Iowa PIC Focus: Co-Occurring Disorders

Care of Clients with Co-Occurring Disorders

(*Reprinted in part from "Principles of Care for Persons with Co-occurring Addictive and Mental Disorders" Suncoast Practice and Research Collaborative Practice Brief, vol. 2, no. 1, March, 2001, by Charles O. Matthews, Ph.D., Florida Mental Health Institute, University of South Florida. For complete SPARC Practice Briefs, please visit the website at www.fmhi.usf.edu/sparc/statement.html*).

Introduction

Approximately 10 million people in the U.S. have co-occurring addictive and mental disorders (SAMHSA, 1997). (Note: The term "co-occurring" disorders is used here instead of the more widely used term "dual diagnosis" because people in this population often have more than two disorders.) This group is defined as individuals with at least one substance disorder in the presence of at least one major mental disorder (including Major Depression, Bipolar Disorder, or a psychotic disorder such as Schizophrenia). When other mental disorders (such as anxiety disorders) are also included, many more people would be considered to have co-occurring disorders at some point in their lives.

For instance, in a landmark study, Kessler et al. (1994) found that 52% of a representative national sample of community respondents with a history of alcohol disorders and 59% of those with a history of illicit drug disorders also had a history of at least one mental disorder. Such statistics have led a number of experts to declare that clients with co-occurring disorders should be the "expectation, not the exception," for treatment providers in the public substance abuse and mental health treatment systems.

Individuals with co-occurring disorders typically have multiple co-occurring disorders and problems, and as a group have high rates of physical illness, death, unemployment, homelessness, and criminal justice involvement, which often lead to greater costs for public services. While clients with co-occurring disorders are more likely to drop out of outpatient mental health and substance abuse treatment programs and have poorer outcomes in these systems than single disordered clients, they are often high users of expensive hospital and inpatient services due to the severity of their disorders and the frequency of their crises. Many substance abuse and mental health programs use criteria which exclude people with co-occurring disorders from their programs, contributing to higher rates of incarceration.

The public mental health and substance abuse service systems are typically separate in most states, have little cross-training for staff, and limited availability of integrated treatment for co-occurring disorders. This is a crucial deficit, because the primary cause of relapse into mental illness is untreated substance abuse, and the primary cause of relapse into substance abuse is untreated mental illness (SAMHSA 1997). Clearly, the co-occurring disorders population needs to be a priority for both public health and economic reasons, as many agencies are beginning to recognize.

The Connection Between Addictive and Mental Disorders

People with mental disorders are typically much more susceptible to the negative effects of substance abuse. Even using a small amount of drugs or alcohol can rapidly destabilize someone who has a mental illness and make their symptoms much worse. Conversely, when someone has a mental disorder, that can also make it more difficult for them to maintain abstinence or comply with treatment, since there are often cognitive impairments associated with mental disorders such as increased confusion, impaired judgment, impulse problems, memory problems, difficulty paying attention or concentrating, and difficulty planning ahead.

According to Marlatt and Gordon (1985), the three highest risk situations for relapse into substance abuse are: 1) Negative Feelings, 2) Interpersonal Conflict, and 3) Social Pressure. Mental illness

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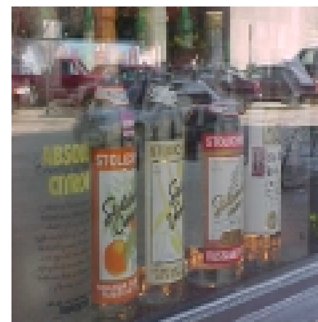


Alcohol: Iowa's # 1 Drug Problem

can put someone at higher risk for having negative feelings, such as low mood, anxiety, anger, or irritability. Additionally, many people with severe mental illness do not have well-developed social skills to cope with interpersonal conflict and social pressure. Thus, increased exposure to high-risk situations and decreased ability to cope with them help explain why having a mental illness puts one at higher risk of substance abuse relapse.

Different Treatment Models for Co-occurring Disorders

There are a number of different treatment models for people with co-occurring disorders. These include:

- No Treatment – the most common, and least effective model.
- Sequential Treatment – the client first goes through the substance abuse treatment system followed by treatment in the mental health system, or vice versa.
- Parallel Treatment – the client receives services in both mental health and substance abuse treatment settings at the same time.
- Integrated Treatment – the client receives treatment for both types of disorders at the same time and in the same service setting, with staff who are cross-trained to address both mental and substance disorders concurrently.

Which Treatment Model Works Best?

- Although both sequential and parallel treatment models work better than no treatment, they tend not to be very effective. One problem with these two treatment models can be that they give the client different messages about what they need to do to recover. Clients with co-occurring disorders are often the least able to integrate these different messages and navigate two different treatment systems.
- For example, clients with co-occurring disorders commonly receive different messages from the substance abuse and mental health treatment systems regarding psychiatric medications. While the official position of national 12-step organizations is to be supportive of the use of non-addictive psychiatric medications when needed and used as prescribed, some local substance abuse treatment programs or recovery self-help groups may discourage the use of any medications, including ones prescribed for clients by the mental health system in order to stabilize their mental illness. This opposition to medication is usually based on a misconception that psychiatric medications are addictive, when the vast majority of them are not. Non-addictive psychiatric medications include antidepressants to treat depression, mood stabilizers to treat bipolar disorder, and antipsychotics to treat psychotic disorders such as schizophrenia. When clients with severe mental illness stop their psychiatric medications without consulting their doctor, this puts them at a much higher risk for relapsing into both mental illness and substance abuse.
- As described in a review by Drake, Mercer-McFadden, Mueser, McHugo, and Bond (1998), clients with co-occurring disorders who receive traditional non-integrated treatment often have high drop-out rates and achieve little to no reduction in substance use. Their research indicates that integrated, long-term, comprehensive treatment programs, which include assertive outreach and motivational interventions, are most likely to retain clients with co-occurring disorders and help them achieve meaningful reductions in substance use.

References

Drake, R., Mercer-McFadden, C., Mueser, K., McHugo, G., & Bond, G. (1998). Review of integrated mental heath and substance abuse treatment for patients with dual disorders. Schizophrenia Bulletin, 24(4), 589-608.

Kessler, R., McGonagle, K., Zhao, S., et al. (1994). Lifetime and 12 month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry, 51, 8-19.

Marlatt, A. & Gordon, J. (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. New York: Guilford.

SAMHSA. (1997). Improving services for individuals at risk of, or with, co-occurring substance-related and mental health disorders: A SAMHSA conference report and a national strategy. Rockville, MD: Authors.

Training for Co-Occurring Disorders

The Iowa PIC has a project that involves cross-training of substance abuse counselors, mental health providers, and department of corrections treatment staff on integrated treatment of clients with co-occurring disorders. The first training will be held in Iowa City on September 27 and 28 and a second training in Carroll on October 4 and 5. This two day training will provide participants with concrete skills in assessment and treatment with a focus on clinical management strategies. There will also be a follow-up session in Des Moines on clinical supervision and the client with co-occurring disorders on October 15. The curriculum was developed by Drs. Anne Helene Skinstad and Peter Nathan through their work at the Center of Excellence on Co-Occurring Disorders at the Prairielands Addiction Technology Transfer Center, with help from Patrick Smith, Tim Guetterman, and Chris Anderson. This curriculum will provide learners with the most up-to-date research-based information on the most common types of co-occurring disorders in a form that is useful in the field. If you want more information about this training, please contact us at 319-335–5368 and we will send the registration information as soon as it becomes available.

Want training on co-occurring disorders? Read this section!

Resources about Co-Occurring Disorders

Books:

Evans, K & Sullivan, J.M. (1990). Dual diagnosis: Counseling the mentally ill substance abuser. NY: Guilford Press.

Heinemann, A.W. (1993). Substance abuse and physical disability. NY: Haworth.

O'Connell, D.F. (1998). Dual disorders: Essentials for assessment and treatment. NY: Haworth.

Daley, et al. (1993). Dual disorders: Counseling clients with mental illness and chemical dependency. Center City, MN: Hazelden

Milller, N. (1994). Treating co-existing psychiatric and addictive disorders. Center City, MN: Hazelden.

Reference Guides:

Ries, R. (1994). Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse. CSAT, TIP #9. (FREE: CSAT will have a new volume on COD coming out in the next few month—check NCADI for details)

Onken, L et al. (1997). Treatment of drug-dependent individuals with co-morbid mental disorders. NIDA Research Monograph 172.

Web Sites: Substance Abuse Oriented:

http://www. treatment.org This site lists numerous government publications and resources. In particular, check out NIDA's Dual Disorders Recovery Counseling Manual.

http://64.226.226.20/gains This is the site of the National GAINS center which focuses on COD in the criminal justice system.

Web Sites: Mental Health Oriented:

http://www.nami.org/helpline/dualdiagnosis.htm This is the National Alliance for Mental Illness website.

Did you know: People with permanent disabilities who received addiction treatment have medical bills that are on average $774 lower than people who did not receive addiction treatment. Source: Alcoholism and Drug Abuse Weekly, July 2.

Pilot #1 Results: Attitudes about Clients with COD

Iowa PIC Pilot Study #1 arose from a needs assessment conducted by the PRC Treatment/Intervention Committee in 1999-2000. The objective of Pilot #1 was to develop an instrument that would measure treatment center staff perceptions of clients with co-occurring disorders (COD's) and to allow for the proper evaluation of the training to be given in the COD training project outlined earlier. Survey instruments were given to direct treatment staff, clinical supervisors, and program directors. Following are selected findings from the Pilot #1 survey.

Program directors and treatment staff differ in some of their opinions about staff ability to work with clients with co-occurring disorders. The PIC wishes to thank the many providers and program directors who took time out of their busy schedules to complete these forms.

- Treatment directors tended to rate the training experiences of their staff on co-occurring disorders more highly than did the staff themselves.
- Treatment staff report lower levels of satisfaction than do directors with the care that COD clients in their agencies receive. However, directors expected staff to report higher levels of satisfaction than the directors themselves reported.
- Treatment staff and directors have similar perceptions of the best treatment protocols for clients with COD's, with 96% of staff and 100% of directors believing that simultaneous or integrated treatment is best for most clients.
- The vast majority of staff and directors believe that their agency successfully coordinates services with mental health referral agencies to provide optimal treatment for their clients.
- Fifty-eight percent of directors believe that mental health agencies successfully coordinate services with their substance abuse agency to provide optimal treatment for their clients, whereas 40% of treatment staff believe that.
- And, 79% of agency directors feel that having different funding streams and credentialing sources for mental health and substance abuse treatment impacts treatment for COD clients in a negative way.

A full report of survey results is available on the Iowa PIC website: www.uiowa.edu/~iowapic. Information on directors' perceptions of barriers to improving services to clients with co-occurring disorders is also included in the report.

Women's Network

Staff who work with special populations, like women, often feel isolated and unconnected. In addition, women are more likely to have co-occurring disorders than men, thus are more challenging to treat. Therefore, the Iowa PIC developed a supportive network for treatment staff who work with women and children so that they can share their experiences and find colleagues and mentors. This network was initiated in the spring of 2001 and currently includes the coordinators of all the existing women's and children's programs. In the near future, trainings and instructional materials on working with women and children will be developed. Anne Helene Skinstad is directing the women's network project and Mickey Eliason is directing a related project on children's issues that will begin this fall. Contact either of them if you want more information or want to be involved.

What is the Iowa PIC?

The Iowa PIC is part of a national network funded by the Center for Substance Abuse Treatment (CSAT) with the purpose of bridging the gap between research and practice. The program was originally called the Practice Research Collaboratives project and began in 1999. Early in the second year of the project, CSAT changed the name to Practice Improvement Collaboratives, to reflect the differences in priorities between the National Institutes of Health (NIDA and NIAAA) which focus on experimental research, and the Substance Abuse and Mental Health Services Administration (SAMHSA), which focuses more on practice issues and getting research findings and evidence-based practices implemented.

The Iowa PIC is part of a national network dedicated to bridging the gap between research and practice.

Although the name will change to Iowa Practice Improvement Collaborative, the Iowa PIC will retain its commitment to a multidirectional focus. We will foster the improvement of practice, but believe that practice has much to offer researchers as well. Therefore, we will maintain our close relationships between researchers, providers and policy-makers in developing research projects as well as training and informational materials that are aimed at improving treatment. We have four focus areas, derived from several committees formed in the first year of the project. The committees each were composed of researchers, providers, and policy-makers who identified the top priorities for our state. Our focus areas are:

- clients with co-occurring disorders,
- women and children,
- criminal justice and substance abuse, and
- technical assistance.

We have developed projects that address each of these focus areas. We are currently completing a project that provides technical assistance to substance abuse providers—see p.6 of this newsletter and our web page for more information. We also co-sponsored a workshop on Offender Re-Entry in March that dealt with the need for substance abuse aftercare in the community after offenders are released from prison. Dr. Kevin Knight from Texas Christian University presented research showing the effectiveness of substance abuse treatment for the offender population. Over 70 professionals attended this presentation.

In May, co-chairs Art Schut and Gene Lutz were invited to speak at the Suncoast PRC at their Miami meeting. The purpose of this meeting was to establish a Florida Research to Practice Consortium. Art and Gene talked about the experiences of establishing the Iowa Consortium and the Iowa PIC which are considered valuable models for collaboration across the nation.

The Iowa PIC is a partnership between the Iowa Consortium for Substance Abuse Research and Evaluation, the Prairielands Addiction Technology Transfer Center, the Iowa Substance Abuse Program Directors Association, the Iowa Department of Public Health, the Iowa Department of Corrections, and the Iowa Division of Criminal and Juvenile Justice. We solicit help from substance abuse and mental health treatment providers at community-based agencies for many of our projects. If you are interested in being more involved in the Iowa PIC, or getting more information about us, please call, write, or email us at addresses/numbers on the back of

The National Center on Addiction and Substance Abuse at Columbia University in a 1998 report entitled, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, reports:

Nationwide of each $1 spent, 96 cents goes to shovel up the wreckage of substance abuse; 4 cents goes to prevention, treatment, and research.
In Iowa, only 1 cent on the dollar goes to treatment and less than 1 cent on prevention.

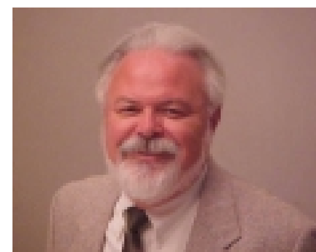
For more details, see http://www.casacolumbia.org

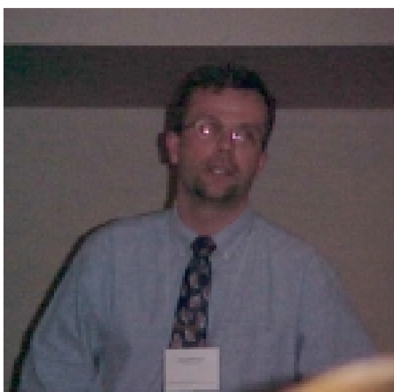
Technical Assistance for Substance Abuse Treatment Providers Coming in October

Iowa PIC's Pilot #7 project team is developing web-based resources for substance abuse treatment providers. Three technical assistance modules will be available: Finding and Using Effective Search Engines, Outcomes-Based Program Evaluation, and Writing Grant Proposals. The website will also include links to relevant agencies, institutions, and other resources, including data resources. These tools will become available in early October on the Iowa Substance Abuse Information Center's website: http://isaic.cedar-rapids.lib.ia.us/ISAICHome.html.

Photo Gallery

Photos below, clockwise from left: Dick Spoth (far right); Bruce Upchurch (l.) and Dick Moore (r.); Jack Barnette; Michael Flaum; Janet Zwick (l.), Lowell Brandt (center), and Diane Thomas(r.); John Mileham.





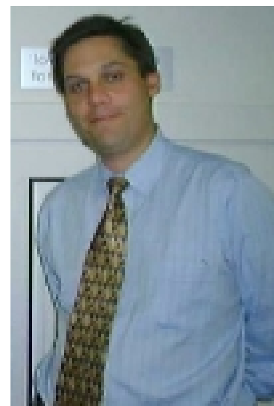


Photo Gallery

Iowa PIC Co-chairs, staff, providers, and board members (photos below, clockwise from left): Steve Arndt (l.) and Kristina Barber (r.); Anne Helene Skinstad; Chris Richards; Gene Lutz (l.) and Keith Crew (r.); Kris White; Art Schut (l.) and Becky Swift (r.); Ed Barnes.

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