Substance Abuse Treatment For Persons With Co-Occurring Disorders At A Glance*

Co-occurring disorders (COD) refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of COD occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. Many may think of the typical person with COD as having a severe mental disorder combined with a severe substance use disorder, such as schizophrenia combined with alcohol dependence. However, counselors working in addiction agencies are more likely to see persons with severe addiction combined with mild- to moderate-severity mental disorders; an example would be a person with alcohol dependence combined with a depressive disorder or an anxiety disorder. Efforts to provide treatment that will meet the unique needs of people with COD have gained momentum over the past 2 decades in both substance abuse treatment and mental health services settings.

TREATMENT

Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. **Integrated treatment reflects the longstanding concern within substance abuse treatment programs for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems**. As developed in the substance abuse treatment field, the recovery perspective acknowledges that recovery is a long-term process of internal change in which progress occurs in stages, an understanding critical to treatment planning**. In preparing a treatment plan, the clinician should recognize that treatment takes place in different settings (e.g., residential and outpatient) over time, and that much of the recovery process typically occurs outside of, or following, treatment (e.g., through participation in mutual self-help groups).**

Treatment planning begins with screening and assessment. The screening process is designed to identify those clients seeking substance abuse treatment who show signs of mental health problems that warrant further attention.

The use of proper medication is an essential program element, helping clients to stabilize and control their symptoms, thereby increasing their receptivity to other treatment. With the support of better medication regimens, many people with serious mental disorders who once would have been institutionalized, or who would have been too unstable for substance abuse treatment, have been able to participate in treatment, make progress, and lead more productive lives To meet the needs of this population, the substance abuse treatment counselor needs both greater understanding of the signs and symptoms of mental illness and greater capacity for consultation with trained mental healthcare providers. As substance abuse treatment counselors learn more about mental

illness, they are better able to partner with mental health counselors to design effective treatment for both types of disorders. Such partnerships benefit mental health agencies as well, helping them enhance their ability to treat clients with substance abuse issues

Strategies from the substance abuse field are being adapted for COD:

Motivational Interviewing (MI) is a client-centered, directive method for enhancing intrinsic motivation to change (by exploring and resolving ambivalence) that has proven effective in helping clients clarify goals and commit to change. MI has been modified to meet the special circumstances of clients with COD, with promising results from initial studies to improve client engagement in treatment.

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through the introduction of a planned and organized system of positive and negative consequences. It should be noted that many counselors and programs employ CM principles informally by rewarding or praising particular behaviors and accomplishments. Similarly, CM principles are applied formally (but not necessarily identified as such) whenever the attainment of a level or privilege is contingent on meeting certain behavioral criteria. Demonstration of the efficacy of CM principles for clients with COD is still needed.

Cognitive-Behavioral Therapy (CBT) is a general therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviors, and is aimed at achieving change in both. Cognitive-behavioral therapy uses the client's cognitive distortions as the basis for prescribing activities to promote change. Distortions in thinking are likely to be more severe with people with COD who are, by definition, in need of increased coping skills. Cognitive-behavioral therapy has proven useful in developing these coping skills in a variety of clients with COD.

Relapse Prevention (RP) has proven to be a particularly useful substance abuse treatment strategy and it appears adaptable to clients with COD. The goal of RP is to develop the client's ability to recognize cues and to intervene in the relapse process, so lapses occur less frequently and with less severity. RP endeavors to anticipate likely problems, and then helps clients to apply various tactics for avoiding lapses to substance use. Indeed, one form of RP treatment, Relapse Prevention Therapy, has been specifically adapted to provide integrated treatment of COD, with promising results from some initial studies.

Two outpatient models from the mental health field have been valuable for outpatient clients with both substance use and serious mental disorders: Assertive Community Treatment (ACT) and Intensive Case Management (ICM).

ACT programs, historically designed for clients with serious mental illness, employ extensive outreach activities, active and continuing engagement with clients, and a high intensity of services. ACT emphasizes multidisciplinary teams and shared decision-making. When working with clients who have COD, the goals of the ACT model are to engage them in helping relationships, assist them in meeting basic needs (e.g., housing), stabilize them in the community, and ensure that they receive direct and integrated substance abuse treatment and mental health services. Randomized trials with clients having serious mental and

substance use disorders have demonstrated better outcomes on many variables for ACT compared to standard case management programs. The goals of ICM are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client.

ICM has proven useful for clients with serious mental illness and co-occurring substance use disorders. (The consensus panel notes that direct translation of ACT and ICM models from the mental health settings in which they were developed to substance abuse settings is not self-evident. These initiatives likely must be modified and evaluated for application in such settings.) Residential treatment for substance abuse occurs in a variety of settings, including long- (12 months or more) and short-term residential treatment facilities, criminal justice institutions, and halfway houses. In many substance abuse treatment settings, psychological disturbances have been observed in an increasing proportion of clients over time; as a result, important initiatives have been developed to meet their needs.

The Modified Therapeutic Community (MTC) is a promising residential model from the substance abuse field for those with substance use and serious mental disorders. The MTC adapts the principles and methods of the therapeutic community to the circumstances of the client, making three key alterations: increased flexibility, more individualized treatment, and reduced intensity. The latter point refers especially to the conversion of the traditional encounter group to a conflict resolution group, which is highly structured, guided, of very low emotional intensity, and geared toward achieving self-understanding and behavior change. The MTC retains the central feature of TC treatment; a culture is established in which clients learn through mutual self-help and affiliation with the peer community to foster change in themselves and others. A series of studies has established better outcomes and benefit cost of the MTC model compared to standard services. A need for more verification of the MTC approach remains.

Returning to life in the community after residential placement is a major undertaking for clients with COD, and relapse is an ever-present danger. Discharge planning is important to maintain gains achieved through residential or outpatient treatment. Depending on program and community resources, a number of continuing care (aftercare) options may be available for clients with COD who are leaving treatment. These options include mutual self-help groups, relapse prevention groups, continued individual counseling, psychiatric services (especially important for clients who will continue to require medication), and ICM to continue monitoring and support. A carefully developed discharge plan, produced in collaboration with the client, will identify and relate client needs to community resources, ensuring the supports needed to sustain the progress achieved in treatment.

* Adapted from Substance abuse treatment for persons with co-occurring disorders. National Guideline Clearinghouse