The Forum

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On Co-Occurring Mental Health and Substance Abuse Disorders

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Co-Occurring Disorders Committee

CREATING INTEGRATED RESIDENTIAL TREATMENT PROGRAMS FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

By Melissa Anderson, LCSW, LSATP

In the early 1980s, the diagnosis and treatment of co-occurring substance abuse and mental health disorders became a defined public health concern. Previously, social service systems were organized to respond administratively and programmatically to single disorders. However, during the past two decades, advances have been made in the treatment arena, and many programs have been developed that appropriately address the needs of individuals with co-occurring disorders[1].

In the realm of community-based residential treatment, the *Modified Therapeutic Community*[2] is a widely known and researched model for providing services to co-occurring clients. Simply put, the Modified Therapeutic Community is a long-term, highly intensive, residential program. Other residential programs have also adapted to the needs of this population by creating programs with integrated services and greater clinical flexibility in a variety of other settings. For example, therapeutic environments such as group homes, 30 to 90-day settings, supportive housing programs and homeless shelters all have the capacity to incorporate modifications that adequately address the treatment needs of this population.

In order for a therapeutic environment to be successful, key modifications should include:

- Well–trained staff in all aspects of co-occurring disorders;
- Commitment to an ongoing assessment and diagnostic process;
- Sensitivity to and interventions based on Stages of Recovery;
- Programming flexibility in providing individualized services; and
- Group activities and therapy specifically designed to treat co-occurring disorders.

Co-occurring disorders can be clinically complex requiring special skills by any one counselor and the entire treatment team. All staff must be well versed in a variety of standard substance abuse and mental health treatment approaches. Most importantly, staff must understand the "interplay" between substance abuse and mental disorders.

Residential, continued on page 5

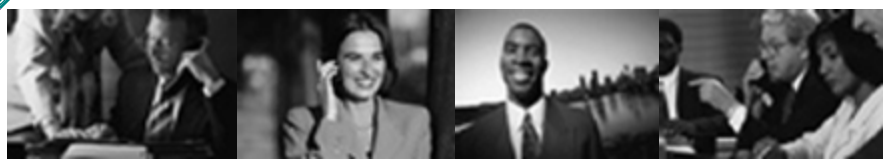
THE CHANGING OF THE GUARD

In 1990, the COG's Co-Occurring Disorders Committee was born and nurtured under the stewardship of COG's Senior Manager of Health, Mental Health, and Substance Abuse, Carol Small, and Ed Hendrickson and Marilyn Schmal of Arlington County. Over the past 12 years, the Co-Occurring Disorders Committee has advanced an "integrated approach" to the treatment of individuals with co-occurring substance abuse and mental health disorders. This committee has promoted interagency communication and collaboration among public and private treatment programs and clinical counseling staff. Specifically, the committee has developed state-of-the-art training initiatives on best practices for professionals who provide direct treatment services to individuals with these chronic health problems.

Carol, Ed, and Marilyn led this Committee through many other projects and accomplishments. The most notable achievements were developing policy papers on the treatment of co-occurring disorders and providing expert witness testimony at public hearings concerning the specific treatment needs of persons with drug dependence and mental illness.

Guard, continued on page 3

INSIDE



O P E N F O R U M

MY PSYCHOTIC BREAKS

By Will B.

Just before my first psychotic break and hospitalization ten years ago, I was a beer-drinking, dope-smoking, acid-dropping, class-skipping biology major in college. The order of the events prior to my first hospitalization is blurry, but I vividly remember being severely paranoid. I felt that my friends were adversaries and my family a source of frustration. I tried to get my parents' attention by telling them I was taking drugs and not going to classes. It was my "cry for help".

My girlfriend at the time took me to the university's psychiatrist who recommended immediate inpatient hospitalization. Though I was nervous, I remained cooperative and answered anything and everything the hospital personnel asked me. However, I spent only one night under observation because the doctors were waiting for the effects of LSD to wear off, though I denied any recent LSD use. When my dad arrived at the hospital, he was surprised and shocked to find me in such a chaotic state. I felt like I was acting rationally, but I was misled by my own mind. Actually I was in the midst of my first psychotic break. And during a judicial review hearing I was committed involuntarily to psychiatric treatment.

Doctors and medical staff believed that I was suffering from an acute psychotic reaction to LSD but they were wrong. Many disorders have similar symptoms and so psychiatrists often rely on incomplete or unreliable diagnostic information and therefore prescribe medications on an experimental basis. I was placed on Thorazine, Haldol, and Cogentin and advised not to run away, not to hurt the staff, and to take my medication. Introverted and suspicious of other patients, I could identify with them and in time I made friends. I realized they were honestly interested in both my spiritual and mental health. Older patients were the easiest to talk to because many of them had been dealing with their illnesses for years. Also, my individual therapist was very kind and understanding.

I became less paranoid when a flood of visitors appeared each day. My brother, my parents, and some of my friends who also had prior experiences with psychiatric situations intuitively knew what to say and do. I felt guilty about using drugs and becoming such a burden. Overall, I spent more than a month as an inpatient and then completed an outpatient day treatment. I immediately got a summer job working for my father as an intern at his political institute.

As I recovered, my doctor visits decreased and my medication was lowered until I was off all medications. Unfortunately, not long after that, I began drinking and using drugs again.

I wasn't ready to go completely clean and didn't realize how terrible the consequences could become. Foolishly I began to hang out with people who abused drugs heavily, and I dove headfirst into the party scene by going on the road to follow the Grateful Dead's East Coast tour. This tour was a psychedelic road/camping trip saga. Soon after, the police caught me with marijuana and I would have been taken to jail if it hadn't been my first offense. My driver's license was restricted, I paid a fine, and was placed on criminal probation.

Familiar symptoms reemerged. I had trouble sleeping, and I often didn't make sense. I was hospitalized again but not long after my admission, I became worse. The psychiatrists diagnosed me with a Bipolar Disorder and prescribed Lithium. Reluctantly I cooperated, believing that I would get well soon. The facility was clean and comfortable and helped me feel safe. But after about a month, I became paranoid again and could no longer fully participate in group counseling and/or other classes. The Lithium was not working, and it was obvious that my condition was getting worse.

My insurance ran out, and my parents were paying for my treatment out of pocket. Subsequently, I was committed to Northern Virginia Mental Health Institute (NVMHI) for three months, where inpatient treatment was subsidized.

I became defensive, reclusive, and resentful for what I was going through. And because I was unable to take care of myself entirely, I was monitored very closely.

Breaks, continued on page 4

Guard, continued from page 1

The committee has also compiled community resource guides and offered consultation to local programs about implementing and improving core clinical services. Since 1990, the committee has sponsored more than 20 workshops and seminars on topics related to the working with clients with co-occurring disorders. *The Forum* is also a product of the Committee's commitment to share and disseminate information on research–based treatment programs and to increase awareness about co-occurring disorders.

Following the events of September 11, 2001, Committee leaders were primary advocates at several COG interagency meetings on the specific mental health needs of the metropolitan Washington community at large. Carol, Ed, and Marilyn articulated emergency response needs and advanced ideas on how to address the mental health and substance abuse needs of this region. Their work resulted in creating a new committee (the Substance Abuse and Mental Health Committee), to provide a greater advocacy in the treatment of persons living with co-occurring substance abuse and mental health disorders.

The founders of the Co-Occurring Disorders Committee created a template for a new level of professional advocacy. Together, they helped harvest the energies and expertise of many mental health and substance abuse professionals around the region. Carol Small, Ed Hendrickson, and Marilyn Schmal leave a legacy and a blueprint for the advancement of clinical services to people with drug abuse and mental health issues.

All previous and present members of the Co-Occurring Disorders Committee who worked under their leadership thank them for a decade's worth of achievements and success. Their collective spirit continues to inspire and guide the Committee's future endeavors.

How to Identify & Assist Individuals with Co-Occurring Disorders: Strategies to Maximize Success

October 3, 2003
Metropolitan Washington Council of Governments
777 North Capitol Street, NE
Washington, D.C. 20002

CEU & Contact Hours Available
To register, call 202-962-3275

A DECADE OF WORKSHOPS AND SEMINARS

The Co-Occurring Disorders Committee promotes sufficient and effective treatment services for individuals with co-occurring mental health and substance use disorders by providing low cost trainings on dual diagnosis topics. Below is a list of training conferences that the Committee has sponsored. For a list of available conference proceedings, please visit www.mwcog.org.

- Networking with Treatment Professionals
- The Origins of Dual Disorders
- Group Treatment for the Dually Diagnosed
- Working with Sexually Abused Clients
- Treatment Communities for the Dually Diagnosed
- OTC and Prescription Medication Misuse
- The Dual Diagnosed Offenders and the Criminal Justice System
- HIV and the Dually Diagnosed Client
- The DSM-IV and the Diagnosis Process
- Relapse Prevention of the Dually Disordered
- Quarterly Case Conferencing (1995-1998)
- Managed Care and the Dually Diagnosed
- The Science and Art of Dual Diagnosis Treatment
- Older Adults with Co-Occurring Disorders
- Institute for Standard Treatment Practices for Co-Occurring Disorders (30-Hours)
- Assessment and Treatment of Co-Occurring Disorders
- Trauma Assessment and Treatment Options
- Motivational Interviewing and Co-Occurring Disorders
- Co-Occurring Disorders: Adolescents and Young Adults
- Managing Dual Diagnosis Programs for Co-Occurring Disorders

Breaks, continued from page 2

I understood that there were other patients at NVMHI who would never get well, and I feared joining their ranks. My psychiatrist put me on a new antipsychotic medication, Risperdal, which works very slowly. Also, this treatment regimen led to my being diagnosed with Chronic Paranoid Schizophrenia.

I was discharged to my parents' home and entered a day treatment program. However, Risperdal was not controlling my symptoms very well so another medication, Loxapine, was prescribed. Fifteen minutes after taking the first dose I felt normal - no paranoia, no uncomfortable feelings, no frustration, and could focus on my life's problems. Most importantly, I could communicate with people much more easily. Group therapy and counseling were taxing, but proved to be effective. I was warned that substance abuse could cause me to have another psychotic break, and that warning alone was enough to keep me sober.

Soon thereafter I went back to college and graduated with honors. Later I was able to obtain a rewarding full-time job. Presently, I see a psychiatrist regularly and experience minimal psychotropic side effects except for some occasional drowsiness. I've been drug free for years and have adjusted well to sobriety. My friends understand that I need to remain sober, and I avoid putting myself into situations where drugs are likely to be present. Clearly, I don't want to relapse and become psychotic again. I owe a lot of gratitude to my family, friends, and a variety of mental health personnel. I realize now that it was their infinite patience and my belated commitment to treatment that assisted me in my past therapies and present ongoing recovery.

SAMHSA'S REPORT TO CONGRESS

In December 2002, the U.S. Department of Health and Human Services (HHS) provided Congress with a much-anticipated report on the ongoing treatment services available to individuals with co-occurring substance abuse and mental disorders. Two years in the making, this report entitled "Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders" was compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA), which includes the Centers for Substance Abuse Treatment (CSAT) and Mental Health Services (CMHS). The report provides information on four distinct areas of concern: (1) develop strategies that *prevent* substance abuse disorders among individuals with mental illnesses, (2) provide *access to treatment* for persons with co-occurring disorders, (3) research and disseminated *evidence-based practices* that effectively promote recovery, and (4)identify resources to *ensure treatment opportunities and services* are readily available.

The prevalence of co-occurring substance abuse and mental disorders directly affects 7 to 10 million Americans. This report identifies important issues that substance abuse and mental health treatment systems and clinical staff must resolve to become effective and successful. Timely access to diagnostic and counseling services is lacking. Simply stated, the report recommends that providing comprehensive and "integrated treatment" to this population is of paramount concern to the nation's entire public health system.

The report consists of five chapters with seven appendices. Chapter One examines the demographics and behaviors of people with co-occurring disorders and their specific treatment needs. This chapter describes co-occurring disorders as both common and complex. Individuals with these disorders experience a wide range of personal and social problems requiring professional services. Though a multitude of barriers to treatment exist, evidence-based practices have shown that individualized, targeted interventions can improve treatment outcomes. Chapter Two deals with the importance of federal block grants as the primary source of funding for existing programs and discusses the need to research and develop innovative programs. At this time, substance abuse block grants do not require that treatment services address mental health issues. Mental health block grants are restricted to adults with serious mental illnesses and/or adolescents with serious emotional disturbances.

Appendix III discusses some exemplary methods of financing "integrated service programs" for individuals with co-occurring disorders and provides descriptions of how a variety of public and private programs can fund these services.

Report, continued on page 6

Residential, continued from page 1

It is imperative that staff members know the ongoing, dynamic nature of the assessment process, stages of change and recovery, motivational enhancement techniques and various group therapy modalities. Correspondingly, the staff may require higher levels of clinical supervision to achieve training and staff development objectives as well as assist clinicians with the difficult counter-transference experiences they will encounter.

Clients often enter residential treatment with voluminous case records with a history of different diagnoses, complicated treatment histories and contradictory information. This historical information underscores the dynamic nature of co-occurring disorders. As such, a client's "actual" diagnosis is best viewed as an open-ended developmental process that is modified in response to new information[3]. Also, the client's response to all past and present medication regimes is particularly important to measure and understand; and clients enter programs at various levels of readiness for treatment and change. Therefore, clinicians must be willing to make preliminary diagnoses, develop a treatment plan based on the initial assessment, and carefully examine the client's response to interventions (See "Open Forum").

Dan Thompson assists Melissa Anderson in their presentation on Integrated Residential Treatment Programs to substance abuse and mental health professionals on April 4th at COG.

Perhaps the most difficult challenge for residential programs is developing techniques to address the needs of individuals who are not ready for the demands and intensity of residential treatment. Clients may enter treatment for many reasons, including homelessness, and may not be ready or able to accept the seriousness of their mental illness or substance abuse condition. This "denial" can be manifested in many ways.

After a brief stay in a hospital or detox setting, clients may require several medication adjustments to fully stabilize their psychiatric symptoms. The side effects of medications may create cognitive impairments and interfere with therapeutic interventions. Creating groups specifically designed to allow for such variations in the earlier phases of treatment can successfully address these challenges. Psycho-educational material presented in shorter, less intensive groups may allow clients to explore their illnesses and prepare for other phases of treatment.

Despite the best efforts of treatment providers, some clients will not move to greater levels of treatment readiness. Behavioral problems (such as refusing to attend group sessions, substance use relapse, medication refusal, and excessive sleeping) may compromise the client's ability to utilize treatment. Notwithstanding the above, numerous interventions must be attempted to engage the client. At times, the client's personality disorder may complicate these problems; necessitating the establishment and enforcement of behavioral limits. Clients who truly are unwilling or unable to engage in residential treatment should be referred to other services in the community with an invitation to return to treatment, should the circumstances change.

Ideally, residential services should be provided along a continuum of services. Though it may be difficult to provide services to clients with a broad range of diagnoses and adaptive functioning levels, staffing patterns should allow for multiple types of services to be conducted simultaneously. A client with persistent psychotic symptoms and cognitive impairments may be unable to benefit from a process-oriented group designed to explore relapse behaviors; whereas a client with serious borderline pathology and related symptoms may actually need such group treatment. Some clients may benefit from intensive treatment delivered on-site, while others may need a lower demand home setting, with day-treatment services delivered by a partial hospitalization program. When service delivery systems lack a continuum of services for clients with co-occurring disorders, programs must compensate by adapting "individualized" treatment regimes for the members of its therapeutic community.

References:

1. *U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (November 2002). Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.*
2. *Sacks, S (2000). Co-occurring mental and substance use disorders: Promising approaches and research issues. Substance Use and Misuse 35 (12-14).*
3. *Koefod, L. (1991). Assessment of comorbid psychiatric illness and substance disorders. In Minkoff, K., & Drake, R.E. (Eds). Dual Diagnosis of Major Mental Illness and Substance Disorder. San Francisco, CA: Jossey-Bass.*

Report, continued from page 4

Chapter Three deals with the prevention of co-occurring disorders and concludes that many of the risk factors for psychiatric and substance abuse disorders may be similar. Programs designed to prevent one disorder may in reality prevent or forestall the development of the other disorder. Successful prevention strategies for both adolescents and adults are outlined. Chapter Four reviews the development of evidence-based treatment interventions. It concludes that early identification and treatment of both disorders appears to be cost-effective. This chapter reviews research finding concerning treatment approaches that appear to be successful and the methods used to integrate mental health and substance abuse treatment.

SAMHSA's five-year national action plan to ensure accountability and effectiveness in the prevention, diagnosis, and treatment of co-occurring disorders is outlined in Chapter Five. To achieve the goals outlined in the action plan, the report recommends that SAMHSA take the leadership in ensuring the development of a well-trained and educated workforce to address co-occurring substance abuse and mental health disorders. This is best achieved by providing technical assistance and training to the state and local agencies in form of State Incentive Grants. These grants promote the integration of mental health and substance abuse treatment. Treatment providers must continue to improve, refine, test, and apply reliable outcome measures for this population as well as examine the complex issues of the use of psychotropic medication. This can best be accomplished by convening a national summit on co-occurring disorders.

This Report to Congress is the first comprehensive statement to acknowledge the importance of providing treatment services to this too often neglected population. Substantial recommendations on how SAMHSA can increase its leadership role in promoting expansion and development of clinical services are detailed. The key ingredients for effective services delivery are outlined as well as the need for ongoing Federal and State funding to better educate and train staff to promote effective clinical practices. As such, it becomes *our collective responsibility* to promote the implementation of such changes on a national and local level.

The entire report is located at http://www.samhsa.gov/news/cl_congress2002.html.

The Forum *is published twice yearly by the Metropolitan Washington Council of Governments Co-Occurring Disorders Committee.*
To become a member of the Co-Occurring Disorders Committee, please contact Gary Lupton at 703-799-2755.
To submit articles, resources, or other information on co-occurring disorders, please contact Robert Hordan at 301-883-3505.

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