THE NATIONAL JUDICIAL COLLEGE

Est. 1963

CO-OCCURRING MENTAL AND SUBSTANCE ABUSE DISORDERS

Basics of Co-Occurring Disorders and Treatment

BJA Bureau of Justice Assistance

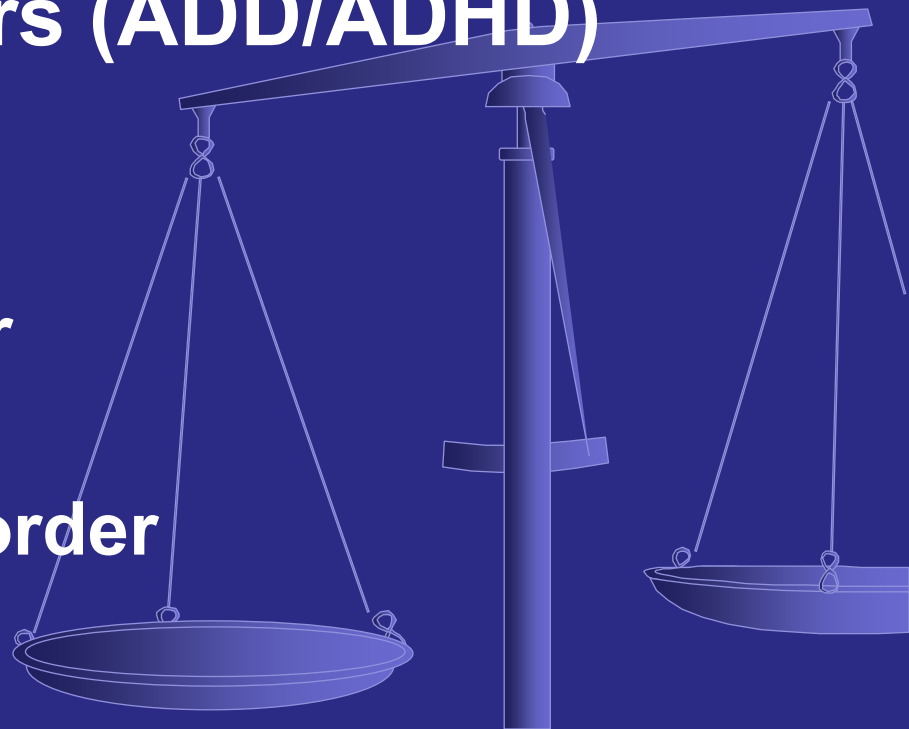
Office of Justice Programs U.S. Department of Justice

Recovery

A process of inner growth that is associated with increased acceptance of illness, increased ability to make healthy choices about treatment, and increased motivation and hope.

Addiction Risk Factors

- Genetics
- Young age of onset
- Childhood trauma (violent, sexual)
- Learning disorders (ADD/ADHD)
- Mental illness
  - Depression
  - Bipolar disorder
  - Psychosis
  - Personality disorder



Three C's of Addiction

Control - impaired

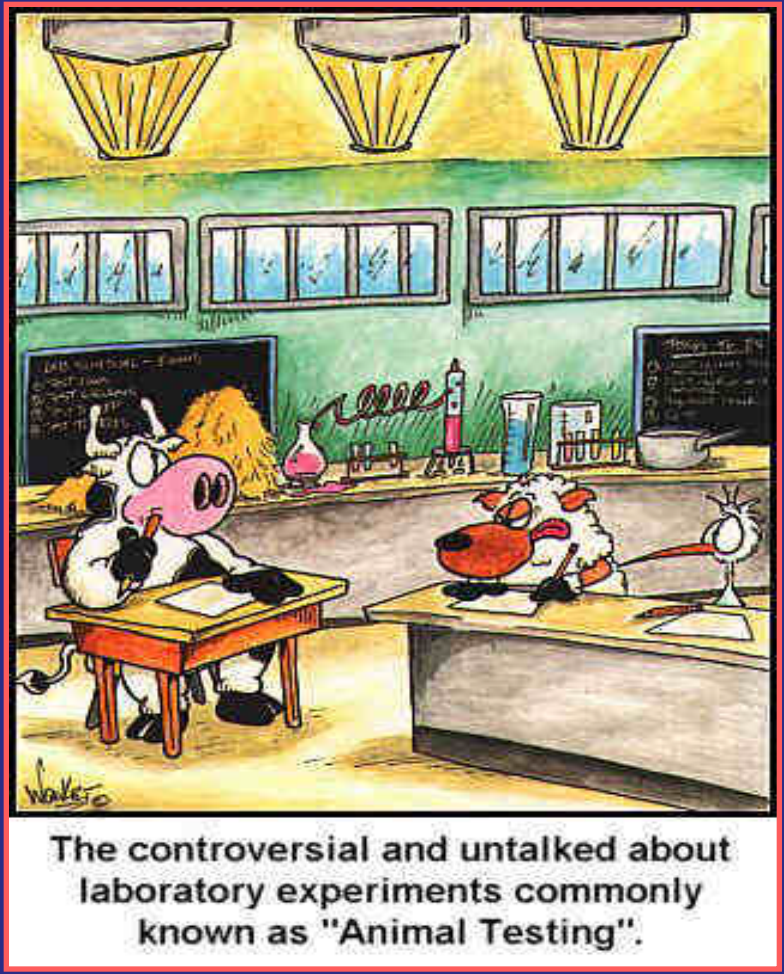
Compulsion to use

Continued use
despite problems

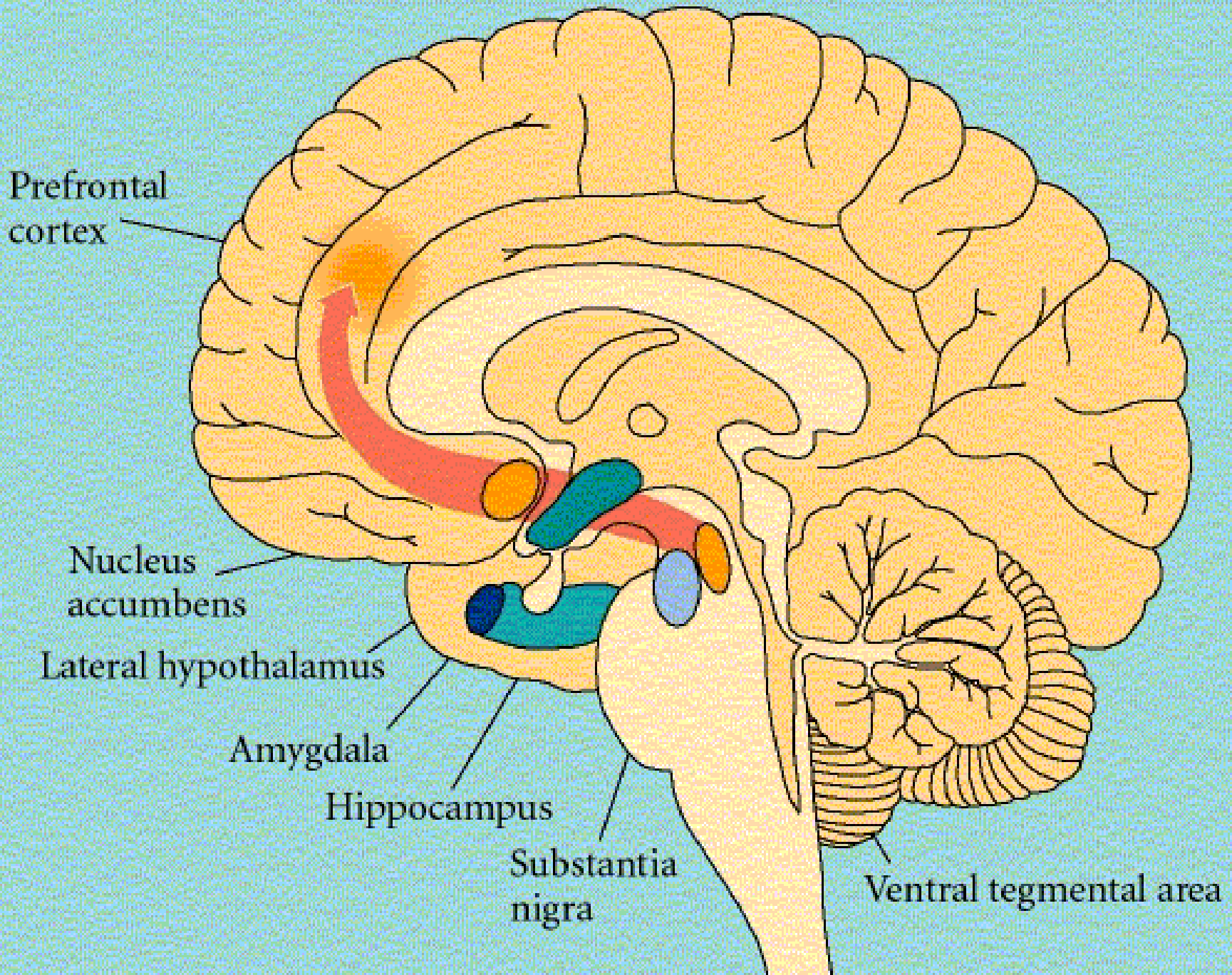
Those with Addictions

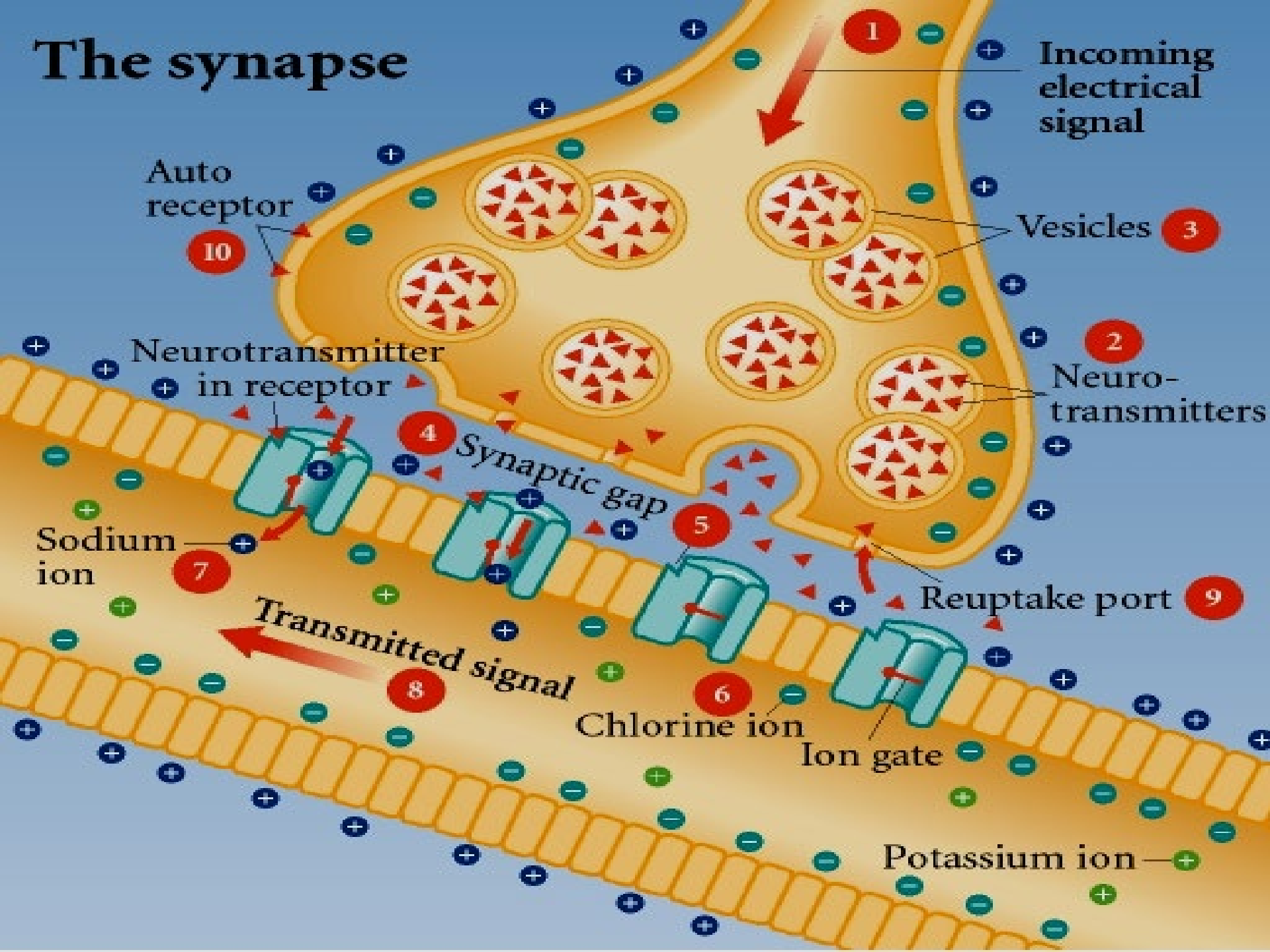
- Practice addiction most of the time
- Continue use despite adverse consequences
- Deny there's a problem
- Have a strong tendency to relapse after withdrawal
- Have lost control
- Have altered brain chemistry & function

Pathophysiology



Animals will ignore need for water, rest, and food if lever press stimulates dopamine system.


Prefrontal cortex
Nucleus accumbens
Lateral hypothalamus
Amygdala
Hippocampus
Substantia nigra
Ventral tegmental area


The synapse
1
Incoming electrical signal
Auto receptor
10
Vesicles
3
2
Neuro-transmitters
Neurotransmitter in receptor
4
Synaptic gap
5
Sodium ion
7
Reuptake port
9
Transmitted signal
8
6
Chlorine ion
Ion gate
Potassium ion

Particular substance issues

- Cannabis today is 10-20 times more potent than 20 years ago
- Methamphetamine: the "rush" and the "wall"
- Prescription drug abuse
- Cocaine and heroin are back

Natural History Alcoholism

1st Drink	12-14 years
1st Intoxication	14-18 years
1st Problem	18-25 years
3+ Problems (Dx)	23-33 years
Enter treatment	40 years
Age of death	55-60 years
Abstinent in any year	24-33%
Controlled drinking	1-5%

Diagnostic and Statistical Manual of Mental Disorders

Fourth Edition, TR (Text Revised) 2000

American Psychiatric Association

Multiaxial Diagnoses

Axis I	**Clinical Disorders**
Axis II	**Personality Disorders & MR**
Axis III	**Medical Conditions**
Axis IV	**Psychosocial Factors**
Axis V	**Global Assessment of Functioning (GAF)**

What Is a "Mental Disorder"?

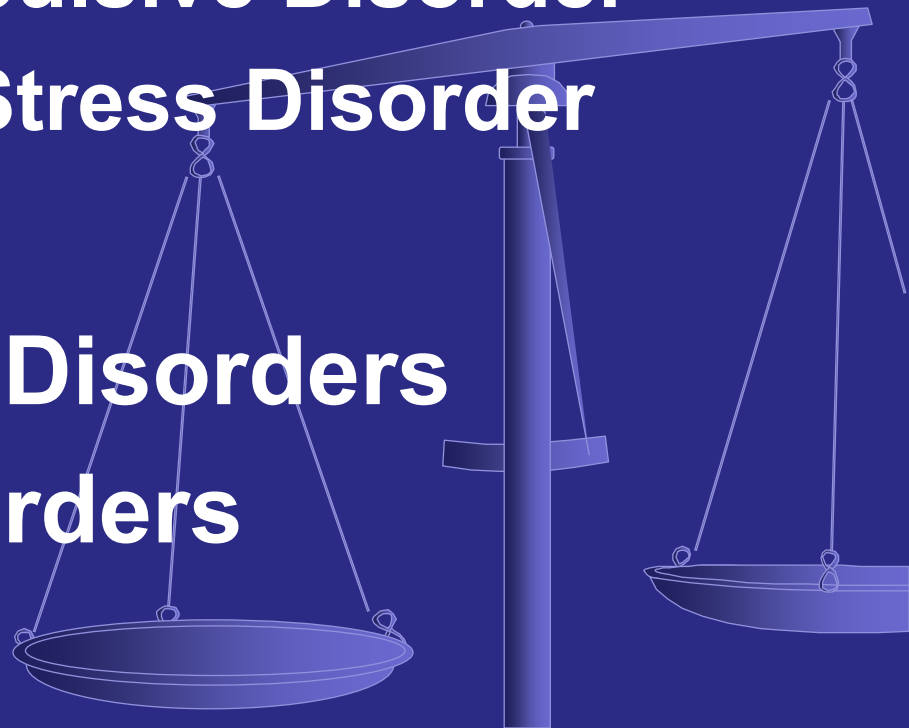
"A clinically significant behavioral or psychological syndrome or pattern associated with present distress or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom…"

Axis I

- Substance-Related Disorders
- Psychotic Disorders
  - Schizophrenia
  - Delusional
- Mood Disorders
  - Major Depression
  - Bipolar: mania/hypomania & depression

Axis I

- Anxiety Disorders
  - Social Phobia
  - Obsessive Compulsive Disorder
  - Post Traumatic Stress Disorder
- Paraphilias
- Impulse-Control Disorders
- Adjustment Disorders



Personality Disorders

- Antisocial
- Borderline
- Histrionic
- Narcissistic
- Paranoid
- Avoidant
- Schizoid

Co-Occurring Disorders

"Only [since 1987] . . . have epidemiological data and various studies begun to demonstrate the high degree of comorbidity between psychiatric and substance related disorders."

Co-Occurring Disorders Patients

- Use greater treatment resources
- Have a more complicated course
  - Higher rates of relapse
  - Higher rates of re-hospitalization
  - More frequent ER visits
  - Violence, suicide, homelessness,
  - Increased morbidity and mortality
- Poorer treatment compliance
- More contact with criminal justice

Co-Occurring Disorders

Each disorder affects the course of the other and the outcome of treatment.

Implications for Co-Occurring Disorders

Both disorders are associated with

- Negative mood states
- Poor object relations
- Poor impulse control

- More rapid progression
- Poor bonding to treatment staff
- Rapid relapse from a slip

Treatment Provider

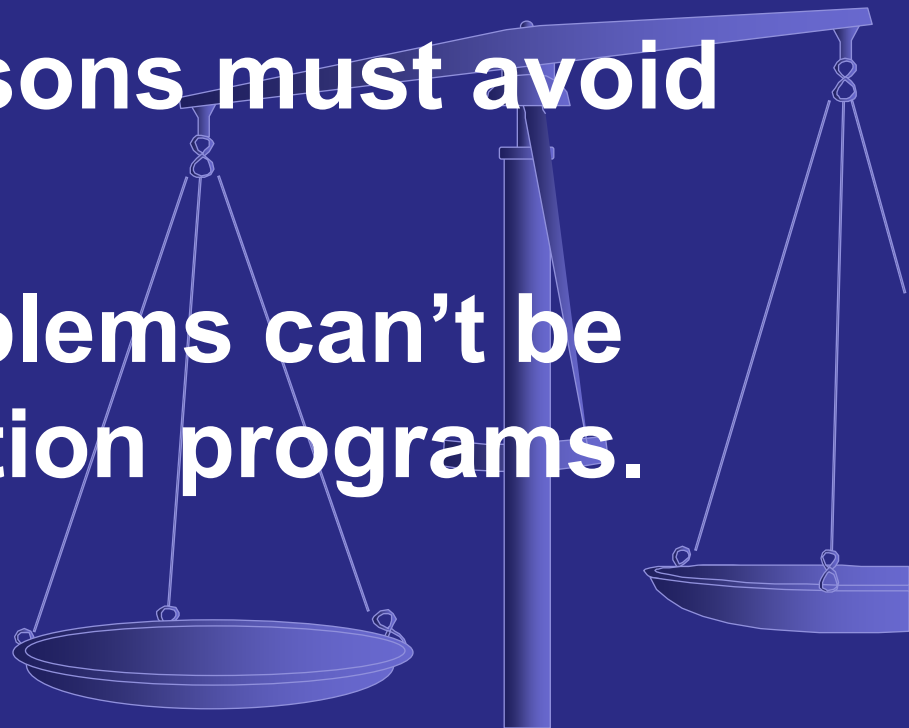
- Psychiatrist (MD)
- Psychologist (PhD)
- Psychiatric Social Worker (LCSW)
- Marriage and Family Therapist (MFT)
- Substance Abuse Counselor (CADAC)

Myths? in Mental Health

- Addiction is secondary to a mental disorder.
- AA/NA are religious and non-scientific.
- Addiction will respond to directives to stop using.

Myths? in Addiction Treatment

- A 12-step program will relieve most mental disorders.
- Recovering persons must avoid all medications.
- Psychiatric problems can't be treated in addiction programs.



Methods of Treatment

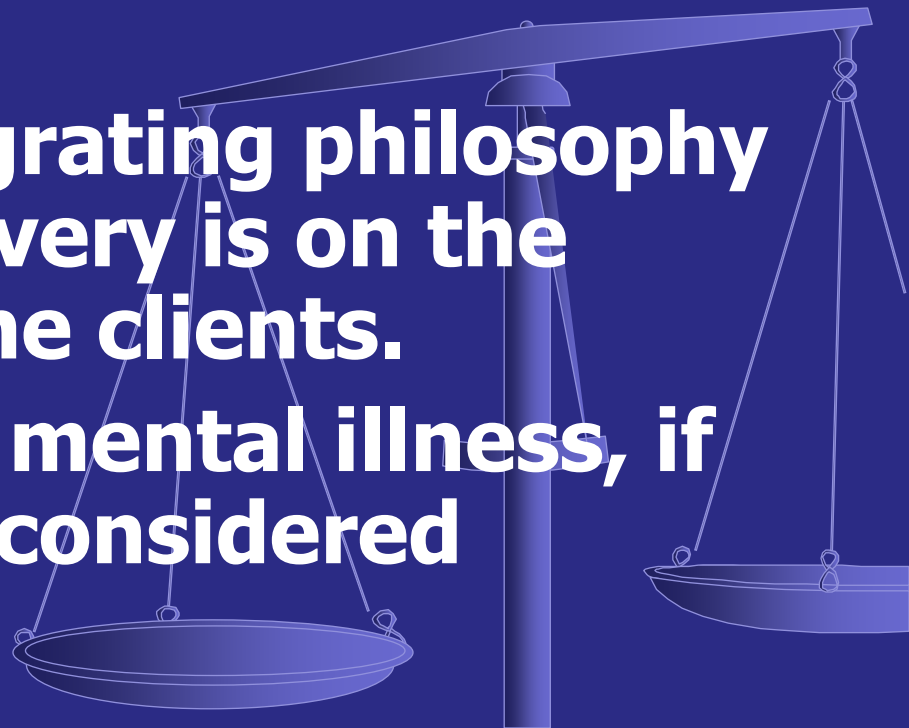
- Serial (consecutive)
- Parallel (concurrent)
- Linked
- Integrated

Remember

- Substance use disorders and mental illnesses are brain based
- Genetic and environmental factors
- Treatment works-but change expectations: think diabetes, not "flu"
- "Traditional" treatment isn't the norm anymore…

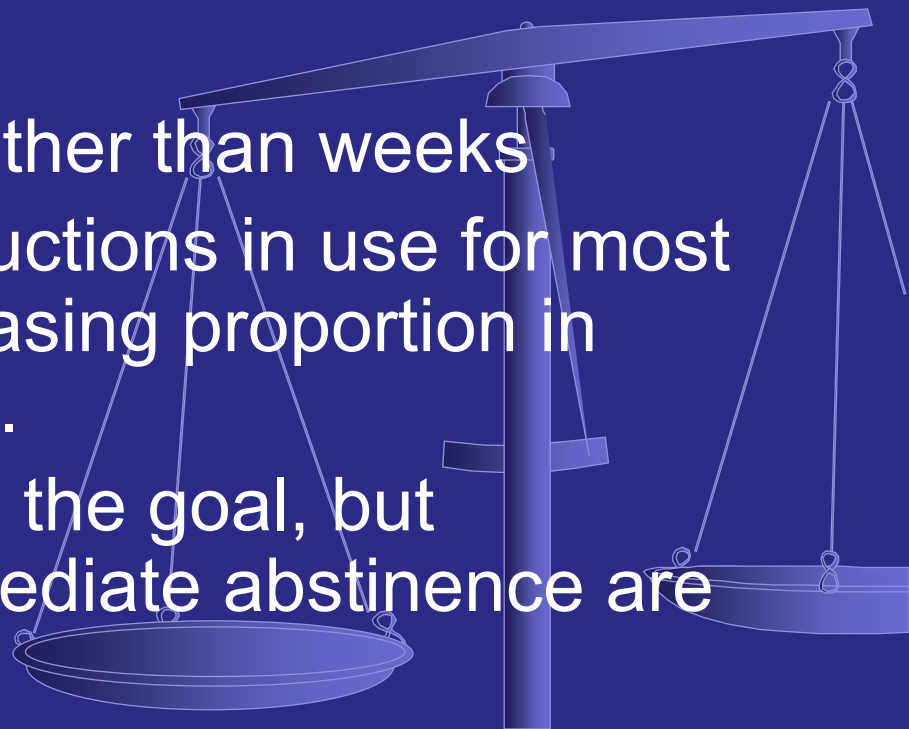
What about treatment?

- Integrated treatment works.
- The treatment team takes responsibility for combining mental health and substance abuse interventions at the level of clinical delivery.
- The burden of integrating philosophy and models of recovery is on the providers, not on the clients.
- Both addiction and mental illness, if present, should be considered primary.



Integrated Treatment

- **Treatment should be parallel, not sequential.**
- **Recovery process in the dually diagnosed:**
  - Stage-wise
  - Occurs over years rather than weeks
  - Involves gradual reductions in use for most clients, with an increasing proportion in abstinence over time.
  - Abstinence is always the goal, but expectations for immediate abstinence are not realistic.



Integrated Treatment, con't.

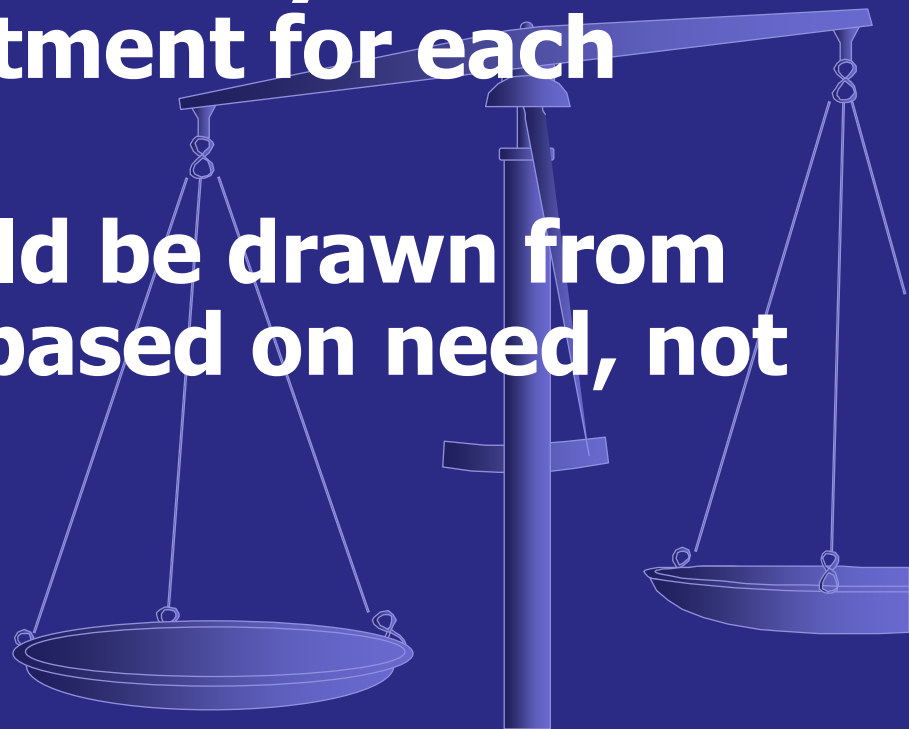
- **Basic tasks for treatment of either MI or CD are to:**
  - Stabilize acute symptoms
  - Engage the client in a program of treatment
  - Foster rehabilitation and recovery over time

Integrated Treatment, con't.

- There are parallel phases of recovery for each illness, but individual clients do not proceed through these phases in parallel.
- Clients tend to stabilize one illness at a time.
- Engagement in treatment for the other illness may take place months or years later.
- There is no one type of treatment program for dually diagnosed clients.

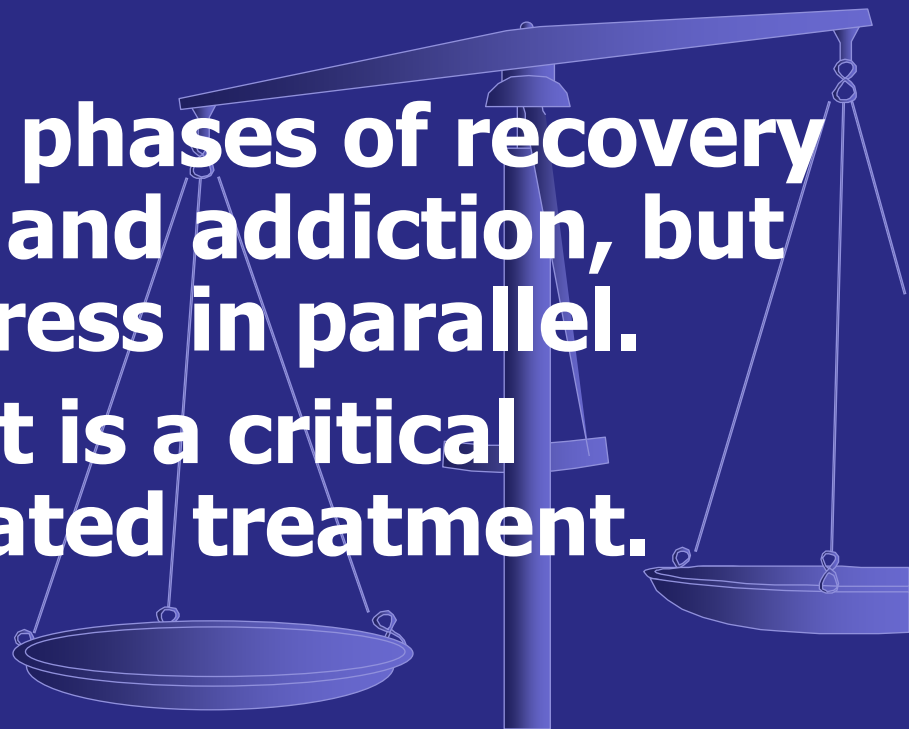
Integrated Treatment, con't.

- Specific treatment interventions depend on careful assessment of specific diagnoses, degree of severity, phase of recovery and motivation for treatment for each disorder.
- Interventions should be drawn from a menu of options based on need, not program structure.



In the public sector….

- Integrated treatment of co-occurring disorders is a cornerstone of success.
- There are parallel phases of recovery for mental illness and addiction, but clients don't progress in parallel.
- Case management is a critical element in integrated treatment.



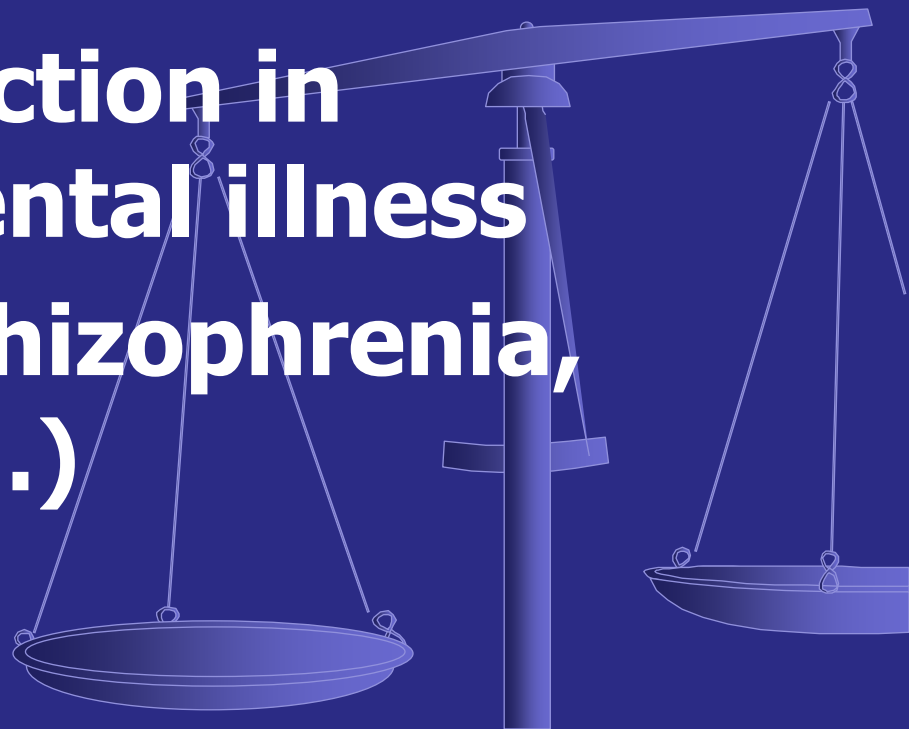
Why Case Management?

- **Linkage to multitude of services (mental health, addiction, social, medical, etc…)**

Assist in retention in treatment

Insight

- The capacity to discern the true nature of a situation
- Examples of problems:
- Cognitive dysfunction in addiction and mental illness
- (meth, other. Schizophrenia, bipolar disorder…)



Treat Both Disorders

"Ample evidence in the literature supports the notion that inadequately treated psychiatric symptoms interfere with addiction treatment."

Useful concepts

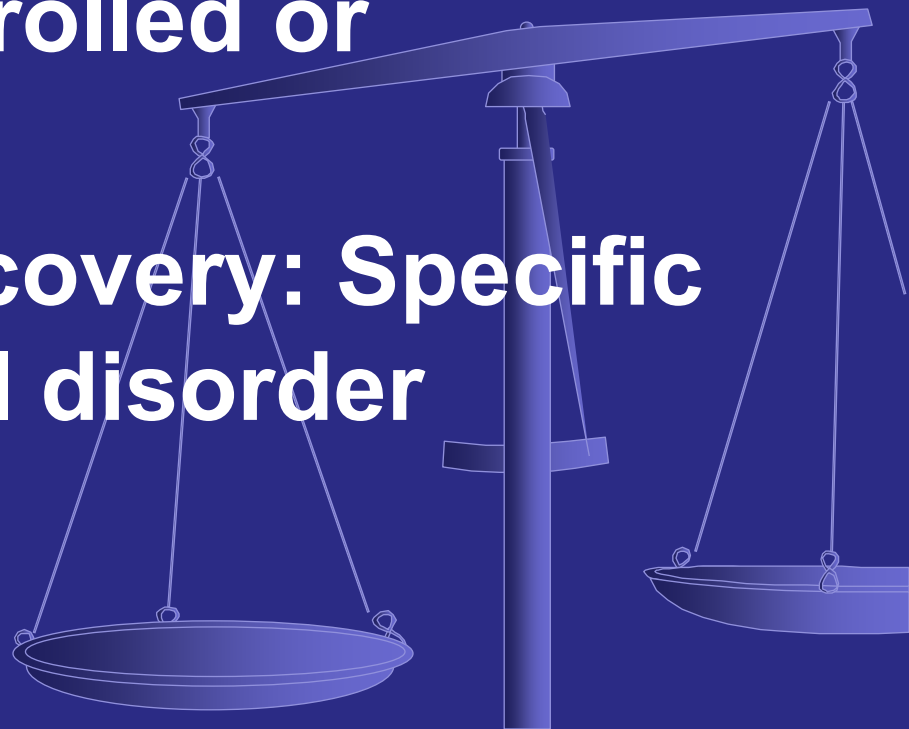
- Compassionate coercion
- Benevolent skepticism
- Working your program

Treat Both Disorders

- Requires BOTH addiction and mental health treatment
- Treatment professionals have difficulty with this need.
- Problems
  - Ignorance
  - Poor communication
  - Lack of respect and cooperation

Medication in Treatment
A Double-Edged Sword

- A trap for relapse: addicting = controlled or scheduled C_{II-V}
- A support for recovery: Specific help for a mental disorder



Psychosocial Treatment

Counselor Effectiveness

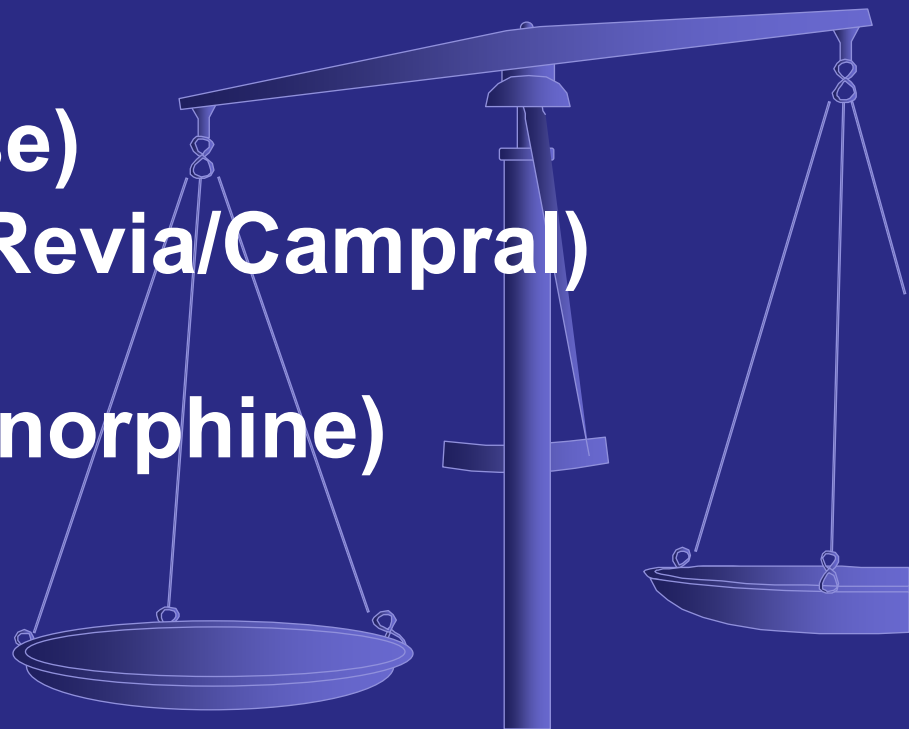
- **Empathy**
- **Positive therapeutic relationship**
- **Client-centered non-confrontational style**
- **A well specified treatment approach, e.g. using manuals**

Psychotherapies

- Types:
  - Psychodynamic
  - Cognitive Behavioral
  - Interpersonal
  - Hypnotherapy
  - Biofeedback
- Individual, Group, Marital, or Family

Psychopharmacology

- Antianxiety
- Antidepressant
- Antimanic
- Antipsychotic
- Aversive (e.g., antabuse)
- Reduction in relapse (Revia/Campral)
- Replacement (e.g.,methadone/buprenorphine)

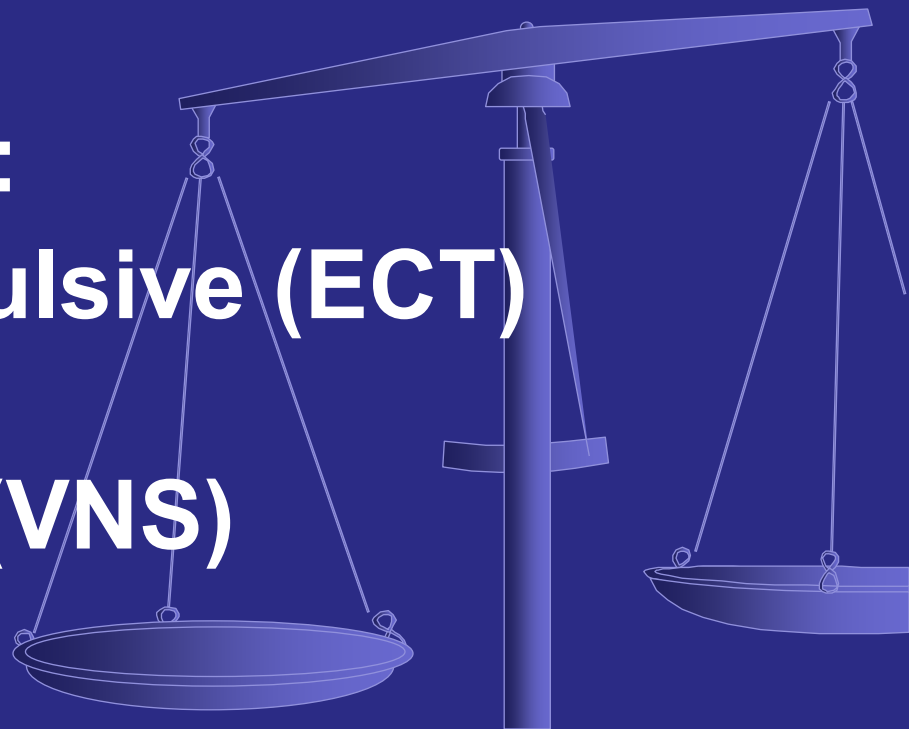


Biological Therapies

- Exercise
- Light
- Acupuncture

More invasive:

- Electroconvulsive (ECT)
- Vagus Nerve Stimulation (VNS)



Benefits of Treatment

- Reduced alcohol use
- Reductions in
  - Other drug use
  - Medical complications
  - Psychiatric complications
  - Relational problems
  - Legal problems
  - Crime

Problems in Treatment

- Poor medication & psychotherapy adherence
- Early dropout
- Relapse: should be considered evidence of treatment effectiveness, not treatment failure

Phases of Treatment

- Stabilization
- Engagement
- Persuasion
- Active Treatment
- Relapse Prevention

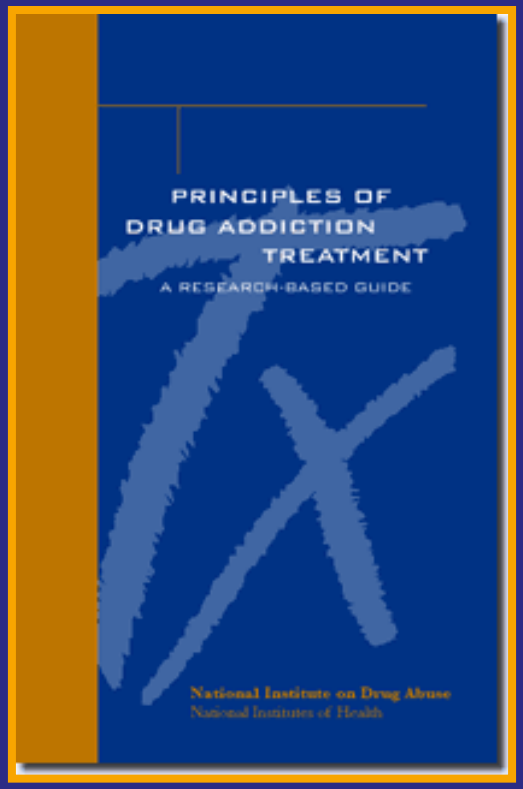
Treatment Settings
Levels of Care – Move to Least Restrictive

- Inpatient Care
- Residential
- Partial Care
- Outpatient
- Aftercare

Principles of Drug Addiction Treatment

National Institute on Drug Abuse

NIH Pub No 99-4180, 1999



Motivate & Work with Resistance

- Recovery-oriented therapies
  - Individual
  - Group
  - Family
- Caring pressure
  - Peer
  - Family
  - Staff, legal, etc.
- Recovery role models

Relapse Prevention

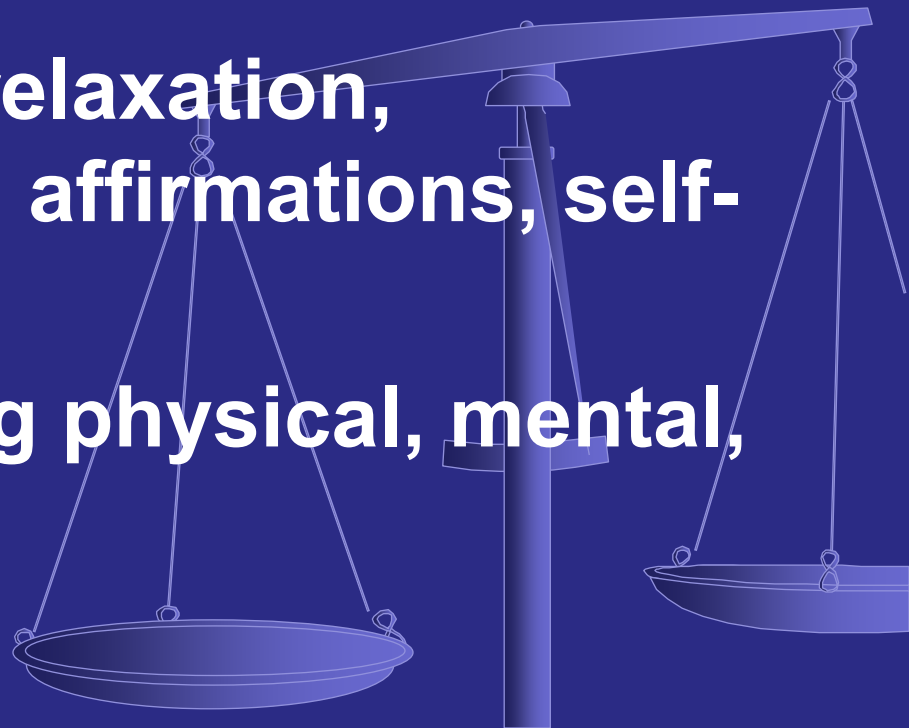
- Avoid “slippery” persons, places, and things.
- Become aware of sensory, relational, or affective triggers for craving or using.
- Learn to deal with peer pressure.
- Encourage requests for intensification of treatment.

Relapse Prevention

- Use urine drug screens and breathalyzer testing.
- Legal pressure can be very useful in relapse prevention.

Alternatives to AOD

- Exercise, hobbies, reading, nutrition, music, relationships, 12 step meetings, prayer
- Personal stressors & stress reactions
- Systematic muscle relaxation, meditation, imaging, affirmations, self-hypnosis
- Skills for maintaining physical, mental, and spiritual health



“Harm Reduction”

Professional or organized activity which attempts to reduce the harm done by problematic behavior

- **Anything above “zero tolerance”**
- **Controversial due to values conflicts**

Harm Reduction: IV Drug Use

- Opioid Replacement Therapy
- Needle Exchange
- Tolerance Houses
  - Holland & Vancouver
  - Pharmaceutical heroin & clean needles

Legal Harm Reduction

- Civil Commitment/Legal Holds
  - Harm to self – Usually suicidal
  - Harm to others – Usually homicidal intent
  - Gravely disabled – unable to care for self
  - Variable times: 24 – 72 hours to six months
- Denial of rights: forcing medication