their loved one and can be critically important since many people with dual diagnosis will relapse into alcohol and drug abuse at some point in their lives (NAMI, 2013). Numerous studies have shown that outcomes improve when families and significant others are involved through individual therapy, family therapy, family psychoeducation, and self-help groups for family therapy. The Depression and Bipolar Support Alliance offers the following advice (DBSA, 2015):

- Educate yourself about mood disorders and alcohol/drug dependence.
- Don’t blame yourself. Keep in mind that your loved one has two treatable medical illnesses. You didn’t cause either one, and you can’t cure either one.
- Don’t take responsibility for making your loved one well. Encourage him or her to get professional medical help for both illnesses.

- Approach the person to talk about getting help when you are calm, and when s/he seems relatively sober/clean and calm. Don't threaten to call the police or put the person in the hospital unless you mean it and are prepared to follow through.
- Don't make it easier for your loved one to continue self-destructive behavior. Don't loan money if you know it will be used to buy drugs or alcohol. Don't lie to others to cover up your loved one's drinking or drug use.
- Don't preach or lecture. Talk to the person about specific things that have happened because of his or her substance abuse and untreated mood disorder that are visible and obvious. For example, s/he may have health, work, family or money problems.
- Don't use guilt to motivate the person to get help.
- Realize that your loved one's illnesses can affect his or her thoughts and views. Know that with good treatment, hopeless and self-defeating thoughts and attitudes can be overcome.
- Do your best to give support and be patient throughout the recovery process. Don't expect the person to recover immediately.
- Allow your loved one to spend the time s/he needs with support groups and treatment as s/he recovers.
- Get support for yourself, whether or not your loved one gets help. Join a support group for friends and family. Seek professional help if you need it.
- Never give up hope.

In some cases, violence and intimidation may be a feature of behaviors of people with dual diagnosis and families must manage their safety first. Additionally, episodes of dual diagnosis often involve trauma and grief and have an impact on the whole family. The best thing that loved ones can do is stay healthy themselves, make sure not to underestimate the impact of the illness on them, and seek support as needed (MIFV, 2013).

Conclusion

The relationship between mental illness and substance abuse or dependence is complex, and these conditions often overlap to exacerbate the course of each illness. Those suffering from dual diagnosis frequently abuse substances as a way to help cope with symptoms, but drugs and alcohol may worsen underlying mental illnesses during acute intoxication and during substance withdrawal (NAMI, 2013). Since about half of the individuals with mental illness also have a substance abuse problem, and more than half of those with a substance use disorder also have a diagnosable mental illness, it is imperative that clinicians have the skills to assess, diagnose, and treat these clients, or refer them to other services when appropriate.

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APPENDIX A

Barriers to Integrated Treatment, Parallels of Addiction and Major Mental Illness, and Parallel Processes of Recovery

Adapted from: ***Dual Diagnosis: An Integrated Model for the Treatment of People with Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems***
by Kenneth Minfoff, M.D

Source: The Mental Health Illness Project, Dual Diagnosis, 2006,
http://www.miepvideos.org/discussionpdfs/DualDiagnosis.pdf

Philosophical & Clinical

BARRIERS TO INTEGRATED TREATMENT

Addiction System		**Mental Health System**
Peer Counseling model	vs.	Medical/Professional model
Spiritual Recovery	vs.	Scientific treatment
Self Help	vs.	Medication
Confrontation and expectation	vs.	Individualized support and flexibility
Detachment/empowerment	vs.	Case management/care
Episodic treatment	vs.	Continuity of Responsibility
Recovery ideology	vs.	Deinstitutionalization ideology
Psychopathology is secondary to addiction	vs.	Substance use is secondary to psychopathology

PARALLELS

Alcoholism/Addiction	**Major Mental Illness**
1. A biological illness	1. A biological illness
2. Hereditary (in part)	2. Hereditary (in part)
3. Chronicity	3. Chronicity
4. Incurability	4. Incurability
5. Leads to lack of control of behavior and emotions	5. Leads to lack of control of behavior and emotions
6. Positive and negative symptoms	6. Positive and negative symptoms
7. Affects the whole family	7. Affects the whole family
8. Progression of the disease without treatment	8. Progression of the disease without treatment
9. Symptoms can be controlled with proper treatment	9. Symptoms can be controllec with proper treatment
10. Disease of denial, relates to both disease & chronicity of disease	10. Disease of denial, relates to both disease & chronicity of disease
11. Facing the disease can lead to depression and despair	11. Facing the disease can lead to depression and despair
12. Disease is often seen as a “moral issue”, due to personal weakness rather than biological causes	12. Disease is often seen as a “moral issue”, due to personal weakness rather than biological causes
13. Feelings of guilt & failure	13. Feelings of guilt & failure
14. Feelings of shame & stigma	14. Feelings of shame & stigma
15. Physical, mental and spiritual disease	15. Physical, mental and spiritual disease

PARALLELS
PROCESS OF RECOVERY

- PHASE 1: **Stabilization**
  - Stabilization of active substance use or acute psychiatric symptoms
- PHASE 2: **Engagement/ Motivational Enhancement**
  - Engagement in treatment
  - Contemplation, Preparation, Persuasion
- PHASE 3: **Prolonged Stabilization**
  - Active treatment, Maintenance, Relapse Prevention
- PHASE 4: **Recovery & Rehabilitation**
  - Continued sobriety and stability
  - One year - ongoing

PROCESS OF RECOVERY
PHASE 1: Stabilization

Detoxification	**Stabilize Acute Psychiatric Illness**
• Usually inpatient, may be involuntary	• Usually inpatient, may be involuntary
• Usually need medication	• Medication
• 3-5 days (alcohol)	• 2 weeks to 6 months
• Includes assessment for other diagnoses	• Includes assessment for effects of substance, and for addiction

PROCESS OF RECOVERY
PHASE 2: Engagement/Motivational Enhancement

Addiction Treatment	**Psychiatric Treatment**
• Engagement in ongoing treatment is crucial for recovery to proceed	• Engagement in ongoing treatment is crucial for recovery to proceed
• Begins with empathy and proceeds through phases of education and empathic confrontation, before patient commits to ongoing active treatment	• Begins with empathy and proceeds through phases of education and empathic confrontation, before patient commits to ongoing active treatment
• Motivational interviewing techniques	• Motivational interviewing techniques
• Education about substance use, abuse, and dependence & empathic confrontation of adverse consequences are tools to overcome denial. Patient accepts powerlessness to control drug without help	• Education about mental illness and the adverse consequences of treatment non-compliance are tools to overcome denial. Patient accepts powerlessness to control symptoms without help
• Education of the family, & involving them in interviews to promote motivation	• Education of the family, & involving them in setting limits on non-compliance
• Engagement may take place in a variety of treatment settings…may need extended inpatient or day treatment rehabilitation (2-12 weeks)	• Engagement may take place in a variety of treatment settings…may need extended inpatient or day treatment rehabilitation (1-6 months)
• Engagement may be initially coerced	• Engagement may be initially coerced
• Multiple cycles of relapse usually occur before engagement in ongoing treatment is successful (revolving door)	• Multiple cycles of relapse usually occur before engagement in ongoing treatment is successful (revolving door)

PROCESS OF RECOVERY

PHASE 3: Prolonged Stabilization

Continued Abstinence

- One-Year
- Patient consistently attends abstinence support programs
- Usually voluntary, but ongoing compliance may be coerced or mandated
- Ongoing education about addiction, recovery and skills to maintain abstinence
- Focus on asking for help to cope with urges to use substances and drop out of treatment
- Must learn to accept the illness and deal with shame, stigma, guilt, and despair
- Must learn to cope with "negative symptoms": social, affective, cognitive, and personality development
- Family needs ongoing involvement in its own program of recovery to learn empathic detachment and how to set caring limits
- May need intensive outpatient treatment and/or 6-12 months residential placement
- Continuing assessment
- Risk of relapse continues

Continued Medication Compliance

- One-Year
- Patient consistently takes medication and attends treatment sessions regularly
- Usually voluntary, but may be coerced or mandated
- Ongoing education about mental illness, recovery and skills to prevent relapse
- Focus on asking for help to cope with continuing symptoms and urges to discontinue treatment
- Must learn to accept the illness and deal with shame , stigma, guilt, and despair
- Must learn to cope with "negative symptoms": impaired cognition, affect, social skills, and lack of motivation/energy
- Family needs ongoing involvement in its own program of recovery to learn empathic detachment and how to set caring limits
- May need extended hospital, day treatment and/or residential placement
- Continuing assessment
- Risk of relapse continues

PROCESS OF RECOVERY

PHASE 4: Recovery & Rehabilitation

Continued Sobriety

- Voluntary, active involvement in treatment
- Stability precedes growth; no growth is possible unless sobriety is fairly secure. Growth occurs slowly (One Day at a Time)
- Continued work in the AA program, on growing, changing, dealing with feelings
- Thinking begins to clear
- New skills for dealing with feelings, situations
- Increasing responsibility for illness, and recovery program brings increasing control of one's life
- Increasing capacity to work and to have relationships
- Recovery is never "complete", always ongoing
- Eventual goal is peace of mind and serenity (Serenity Prayer)

Continued Stability

- Voluntary, active involvement in treatment
- Stability precedes growth; no growth is possible unless stabilization of illness is fairly solid. Growth occurs slowly (One Day at a Time)
- Continued medication, but reduction to lowest level needed for maintenance. Continued work in treatment program
- Thinking begins to clear
- New skills dealing with feelings, situations
- Increasing responsibility for illness, and recovery programs brings increasing control of one's life
- Increasing capacity to work and relate (voc rehab, clubhouse)
- Recovery is never "complete", always ongoing
- Eventual goal is peace of mind and serenity (Serenity Prayer)

APPENDIX B

Glossary of Terms

Source: *Substance Abuse Treatment For Persons With Co-Occurring Disorders, A Treatment Improvement Protocol, TIP 42*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, 2013

Abstinent-Not using substances of abuse at any time

Acute care-Short-term care provided in intensive care units, brief hospital stays, and emergency rooms for those who are severely intoxicated or dangerously ill

Addiction-Physical dependence on a substance of abuse. Inability to cease use of a substance without experiencing withdrawal symptoms. Sometimes used interchangeably with the term substance dependence

Antisocial personality disorder-An illness whose two essential features are: (1) a pervasive disregard for and violation of the rights of others and (2) an inability to form meaningful interpersonal relationships. Deceit and manipulation are important manifestations of antisocial personality disorder

Anxiety disorder-An illness whose essential feature is excessive anxiety and worry. The individual with anxiety disorder finds it difficult to control the worry, and the anxiety and worry are accompanied by additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep, among other signs and symptoms

Assessment-A basic assessment consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, COD diagnosis, disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises. The COD diagnosis is established by referral to a psychiatrist or clinical psychologist. Assessment of the client with COD is an ongoing process that should be repeated over time to capture the changing nature of the client's status

Borderline Personality Disorder-An illness whose essential feature is a persuasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Cognitive–behavioral therapy (CBT)-A therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change—that is, coping by thinking differently and coping by acting differently

Collaboration-In the context of treatment programs, collaboration is distinguished from consultation by the formal quality of the collaborative agreement, such as a memorandum of understanding or a service contract, which documents the roles and responsibilities each party will assume in a continuing relationship

Contingency management (CM)-An approach to treatment that maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. CM assumes that neurobiological and environmental factors influence substance use behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors

Continuing care-Care that supports a client's progress, monitors his or her condition, and can respond to a return to substance use or a return of symptoms of mental disorder. It is both a process of post-treatment monitoring and a form of treatment itself. Sometimes referred to as aftercare

Co-occurring disorders (COD)-Refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have COD have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs

Fully integrated program-A treatment program that actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively

Integrated treatment-Any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting. It recognizes the need for a unified treatment approach to meet the substance abuse, mental health, and related needs of a client, and is the preferred model of treatment

Mood disorders-Include the depressive disorders ("unipolar depression"), the bipolar disorders, and two disorders based on etiology—mood disorder due to a general medical condition and order due to a general medical condition and substance-induced mood disorder

Motivational interviewing (MI)-A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

Mutual self-help-An approach to recovery from substance use disorders that emphasizes personal responsibility, self-management, and clients' helping one another. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-step methods that prescribe a planned regimen of change

Personality disorders-Rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause internal distress or significant impairment in functioning. Personality disorders are enduring and persistent styles of behavior and thought, rather than rare or unusual events in someone's life

Motivational interviewing (MI)-A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

Mutual self-help-An approach to recovery from substance use disorders that emphasizes personal responsibility, self-management, and clients' helping one another. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-step methods that prescribe a planned regimen of change

Posttraumatic stress disorder (PTSD)-An illness whose essential feature is the development of characteristic personal symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury

or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close friend or relative

Quadrants of care-A conceptual framework that classifies settings within which clients with COD are treated. The four quadrants are based on relative symptom severity, rather than by diagnosis

Relapse-A breakdown or setback in a person's attempt to change or modify any particular behavior. An unfolding process in which the resumption of substance abuse is the last event in a series of maladaptive responses to internal or external stressors or stimuli

Schizophrenia-A type of psychosis. Persons diagnosed with schizophrenia are subject to hallucinations occurring in the absence of insight into their pathological nature, as well as disorganized speech and grossly disorganized or catatonic behavior. The disorder lasts for at least 6 months and includes at least 1 month of active-phase symptoms including two or more of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative behavior

Screening-A formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring substance or mental disorder. The screening process for co-occurring disorders seeks to answer a "yes" or "no" question: Does the substance abuse [or mental health] client being screened show signs of a possible mental health [or substance abuse] problem? Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted

Substance abuse-A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Sometimes used interchangeably with the term substance dependence

Substance dependence-A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to avoid withdrawal symptoms, and other serious behavioral effects, occurring at any time in the same 12month period

Substance use disorders-A class of substance-related disorders that includes both substance abuse and substance dependence

Treatment-Substance abuse treatment is an organized array of services and interventions with a primary focus on treating substance abuse disorders. For the Treatment Episode Data Set, the Center for Substance Treatment defines treatment to include the following general categories: hospital, short and long-term residential, and outpatient. Mental health treatment is an organized array of services and interventions with a primary focus on treating mental disorders, whether providing acute stabilization or ongoing treatment. These programs may exist in a variety of settings, such as traditional outpatient mental health centers (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units

Treatment retention-Keeping clients involved in treatment activities and receiving required services.