

CO-OCCURRING DISORDERS FOR SUBSTANCE USE DISORDER PROFESSIONALS

Presented by:

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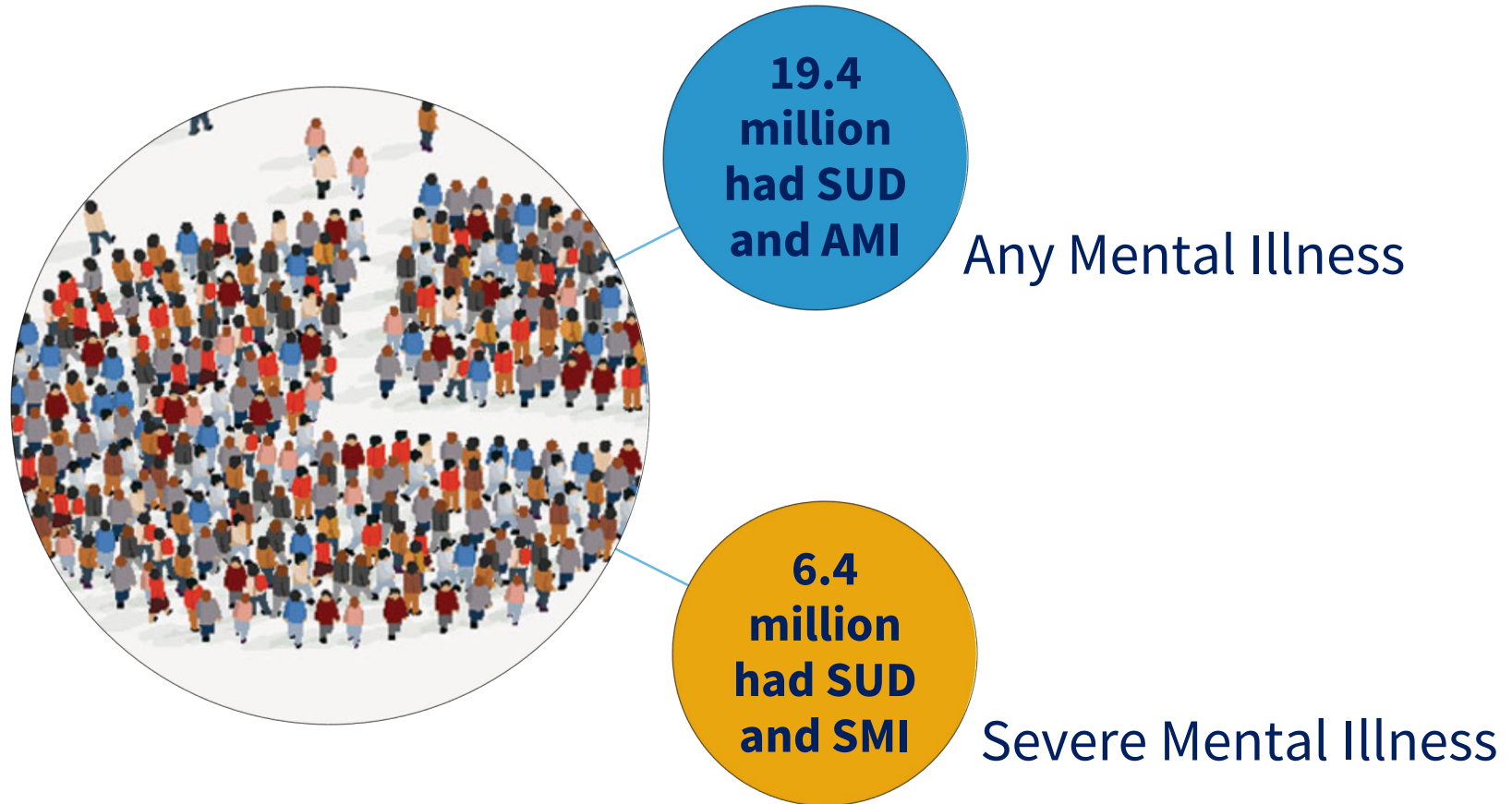
OBJECTIVES

- Define and describe co-occurring disorders and its impact on the individual and community.
- Discuss the role neurobiology plays in addiction and mental illness.
- Develop an understanding of the interactive course of co-occurring disorders and its implications to integrated care.
- Formulate examples of evidence based and evidence supported co-occurring treatment interventions.

CO-OCCURRING DISORDER

- This training defines co-occurring disorders as:
 - *At least one substance use diagnosis as well as at least one mental health diagnosis.*
- Diagnosing is a complicated process as many symptoms mimic and interact with each other.
- Individuals diagnosed with an SUD are 50% more likely to be diagnosed with a co-occurring mental health disorder and vice versa (SAMHSA, 2020).

PREVALENCE OF CO-OCCURRING DISORDERS



Adults aged 18 or older in 2022 with AMI or SMI in the past year were more likely to have SUDs in the past year (36.3 and 48.2 percent, respectively) than were adults with no mental illness (12.7 percent).

DEFINING ADDICTION

- “Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.”

- *American Society of Addiction Medicine (ASAM), 2019*

DEFINING ADDICTION

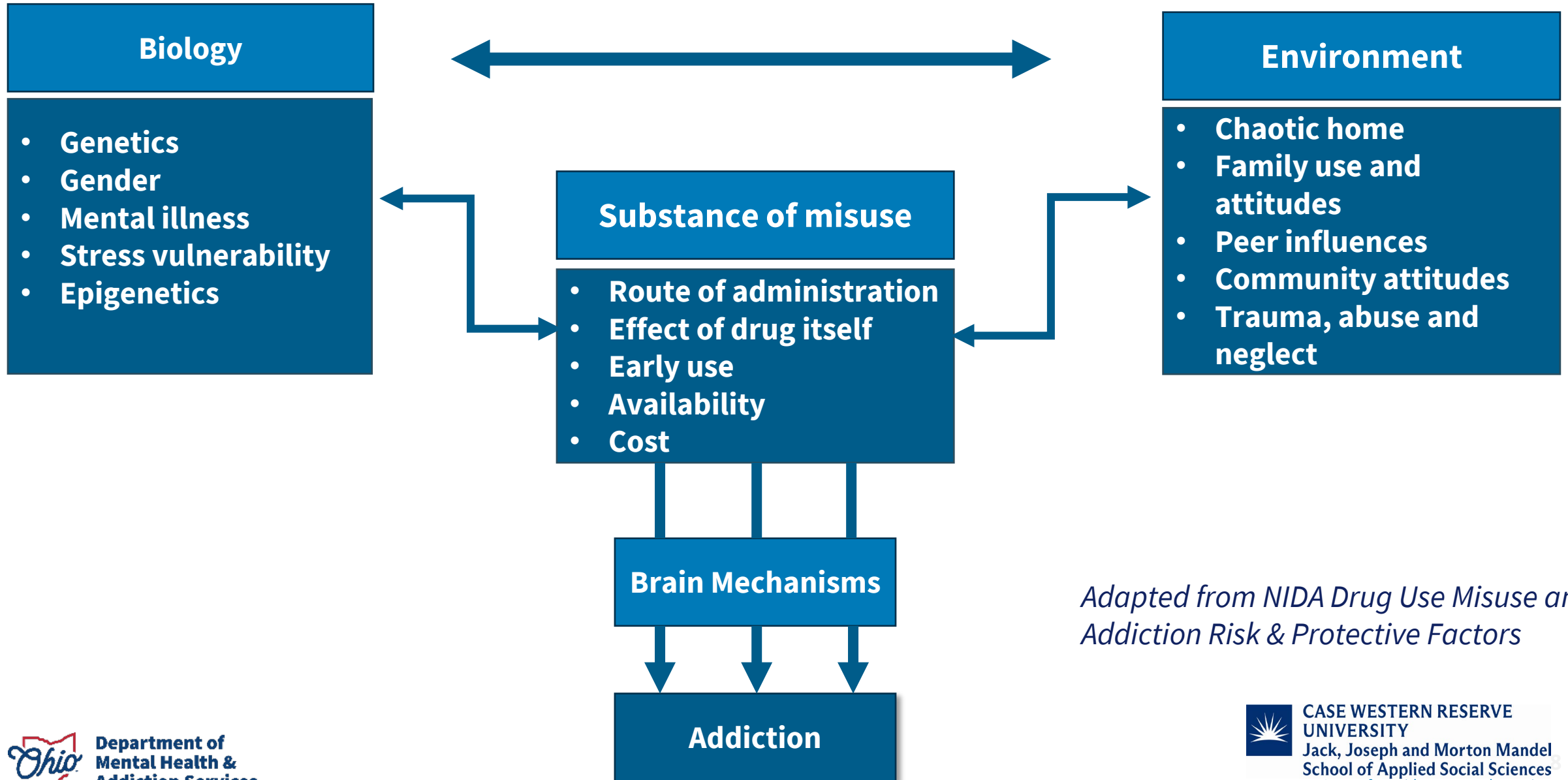
Characterized by:

- Inability to Abstain
- Impairment in Behavioral control
- Craving or increased “hunger” for drugs or rewarding experiences
- Diminished recognition of significant problems and interpersonal relationships
- A dysfunctional Emotional response

IMPACT ON INDIVIDUAL AND COMMUNITY



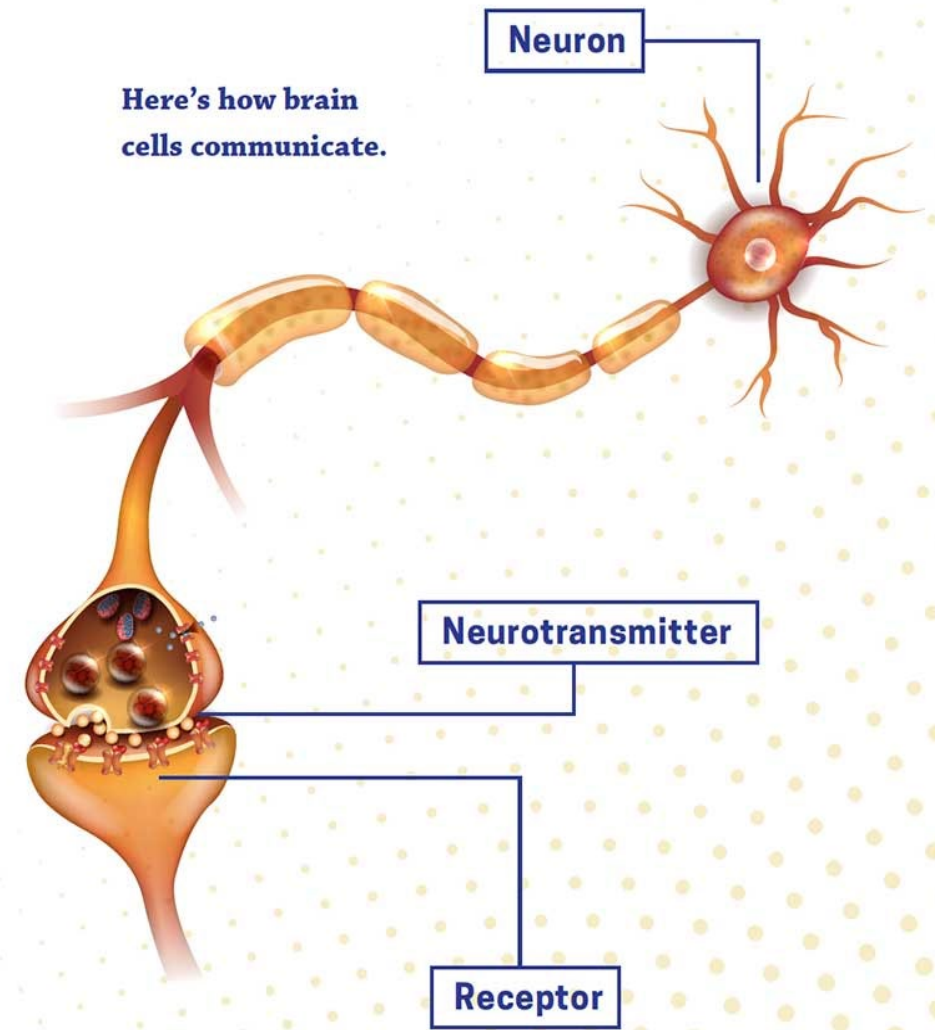
SUBSTANCE USE DISORDER RISK FACTORS

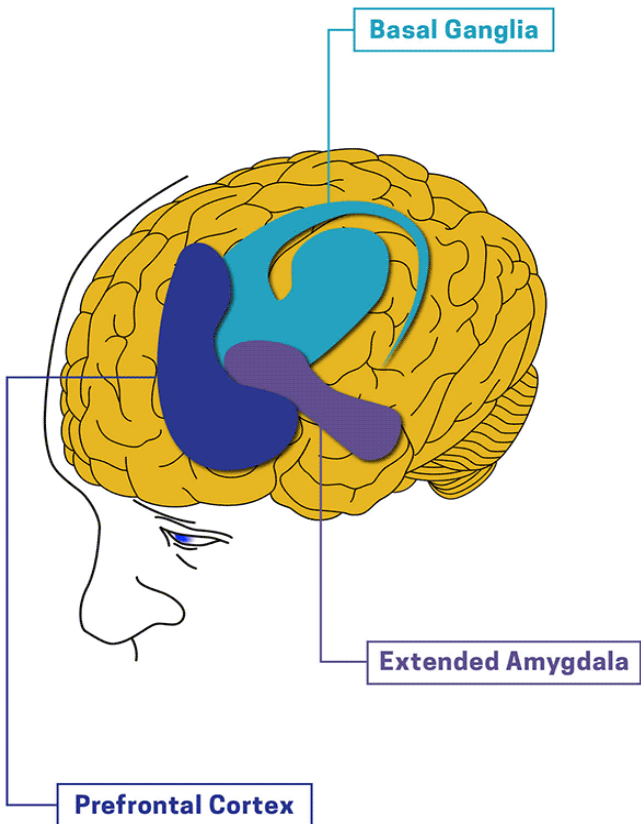


Adapted from NIDA Drug Use Misuse and Addiction Risk & Protective Factors

NEUROBIOLOGY OF ADDICTION

- Alcohol & drugs interfere with the way neurons send, receive, and process signals via neurotransmitters.
- Some drugs, such as cannabis and heroin, activate neurons because their chemical structure mimics that of a natural neurotransmitter in the body.
- Other drugs, such as amphetamine or cocaine, can cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals by interfering with transporters.
- All addictive substances have an effect on our reward centers, reinforcing the “need” to use.





Source: Facing Addiction in America:
The Surgeon General's Report on
Alcohol, Drugs, and Health

Basal Ganglia

- Main reward center of the brain and reinforces pleasurable experiences
- Substances release 2-10x more dopamine than natural rewards
- Conditioning occurs when substance use is paired with environmental stimuli

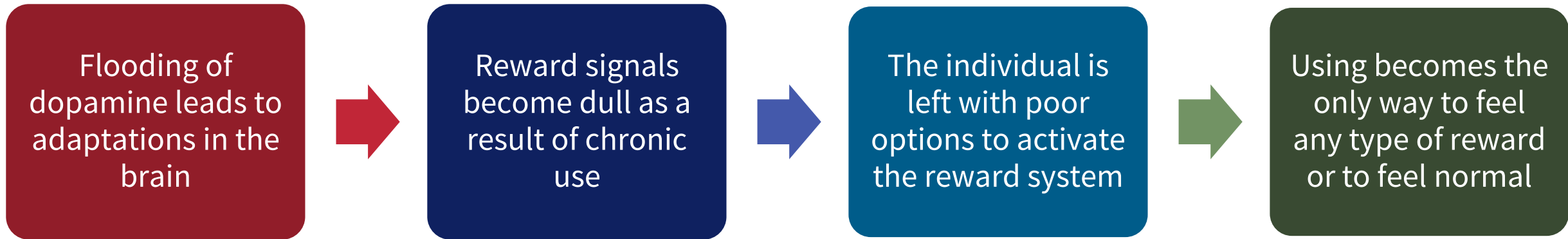
Extended Amygdala

- Mediates memory and emotions and is responsible for our survival
- Amygdala encodes experiences into our memory such as substance use triggering strong cravings

Prefrontal Cortex

- Responsible for ability to think, plan, problem solve, self-regulate, exert control over impulses, & weigh out risks and rewards
- Damage through chronic use inhibits ability to resist strong urges and follow through on decisions to cease use of substances

THE ADDICTIVE PROCESS



The brain can and does repair itself!

However, it can be months or years into the recovery process.

MENTAL ILLNESS

- 50% of mental illness begins by age 14, and three-quarters begin by age 24 (APA, 2022).
- “Addiction counselors encounter individuals with CODs as a rule, not an exception” (SAMHSA, 2020).
- Despite licensure, all Substance Use professionals can and should screen for mental illness.
- Those who are not licensed to diagnose and treat mental illness can provide psychoeducation and make referrals.

SIGNS & SYMPTOMS OF MENTAL ILLNESS

- Sleep changes
- Hygiene changes
- Mood changes
- Social withdrawal
- Impaired functioning
- Poor concentration and focus



- Apathy
- Feeling disconnected
- Illogical thinking
- Nervousness
- Unusual behavior
- Appetite changes

WHAT MENTAL HEALTH DIAGNOSES DO YOU SEE OFTEN IN YOUR PRACTICE?



<https://www.menti.com/alwc74fhjxtd>

GENERALIZED ANXIETY

Symptoms	Prevalence	Treatment
<ul style="list-style-type: none">• Excessive worry about a broad array of topics• Intense, frequent, chronic and disproportionate to the posed problem• Accompanied by additional cognitive/ physical symptoms	<ul style="list-style-type: none">• Women are twice as likely to experience GAD.• 30% of individuals are likely to be diagnosed with an anxiety disorder.• There is a higher likelihood that individuals experiencing GAD will also experience SUD.• Co-morbidity of anxiety and SUD increase suicide risk.	<ul style="list-style-type: none">• Integrated treatment that focuses on CBT• Exposure therapy can be beneficial

MAJOR DEPRESSION

Symptoms	Prevalence	Treatment
<ul style="list-style-type: none">• Excessively sad, empty, or irritable mood• Somatic and cognitive changes that significantly affect ability to function• Loss of interest in nearly all previously enjoyed activities	<ul style="list-style-type: none">• “In 2021, an estimated 14.5 million U.S. adults aged 18 or older had at least one major depressive episode with severe impairment in the past year. This number represented 5.7% of all U.S. adults” (NIMH, 2023).• Those with a drug use disorder are 1.5x-1.9x more likely to have a depressive disorder.	<ul style="list-style-type: none">• CBT in individual or group settings• With or without adjunctive antidepressant medications

(SAMHSA, 2020)

BIPOLAR DISORDERS

Symptoms	Prevalence	Treatment
<ul style="list-style-type: none"> • An individual’s mood fluctuates between manic and depressive symptoms • Depressive characteristics are the same as those reviewed prior • Mania is characterized by extreme euphoria, energy and activity • Delusional thoughts/ beliefs may be present during mania 	<ul style="list-style-type: none"> • In 2021, 65% of individuals diagnosed with Bipolar I were also diagnosed with a SUD. • Co-occurring SUD with bipolar I is linked to lower treatment retention, reduced recovery of functional abilities, increase in use of emergency services, increased impulsivity, and a reduction in response to typical medications used. 	<ul style="list-style-type: none"> • Group CBT, integrated therapy and relapse prevention techniques, but additional research is needed • Mood stabilizing medications and use of Motivational Interviewing to support medication adherence

(SAMHSA, 2020)

SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS

Symptoms	Prevalence	Treatment
<ul style="list-style-type: none"> • Delusions • Hallucinations • Disorganized thinking • Grossly disorganized or abnormal motor behavior • Negative symptoms 	<ul style="list-style-type: none"> • As many as 55% of adults diagnosed with schizophrenia have a lifetime prevalence of SUD. • “People with severe psychotic disorders have 4x greater risk of heavy alcohol use and 3.5x the risk of heavy cannabis use.” (SAMHSA, 2020) 	<ul style="list-style-type: none"> • Antipsychotic medication is the standard of care for reducing positive symptoms (e.g., delusions, hallucinations). • Examples include: CBT, group behavioral therapy, contingency management, 12-Step facilitation, motivational enhancement & interviewing, IDDT, or (preferably) a combination.

(SAMHSA, 2020)

POST TRAUMATIC STRESS DISORDER

Symptoms	Prevalence	Treatment
<ul style="list-style-type: none">• Intrusive re-experiences of the trauma• Persistent avoidance of people, places, objects, and events that remind the person of the trauma• Self-blame, guilt, hopelessness, & social withdrawal• Experiencing sleeplessness or feeling “jumpy,” “on edge,” easily started, irritable, angry, or unable to concentrate	<ul style="list-style-type: none">• Among people with SUDs, lifetime prevalence of PTSD is thought to range between 26% and 52%• Rates of SUDs and current PTSD between 15% and 42%	<ul style="list-style-type: none">• Individual trauma-focused psychotherapy with adjunctive SUD treatment• Mindfulness and coping skills

PERSONALITY DISORDERS

Symptoms

- Inability to form healthy relationships
- Failure to develop adaptive sense of self
- Destructive or problematic thought patterns and feelings about self and others
- Negative ways of behaving towards others
- View focused on meeting own needs
- Often experience difficulties with change that impacts interpersonal functioning

Prevalence

- Prevalence among the general population is difficult to assess because the symptoms are characteristics everyone exhibits. It becomes a disorder when the symptoms are more prevalent than seen in the general population.
- Among those with SUDs, the prevalence ranges from 35% to 65%.

Treatment

- Psychotherapy and CBT are primary interventions, as no medications have been approved for the treatment of personality disorders
- Psychotherapy and CBT is effective in addressing symptoms, including risk of suicide & self-harm, affective dysregulation, maladaptive thought patterns, and poor interpersonal functioning

Co-occurring Disorders Leads To Increased Vulnerability For Suicide

SUICIDALITY

- Per the National Center for Health Statistics(NCHS), from 1999 to 2018, suicide rates in the United States increased 41%, from 10.5 to 14.8 per 100,000 people (Hedegaard et al., 2020).
- Suicide is one of the leading causes of death among those with a substance use disorders. (TIP Series, No. 42)
- The link between substance misuse and suicide may relate to the capacity of substances (especially alcohol) to quell inhibition, leading to poor judgment, mood instability, and impulsiveness. (TIP Series, No. 42)

SUICIDE RATES IN OHIO

- 242 Ohio veteran suicide deaths in 2021.
- Suicide is the leading cause of death for Ohioans ages 10-14.
- Almost 200 non-white Ohioans died by suicide in a single year.
- Annually, more than 1,000 older Ohioans lose their lives to suicide (adults 45+).
- Of those surveyed, 29% of transgender and non-binary youth have reported attempting suicide

(Ohio Prevention Suicide Foundation)
ohiospf.org

SUICIDALITY

Asking someone about suicidal thoughts will not increase the risk of someone completing suicide.

Know your agency policy and procedures.



All suicidal ideation should be taken seriously.

All suicidal ideation requires further assessment and care by an appropriately licensed provider.

SUBSTANCES THAT MIMIC COMMON MENTAL DISORDERS

Mental Disorder	Substances That Mimic Common Mental Disorders During Use (Intoxication)	Substances That Mimic Common Mental Disorders After Use (Withdrawal)
Depression & Dysthymia	Alcohol, benzodiazepines, opioids, barbiturates, cannabis, steroids (chronic), stimulants (chronic)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic), stimulants (chronic)
Anxiety Disorders	Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, PCP, inhalants, stimulants	Alcohol, cocaine, opioids, sedatives, hypnotics, anxiolytics, stimulants
Bipolar Disorders & Mania	Stimulants, alcohol, hallucinogens, inhalants, steroids (chronic, acute)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic)
Psychosis	Alcohol, anxiolytics, cannabis, hallucinogens (e.g. PCP), inhalants, sedatives, hypnotics, stimulants	Alcohol, sedatives, hypnotics, anxiolytics

DIFFERENTIAL DIAGNOSIS

- Substance misuse can cause symptoms that are identical to the symptoms of mental illness. Mental health diagnoses (within scope of practice) should be provisional and re-evaluated periodically.
- Some mental health disorders are really substance-induced mental health disorders, meaning they are caused by substance use.
- After a period of stabilization or symptom reduction, a clearer co-occurring mental health diagnosis may be identified.

6 CORE PRINCIPLES OF TREATMENT FOR CO-OCCURRING DISORDERS

1. Using a recovery perspective

2. Adopt a multi-focused viewpoint

3. Staged approach to treatment

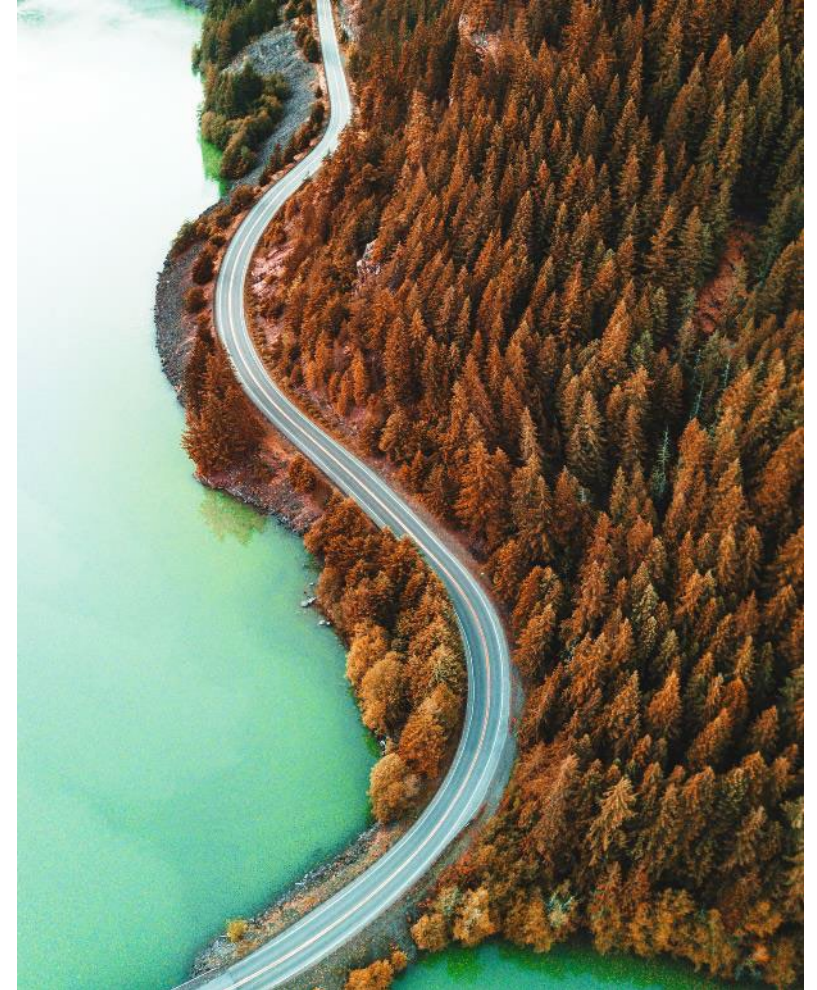
4. Address pragmatic concerns early

5. Plan for individuals cognitive and functional needs

6. Support systems to maintain and extend treatment effectiveness

1. USING A RECOVERY PERSPECTIVE

- Recovery is a long-term process of internal change.
- The treatment plan considers continuity of care over time in a variety of settings.
- Much of recovery occurs outside of the treatment setting – family, mutual support, faith community.

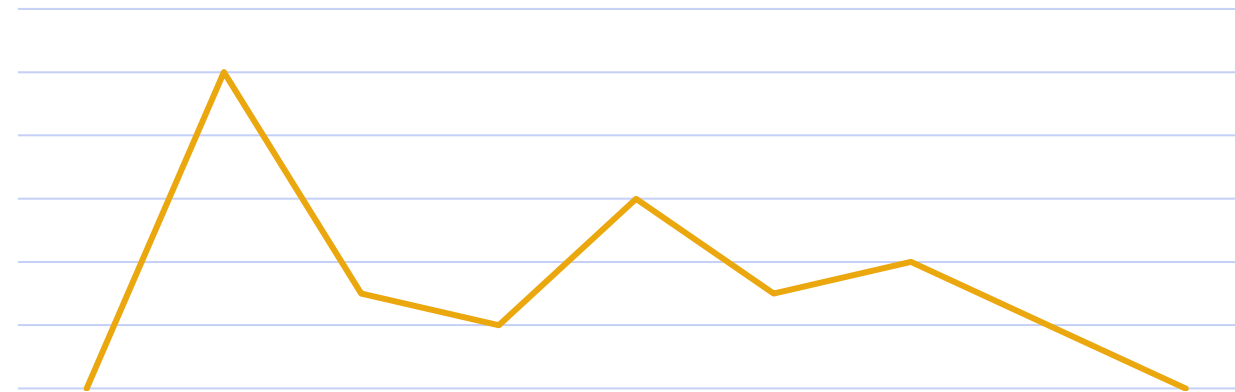


SHIFTING FROM AN ACUTE TO CHRONIC MODEL



Acute Service Model

- Enters treatment when SUD symptoms exacerbate.
- Discontinues treatment when symptoms diminish
- Repeat



Chronic Service Model

- Improve the continuity of care.
- Use monitoring & early intervention
- Provide recovery support

2. ADOPT MULTI-FOCUSED VIEWPOINT

Treatment should be wholistic and address immediate and long-term needs as informed by the comprehensive assessment for:

Housing



Social Supports

Employment



Healthcare

3. STAGED APPROACH TO TREATMENT

A person's stage of change should be considered based on their readiness and motivation for change.

- A person's readiness for change should be incorporated into treatment planning.
- Markers of progress should be meaningful to the client.



Prochaska & DiClemente, 1983

4. ADDRESS PRAGMATIC CONCERNS EARLY

- Support with systemic hurdles regarding housing and employment.
- Solving financial, housing, occupational, and other problems of everyday living is often an important first step towards achieving engagement in continuing treatment.
- Pragmatic considerations such as basic human needs and safety should be attended to before focusing elsewhere.

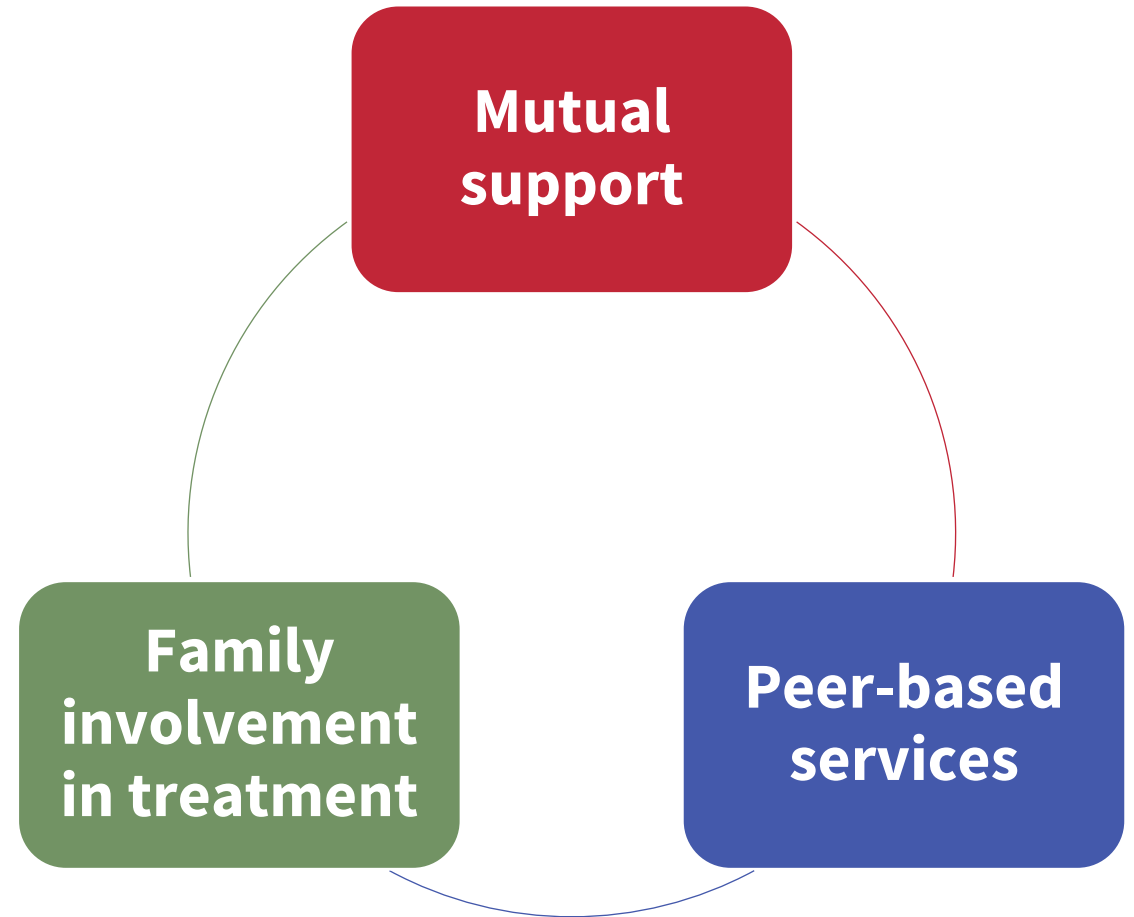
5. PLAN FOR INDIVIDUALS COGNITIVE AND FUNCTIONAL NEEDS

- The way interventions are presented must be compatible with the person's needs and functioning.
- Individual preference should be taken into consideration when determining frequency and duration of appointments, with a focus on safety and practical life needs.
- Gradual pacing, visual aids, and repetition are often helpful.

6. SUPPORT SYSTEMS TO MAINTAIN & EXTEND TREATMENT EFFECTIVENESS

Building recovery capital!

- Individuals with co-occurring diagnoses often experience disconnection from their family & community.
- Often support is needed in navigating previous relationships which encouraged substance use and other maladaptive behaviors.



GUIDELINES FOR PROFESSIONALS



PROVIDING ACCESS TO CARE

- Initial contact is where engagement begins including evaluation and referral in all disciplines.
- Other external factors often impact access to treatment.
- Work to remove systemic barriers to care.

Types of access include:

- Routine
- Crisis
- Outreach
- Involuntary
- No “Wrong Door”



BARRIERS TO CARE

17% of individuals with co-occurring disorders received treatment addressing both diagnoses in 2022.
(SAMHSA, 2023)

**Attitudinal outlooks
and motivational
barriers**

Cultural beliefs

**Racial and ethnic
factors**

Stigma

Insight

**Organizational/
systematic barriers**

Logistic barriers

**Lack access to
advanced trainings**

**Socio-economic
barriers**

**Lack of appropriate
care**

COMPLETING A FULL ASSESSMENT

Screening: Determines whether an individual warrants further assessment for a possible co-occurring mental health disorder.

- Every clinician conducting intake or assessment should be able to screen for the most common CODs.



Assessment: Gathers information on key factors contributing to, exacerbating, and alleviating current symptomatology and functional status.

- Assessment is a multifactor, biopsychosocial approach to determine ways to tailor treatment decisions and continuity of care based on the assessment results.

ASSESSING CO-OCCURRING DISORDERS

- Engage the person and build rapport to facilitate open disclosure of information regarding mental health, substance use, and related concerns.
- Remain objective and curious about the person's individual and complex needs.
- Conduct a detailed chronological history of mental health symptoms, diagnoses, treatment history & functional impairment, particularly preceding substance misuse and during periods of extended abstinence.

ASSESSING CO-OCCURRING DISORDERS

- Identify and contact collaterals (family, friends, other providers) to gather additional information where allowable.
- Identify current strengths, social and community supports, limitations, skill deficits, and cultural barriers as it relates to treatment considerations.
- Determine stage of change for each area of concern along with the level of ability to follow through with treatment considerations.

ASSESSING CO-OCCURRING DISORDERS

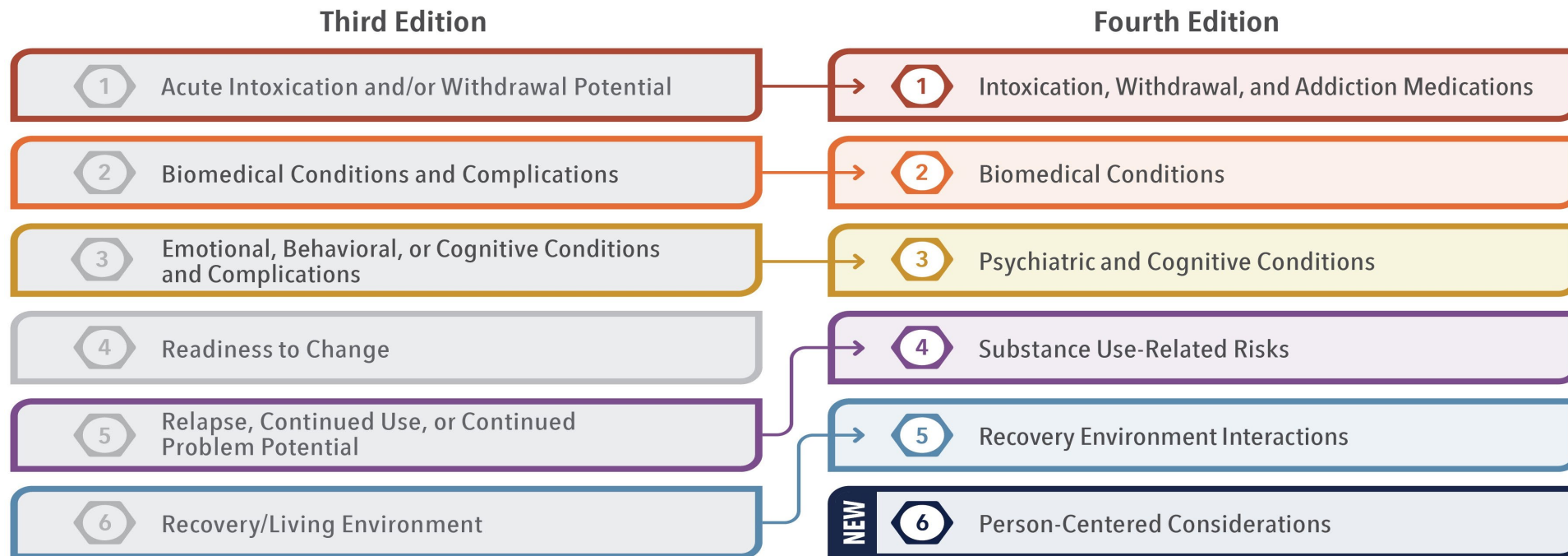
- Don't assume there is one correct treatment approach or program for any type of co-occurring disorder.
- Assessment is an on-going process.
- Needs and symptoms of the person are evolving, and more information becomes available once rapport is established.

PROVIDING APPROPRIATE LEVEL OF CARE

- People enter the treatment system at various levels of need and motivation and encounter agencies with a varying capacity to meet those needs.
- Individuals should be placed in the level of care appropriate to the severity of both their SUD and their mental illness.
- Referrals to programs that are co-occurring capable or co-occurring enhanced are able to support higher severity symptoms of both disorders.
- Individuals may not be in need of or ready for a full continuum of services or participate in programming in a linear fashion.
- If the person refuses the level of care recommended other service options should be explored that the person may be willing to participate in.

ASAM DIMENSIONS

Changes to *The ASAM Criteria* Dimensions in the Fourth Edition

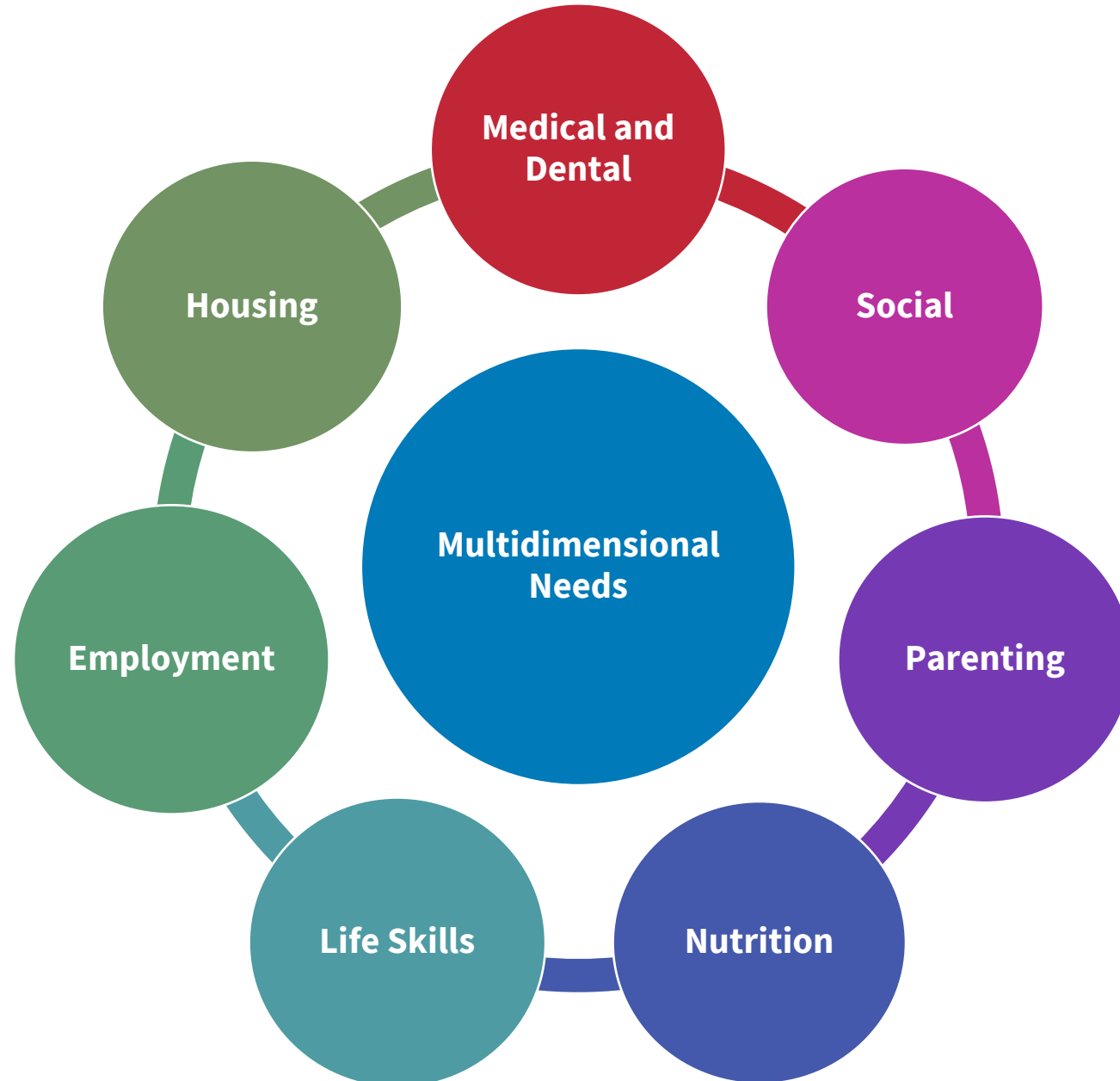


The Fourth Edition reorders the dimensions from the Third Edition. Readiness to change is now considered within each dimension, and the Third Edition Dimensions 5 and 6 were shifted to Dimensions 4 and 5, respectively, in the Fourth Edition. The new Dimension 6: Person-Centered Considerations considers barriers to care (including social determinants of health), patient preferences, and need for motivational enhancement.

ACHIEVING INTEGRATED TREATMENT

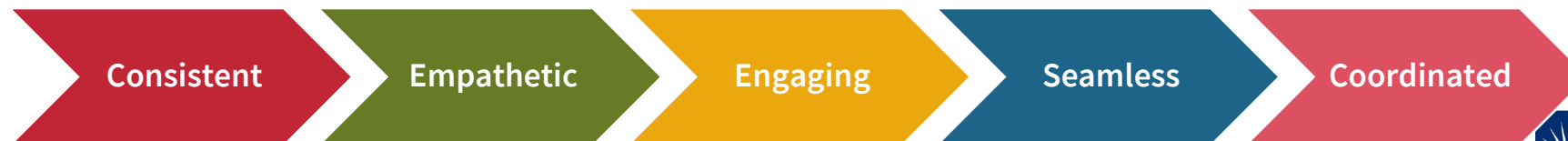
- Mental illness and substance use are both treated concurrently to meet the full range of symptoms equally.
- Providers of integrated care receive training in the treatment of both substance use and mental health disorders.
- Stage wise approach and motivational techniques (e.g., motivational interviewing [MI], motivational counseling) are integrated into care to help individuals reach their goals.
- Substance use counseling is used to help individuals develop healthier, more adaptive thoughts and behaviors in support of long-term recovery.
- Individuals are offered multiple treatment formats, including individual, group, family, and peer support, as they move through the various stages of treatment.
- Pharmacotherapy is discussed in multidisciplinary teams, offered as appropriate, and monitored for safety, adherence, and response.

PROVIDING COMPREHENSIVE SERVICES

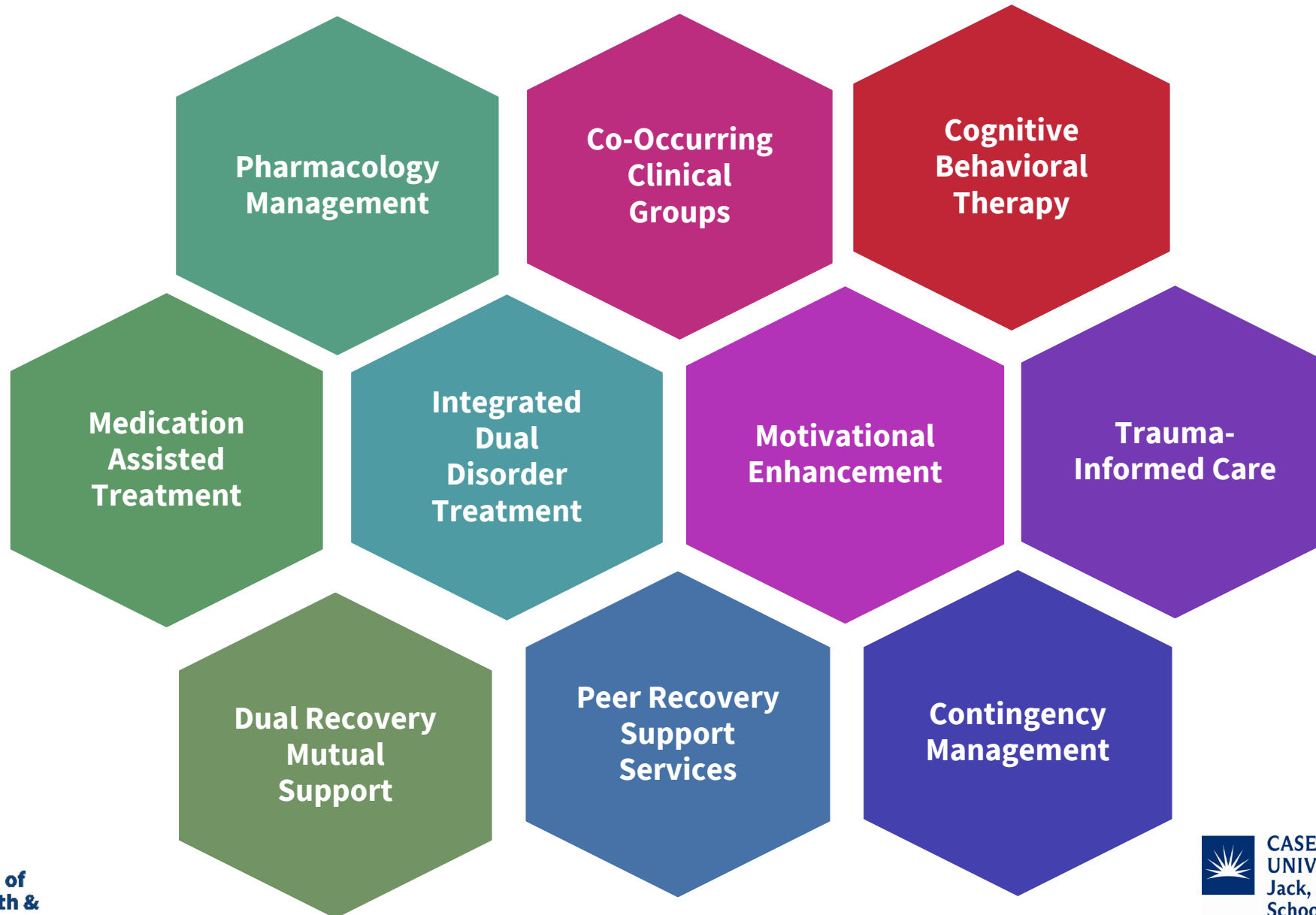


ENSURING CONTINUITY OF CARE

- Both SUDs and mental disorders frequently are long-term conditions, so treatment for people with CODs should take into consideration rehabilitation and recovery over a significant period of time.
- To prevent gaps in care it is ideal to include outreach, employment, housing, healthcare and medication, financial supports, recreational activities, and social networks in a comprehensive and integrated service delivery system.
- Coordination is imperative between treatment providers over an indefinite period of time to support progress, monitor symptoms, and respond to relapse or an increase in mental health symptoms.
- Research has found that good levels of continuity of care are associated with lower symptom severity, increases in functioning, a decrease in hospitalizations, and reduction in violent behaviors.
- To be effective treatment must be:



INTEGRATED INTERVENTIONS



CO-OCCURRING TREATMENT INTERVENTIONS

Cognitive Behavioral Therapy (CBT)	Motivational Enhancement	Contingency Management
<ul style="list-style-type: none"> • CBT is often applied in Substance Use Disorder specific treatment, mental health specific treatment settings and integrated treatment programs. • Identification of thoughts, emotions, behaviors, and situations that lead to substance use and impact mental health • Can be used to address multiple diagnoses at once 	<ul style="list-style-type: none"> • Developed to address problematic substance use • Approach for helping consumers develop intrinsic motivation for behavior change • A guiding style of communication • Designed to empower people to change by drawing out their own meaning • A respectful and curious way of being with people 	<ul style="list-style-type: none"> • Adjunctive treatment for reducing substance use and positive urine screens • Found to increase retention in treatment, primarily among patients with opioid and stimulant use. CM is associated with improved symptoms of depression and psychosis (Kelly, 2014). • Individuals are reinforced or rewarded for evidence of positive behavioral change.

CO-OCCURRING TREATMENT INTERVENTIONS

Dual Recovery Mutual Support	Peer Recovery Support Services	Co-Occurring Clinical Groups
<ul style="list-style-type: none">• A network of support in conjunction with clinical or psychosocial services.• Can aid in stigma reduction, support connectedness, & provide direction and acceptance.• Examples include:<ul style="list-style-type: none">Double Trouble RecoveryDual Disorders AnonymousDual Recovery AnonymousDual Diagnosis Anonymous	<ul style="list-style-type: none">• Provided by someone who is certified and has lived experience with mental health and/or substance use.• Can help improve long-term recovery by supporting abstinence or a reduction in use, decreasing inpatient services and hospitalization, and improving functioning.• Peer recovery supports are becoming a more formal part of the treatment team.	<ul style="list-style-type: none">• A powerful way for people with co-occurring disorders to learn about themselves, discover new skills, explore models of recovery, develop new values, cultivate social supports, and have the experience of helping others.• Provides space to explore the interaction between the co-occurring diagnoses.• Supports stigma reduction and allows for space to openly discuss symptoms with others who have similar experiences.

CO-OCCURRING TREATMENT INTERVENTIONS

Medication Assisted Treatment (MAT)	Pharmacology Management	Integrated Dual Disorder Treatment (IDDT)
<ul style="list-style-type: none"> • Food & Drug Administration (FDA) approved medications for the treatment of alcohol and opioid use disorders. • Normalize brain chemistry, block the euphoric effects & relieve physiological cravings. • Improve survival, retention in treatment, decrease illicit opiate use, improve ability to maintain employment and improves birth outcomes. 	<ul style="list-style-type: none"> • Medications can relieve distressing symptoms and improve functioning for people with mental illness and substance use disorders. • Pharmacology interventions are safe and effective for many individuals with CODs. • Referring to prescribers who capable of treating both mental health and substance use disorders is ideal. 	<ul style="list-style-type: none"> • Developed for the treatment of severe mental illness and severe substance use disorders. • It addresses both disorders at the same time, in the same service organization, by the same team of treatment providers. • Emphasizes that progress occurs incrementally and through small changes made over time.

INTEGRATED DUAL DISORDER TREATMENT

- The New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental and substance use disorders through integrated service delivery.
- It helps people address both disorders at the same time, in the same service organization and by the same team of treatment providers.
- Emphasizes individuals achieving goals (e.g., sobriety, symptom management) through a series of small, overlapping changes that occur over time.
- Individualized to address the unique circumstances of each person's life.
- The gold standard for co-occurring disorder treatment, specifically for those with severe and persistent mental illness & severe substance use disorder (Quadrant IV).

QUADRANT MODEL FOR CO-OCCURRING DISORDERS

Quadrant I

- Less severe mental health
- Less severe substance use

Quadrant II

- More severe mental health
- Less severe substance use

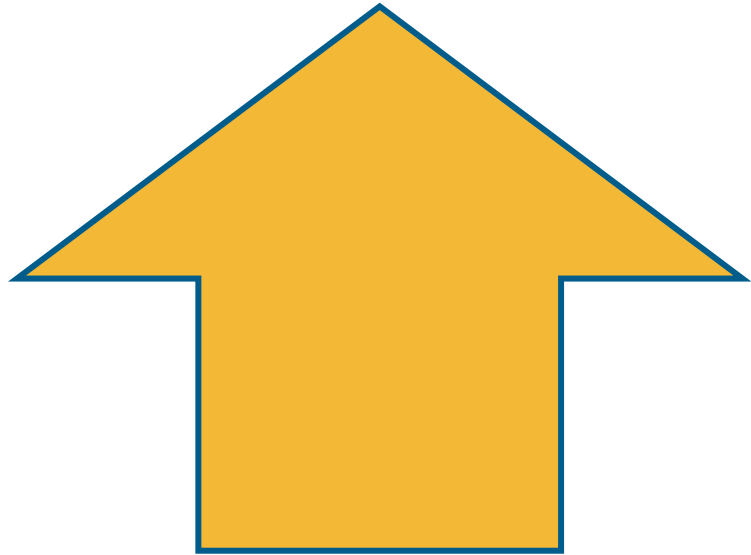
Quadrant III

- Less severe mental health
- More severe substance use

Quadrant IV

- More severe mental health
- More severe substance use

INTEGRATED DUAL DISORDER TREATMENT



IDDT Increases

- Continuity of care
- Consumer quality-of-life outcomes
- Stable housing
- Independent living



IDDT Reduces

- Relapse of substance use and mental illness
- Hospitalization
- Arrest/Incarceration
- Duplication of services
- Service cost
- Utilization of high-cost services

IDDT MODEL TREATMENT CHARACTERISTICS

Multidisciplinary Team

Stage-Wise Interventions

Comprehensive Services

Time-unlimited Services

Assertive Outreach

Motivational Interventions

Substance Use Counseling

Group Treatment

Family Psychoeducation

Pharmacological Treatment

Interventions to Promote Health

Secondary Non-Response
Interventions

Self Help Programs

SUMMARY

- Most substance use disorder treatment centers report having individuals with co-occurring disorders. However, only half report having co-occurring specific programming (SAMHSA, 2020).
- Co-occurring disorders are closely tied to socioeconomic and health factors that can challenge recovery. These factors include unemployment, homelessness, criminal justice involvement, and increased risk of suicide.
- The interaction of co-occurring disorders complicates diagnoses and will take time to establish.
- Integrated, stage-wise interventions improves treatment engagement, retention, and overall outcomes.

QUESTIONS?

MHA.OHIO.GOV

Your feedback is important to us!

QR CODE and LINK

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