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On Co-Occurring Mental Health and Substance Abuse Disorders

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Co-Occurring Disorders Committee

HIV and HCV Infection Among Individuals with Co-Occurring Disorders

By Robert B. Hordan, M.A., LCADC

The behaviors and lifestyles of alcohol and drug abusers often place them at increased risk for medical problems and mental health disorders. Such behaviors increase the likelihood of exposure to injury, infection and other adverse health conditions. The repetitive nature of drug abuse consumption by intranasal and intravenous (IV) means and smoking, as well as excessive alcohol consumption and high-risk sexual behavior, all increase the probability of acquiring one or more adverse medical conditions.

There is a subgroup of individuals with co-occurring disorders (COD) who have histories of IV opioid abuse who require ongoing methadone maintenance treatment (MMT) as well as psychotropic medication. Clients with these complex disorders require a combined pharmacological treatment regimen that attempts to stabilize the chemical equilibrium of these disorders.

Early exposure to any type of drug use increases the possibility of intravenous drug abuse. One study suggests that IV opioid abuse for less than one year by young adults can result in a 64.7% Hepatitis-C (HCV) infection rate (Garfein et al, 1996). Other literature estimates that 65% to 96% of long-term IV drug users entering MMT programs are likely to be infected with HCV (McCarthy & Flynn, 2001). This group is also at risk of becoming "co-infected" with HIV and other Hepatitis viruses that contribute to more complex medical conditions.

Counselors should receive training on the symptoms, diagnostic tests, and sequelae of medical disorders and the contributing neuropsychiatric effects on mental status and on the drug abuse recovery process. Medical and case management interventions should be designed to occur repeatedly during the entire course of ongoing rehabilitation for clients receiving group counseling and individual therapies. Educational groups that graphically present "risk and harm-reduction" principles and impulse control techniques are a cost-effective and vital means to disseminate this information.

Infection, continued on page 5

Integrating Mental Health Services in Methadone Maintenance Treatment

By Jerard Seldin, Ed.D.

During the past decade, clients with co-occurring disorders received services separately in mental health and substance abuse disorder treatment clinics with different clinical and administrative staffs and sources of funding. There was minimal effort to coordinate these services. However, research studies have shown that an "integrated approach" is the most effective treatment outcome for clients with co-occurring disorders. This change in services requires a significant change in the philosophy of treatment. As such, clinicians must accept the responsibility of developing and implementing integrated programs in order to treat clients with co-occurring disorders.

The process of developing an effective integrated treatment program for clients with co-occurring disorders depends on making administrative and clinical decisions that adhere to certain treatment principles. Mueser et al (2003) developed the following core components of an integrated treatment program:

Methadone, continued on page 2

INSIDE

Methadone, continued from page 1

- ASSERTIVENESS: Effective co-occurring disorders treatment programs use assertive outreach to engage reluctant clients. Working with clients in their homes and/or shelters may be necessary due to the clients' limited coping skills. Practical assistance and attention to a client's immediate and tangible needs helps engage the client and begins a working alliance.

- REDUCTION OF NEGATIVE CONSEQUENCES OF HAVING CO-OCCURRING DISORDERS: Alcohol and/or drug use tends to exacerbate mental illness symptoms and diminishes the client's ability to engage in treatment. The initial focus of treatment is to reduce behaviors that reduce the effectiveness of treatment. This is essential in achieving positive outcomes.

- MOTIVATIONAL-BASED TREATMENT: Clinical interventions should be oriented to the client's present motivation for change. The Stages of Treatment approach provides a model for clinicians to define goals and strategies at different points throughout the treatment process.

- LONG-TERM PERSPECTIVES: Co-occurring disorders are usually chronic and severe requiring sustained counseling interventions. Clients tend to gradually improve over time but may require time-unlimited services to achieve major lifestyle changes. Thus putting time constraints on the duration of services causes negative outcomes.

- MULTIPLE PSYCHOTHERAPEUTIC MODALITIES: Individual counseling that focuses on cognitive-behavioral changes and motivational interviewing effectively engages clients. Family counseling should include family psychoeducational interventions with single and multiple family group services.

- INTEGRATION AND COMPREHENSIVE SERVICES: Services for clients must be offered by a team of clinicians within the same program to avoid gaps in service and to ensure continuity. A multidisciplinary treatment team consists of experts in diverse professional fields of knowledge and experience. A team approach can offer a greater chance of coordinated care.

Integrating a co-occurring disorders program into a methadone maintenance treatment (MMT) program is challenging for clients and staff. Methadone is used to assist clients with the physical withdrawal symptoms from heroin use.

Case conferencing is vital in ensuring that all clinical information concerning each client is shared with appropriate treatment team members. These meetings include the psychiatrist, clinical supervisor, case manager, and the addictions counselor and/or mental health clinicians.

Historically, the aim of MMT was to provide methadone medications and associated counseling. However, a concerted effort has been made to broaden the clinical services by emphasizing individual, group and family therapies in order to engage clients. A process of psychoeducation and acceptance is essential as these clients have had minimal exposure to mental health services.

In the development of a co-occurring disorders/ MMT program, it is imperative to assess the training needs of both addictions professionals and mental health specialists. The Prince George's County Department of Health in conjunction with Maryland's Office of Education and Training for Addiction Services (OETAS) offered an 80-hour training event on diagnostic and treatment strategies. Prince George's County also held a 30-hour in service training about the principles of substance abuse disorders, psychopharmacological education and drug interactions.

The creation of a screening and assessment tool that can be used during the initial stages of treatment is critical. If mental health problems are suspected, the client should receive a formal mental health assessment that includes a clinical history, Mini International Neuropsychiatric Interview (M.I.N.I.), a mental status examination and other psychosocial questioning to help determine a DSM-IV-TR psychiatric diagnosis.

Methadone, continued on page 6

Understanding Co-Occurring Disorders

By Ricardo Adrian Rius, M.D., Ph.D.

The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) provides base definitions and organizes the primary concepts used in identifying and diagnosing what is presently considered "Co-Occurring Disorders". For example, a ***mental disorder*** is conceptualized as "a clinically significant behavioral or psychological syndrome" — a group or pattern of symptoms and signs indicative of a disability or "disorder" associated with present distress or impairing areas of functioning (social, occupational, educational, etc.).

Substance abuse is considered as "a maladaptive pattern of substance use causing clinically significant impairment or distress leading to physically hazardous, legal, vocational, family, interpersonal and social problems". ***Substance dependence*** is defined as "a maladaptive pattern of substance abuse that also includes drug tolerance, withdrawal, continuous difficulty to control the amount and frequency of drug consumption, avoidance, neglect and poor performance at work, recreational activities, persistently taken substances in spite of it association to a psychological or physical problem."

In its 2002 Report to Congress, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines an "individual with at least one mental disorder as well as an alcohol or drug disorder" as an individual with a co-occurring disorder. The SAMHSA definition also notes that "while these disorders may interact differently in any one person, at least one disorder of each type can be diagnosed independently of the other."

Co-occurring disorders have been recognized with different terms and acronyms that emphasize specific characteristic components of the disorder. These include: dual diagnosis, dual disorders, concurrent disorders, co-occurring substance abuse and mental disorders, chemically abusing mentally ill (CAMI), co-occurring addictive and mental disorder (COAMD), mentally ill chemically abusing (MICA), mentally ill chemically dependent (MICD), mentally ill substance abuser (MISA), substance abuser mentally ill (SAMI), etc. The diversity of these terms underscores the multi-dimensional nature of mental illness and substance abuse.

Relevant information about the prevalence of co-occurring disorders was obtained from several surveys. The work of Darrel Regier et al from the Epidemiological Catchment Area (ECA) Study was the largest survey of mental disorders in the community undertaken in the United States. During the course of this study, performed in the early 1980's, more than 20,000 persons over 18 years old were clinically interviewed. Results estimated that the lifetime prevalence of having a non-substance-related mental disorder is 22.5%. However, the lifetime prevalence for the presence of a mental and alcohol disorder was 45%, and for a mental and drug abuser disorder was 72%. As such, rates of alcohol and substance abuse/dependence were near three times higher in people with mental disorders when compared to a matched sample of the general population.

According to the 1990 -1992 results of the National Co-Morbidity Survey (NCS), it is estimated that nearly 10 million people in the United States had a mental disorder without any substance abuse or alcohol related disorders. Data from this survey indicates that persons with alcohol abuse problems have about a 60% - 70% higher chance of having a mental disorder sometime during their lifetime. The 2001 National Household Survey on Drug Abuse (NHSDA) measured serious mental illness (SMI) defined as a mental disorder that resulted in a functional impairment. The NHSDA estimated that about 15 million adults over age 18 suffered from SMI. An estimated 16.6 million people age 12 or older had abuse/dependence to alcohol or other drugs. The presence of co-occurring disorders was about 20% of the SMI.

These studies (ECA, NCS, and NHSDA) are descriptive surveys and do not elucidate the underlying mechanism associated with co-occurring disorders. However, several possibilities may explain the link between substance abuse/dependence and mental illness. Most noteworthy is that these disorders share biological, psychological and social "risk factors". In fact, excessive alcohol use, substance abuse, and mental disorders could be triggered by a genetic predisposition, exposure to trauma, family conflict, inadequate social support, other life stressors, etc. Furthermore, illicit substances and alcohol are often used to alleviate the painful affects of mental illness.

Understanding, continued on page 5

BUPRENORPHINE: AN OPIOID AGONIST

By Anne Weiss, LCSW-C, J.D.

There is a developing trend in the field of opiate dependency treatment. As of October 2002, the Food and Drug Administration (FDA) approved the use of "buprenorphine" (a partial agonist) for use by primary care physicians in office-based settings. This narcotic-based, maintenance therapy drug offers clients the opportunity to receive treatment in an environment that is less rigorous than an outpatient substance abuse program or hospital setting.

Buprenorphine can be used for both detoxification and maintenance of an opioid disorder. Moreover, the side effects are considered milder than those associated with methadone, resulting in an increased ability to function at work and in one's personal life.

Physicians or psychiatrists who are not certified in addiction medicine must complete an eight-hour training session in order to prescribe buprenorphine. SAMHSA recommends that primary-care physicians treating patients with buprenorphine should also refer these patients for ancillary counseling treatment in order to enhance the effectiveness of the rehabilitation process.

From a medical perspective, buprenorphine appears to have less risk of lethal overdose, often due to respiratory depression. However, patients are cautioned to avoid benzodiazepines, alcohol, and other psychotropic depressants. Buprenorphine is marketed as Suboxone, a buprenorphine/naloxone combination, to discourage intravenous use. This diminishes its street value and potential for re-sale and diversion.

Overall, United States and European studies show a good retention-in-treatment rate and other positive outcomes with buprenorphine therapy. Currently, SAMHSA's Center for Substance Abuse Treatment (CSAT) is collaborating with the Federation of State Medical Boards to develop a model with policies and guidelines for the office-based administration of buprenorphine. This ongoing research and diligent clinical care should advance the field of drug abuse treatment significantly.

For more information on buprenorphine, please visit:

SAMHSA 's Buprenorphine Site - http://buprenorphine.samhsa.gov/bwns/

NIDA Notes - http://www.nida.nih.gov/NIDA_Notes/NNVol16N2/Buprenorphine.html

Medical Conditions: Implications for Treating Co-Occurring Disorders

Friday, April 30, 2004
9:00am — 3:30 pm
Metropolitan Washington Council of Governments
777 North Capitol Street, NE, Washington, D.C. 20002

Featured Speaker: Eric Morse, M.D., Avery Road Treatment Center, Rockville, MD

Participants will:

- Receive an overview of medical conditions that are frequently associated with co-occurring substance abuse and mental disorders
- Understand how these medical conditions affect treatment of substance use and mental disorders
- Understand how to best interact with medical personnel to facilitate treatment

CEUs through DC Metro NASW & Contact Hours Available
Registration Fee: $35.00
Continental Breakfast and Lunch included
For more information, please call 202-962-3275

Infection, continue from page 1

There are predictable neuropsychiatric consequences associated with extended alcohol and drug abuse and coexisting HIV/HCV-infections. Cases like these require ongoing psychological interventions to deal with the emotional responses that these clients may experience. Importantly, signs of depression, anxiety and other psychosocial symptoms can often interfere with a client's ability to establish and remain abstinent. The pharmacological treatment of HIV and HCV is medically and psychologically manageable by experienced clinicians.

Physicians strongly recommend that individuals with HCV and/or HIV avoid alcohol because of its synergistic effect in causing hepatic injury. In fact, being "co-infected" with HIV/HCV will greatly accelerate the disease consequences for each separate disorder, and alcohol consumption can accelerate the progression of these viral disorders. As such, it is essential that treatment providers address the consequential effects of *any* alcohol use by persons with COD.

The State of Maryland Health Department regulations recommend that a client's "treatment plan" detail a client's individualized needs for physical-medical health services. The prevalence of medical conditions as well as the severity of mental disorders among individuals with COD requires clinicians to plan for a multitude of coordinated healthcare services.

Knowledge, skill and professional experience will ensure that quality services are in place to address these counseling and physical health needs of clients with COD and HIV/HCV. Specific case-management services are often medically required so the primary treatment provider must be skilled at monitoring the treatment process and outcomes of these services. Simply put, the coordination of these collective services is an important aspect of what is often referred to as "integrated treatment."

References:

1. Garfein RS et al. (1996). *Viral infections in short-term injection drug users*. American Journal of Public Health, 86, 655-661.
2. McCarthy, JJ, Flynn, N. (2001). *Hepatitis C in methadone maintenance patients: prevalence and public policy implications*. Journal of Addiction Disorders, 20, 19-31.

Understanding, continued from page 3

Clinically differentiating co-occurring disorders contributes to the discreet development of specific treatment recommendations. As such, the language used to describe and understand mental disorders provides the means to identify and provide the necessary counseling and medical care.

References:

1. American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (Text Revision)*. Washington, DC: American Psychiatric Press.
2. Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD.
3. Regier, D.A., et al. (1990). *Co-morbidity of mental disorders with alcohol and other drugs of abuse: Results from the Epidemiological Catchment Area (ECA) Study*. Journal of the American Medical Association 264 (19): 2511-2518.
4. Kessler, R.C. (1994). *The National Co-morbidity Survey of the United States*. International Review of Psychiatry 6: 365-376.
5. Substance Abuse and Mental Health Services Administration. (2002). *Results from the 2001 national household survey on drug abuse: Summary of national findings.* DHHS Publication No. (SMA) 02-3758. Rockville, MD.

About the Co-Occurring Disorders Committee

The **Co-Occurring Disorders Committee** has been in existence since 1990 and is composed of mental health and substance abuse management and direct service staff from the public and private sector in the metropolitan Washington region. The goals of the committee are as follows:

- To promote sufficient and effective treatment services for individuals with co-occurring mental health and substance use disorders.
- To promote interagency and collegial communication and collaboration among public and private treatment programs and their staff providing these services.
- To provide low cost trainings on dual diagnosis topics for professionals providing treatment for individuals with mental health and substance use disorders.

Methadone, continued from page 2

Clients diagnosed with a psychiatric disorder through the mental health assessment are referred for a psychiatric-pharmacological evaluation. When medication is prescribed, the program ensures that clients receive medications from drug companies or a local pharmacy via direct contract. After a diagnosis is established, clients are referred to selected co-occurring disorder groups that are co-lead by mental health clinicians and addictions counselor specialists.

Case conferencing is vital in ensuring that all clinical information concerning each client is shared with appropriate treatment team members. These meetings include the psychiatrist, clinical supervisor, case manager, and the addictions counselor and/or mental health clinicians. This allows the fields of addictions and mental health to merge, ensuring a more holistic approach to service provision.

Additionally, staff members are given the opportunity to expand their current clinical skills and receive further training in conducting integrated assessments.

As aforementioned, the core components (identified by Mueser and his colleagues) are an integral part of an effective MMT program. Success will be gradual; however a change in clients' attitudes and staff efficiency will establish a new culture of treatment.

References:

1. Mueser, K.T., et al. (2003). *Integrated treatment for dual disorders*. Guilford Press, NY.
2. Daley, D.C., Moss, H.H.. (2002). *Dual disorders*. Hazelden, Center City, MN.

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The Forum is published twice yearly by the Metropolitan Washington Council of Governments Co-Occurring Disorders Committee.
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To submit articles, resources, or other information on co-occurring disorders, please contact Robert B. Hordan at 301-883-3505.

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