

It is of great importance to address the problems of co-occurring disorders because of their high prevalence in both Substance Abuse (50-75%) and Mental Health settings (Substance Abuse and Mental Health Services Administration, Center For Substance Abuse Treatment, 2007). Flynn & Brown (2008) did further research that shows that these numbers have remained fairly constant since the last three decades. Depression and Anxiety are the most common disorder that is seen in populations with Substance Use Disorder (Walten-Moss, K., Kub, J., & Woodruff, K., 2008). Just as with Psychiatric Disorders, there are sex differences in Co-Occurring Disorders. According to the National Survey on Drug Use and Health Report: Co-Occurring Major Depressive Episode (MDE) and Alcohol Use Disorder among Adults" Feb 16, 2007, "Women were nearly twice as likely as men to have past year MDE (9.8 vs. 5.4 percent)"-" They are much less likely to have a diagnosis of APD. The reader is referred to additional resources on this topic by Clark.

Several causal factors have been described for the ways in which co-occurring disorders can arise. These routes include both distinct ways that Substance Use Disorders and Mental Health Disorders emerge independently, as well as overlapping risk factors (such as genetics, trauma, etc) that may promote their dual occurrence (NIDA: Topics in Brief: Comorbid Drug Abuse and Mental Illness, October, 2007). Nunes elaborates that Drug abuse increases the risk of Psychiatric Disorder and this interaction can go in the opposite direction. An example is the hypothesis that individuals become addicted by "self medicating" an underlying disorder. Impaired functioning in brain systems due to a Psychiatric Disorder may allow one to become more easily dependent on a substance. Substance abuse may interfere with Mental Health treatment which can worsen symptoms and exacerbate the disorder. Consequences of drug abuse (such as losses, health problems, etc) may precipitate a Psychiatric condition. Psychiatric symptoms may emerge as the result of intoxication or withdrawal. One condition may arise even when the other is dormant; this is frequently seen when substance use stops (Volkow, 2008).

Because of the complexity of these interactions, assessment and evaluation are crucial in both Mental Health and Substance abuse settings. Assessment must be ongoing due the protracted withdrawal syndrome that often occurs (Substance Abuse Treatment For Persons With Co-Occurring Disorders, 2007). Unfortunately, both mental health and substance abuse clinicians often stick with their own priorities, their knowledge and the training that they have received. This means that most substance abuse counselors may do mental health screenings, but not true mental health assessments (Walten-Moss, K., Kub, J., & Woodruff, K., 2008). By the same token, mental health professionals are often poorly informed of substance use disorders and the assessments used. Efforts are underway to bring attention to this situation and to address the imbalance. Increased education and certifications for both substance abuse and mental health clinicians has been increasing and can be expected to accelerate.

One crucial element of any assessment regards safety. This includes not only suicidality and self-harm, but also risk factors for relapse of substance abuse and psychiatric symptoms. Several sources point out that both alcohol and other drug intoxication and withdrawal can mimic psychiatric symptoms and lead to mis-diagnosis. Signs that there

may be an undiagnosed Psychiatric illness with substance abuse clients are: symptoms that persist after abstinence, if clients relapse while in treatment, and if there have been multiple treatment failures. There are many PsychoSocialAssessments that have been tailored to a particular agency. Most include the essentials: detailed histories concerning substance abuse and psychiatric symptoms as well as family histories. Collateral sources should be used as much as possible.

There are many good assessment instruments. The author assumes that the reader has some familiarity with the many available. For this reason, they will not be described in great detail. Simple and brief ones that are used in an interview include the CAGE (cut-down, annoyed, guilty, and eye opener) as well as the TWEAK (tolerance, worry, eye opener, amnesia, and cut down). Examples of tests include: PRISM, SCID IV, MMPI and the SASSI. Of course, assessment is integrally tied to treatment planning and treatment placement.

Our models of treatment placement have improved over time, just as our understanding has increased of the complexity of dual disorders. This has led to significant treatment improvements. Mental Health and Substance Abuse counselors had very distinct roles that often differed significantly. Over the past decades, greater emphasis has been placed on raising the bar for addiction providers and resulted in higher education, licensure and certification. Many "old school" addiction counselors have attained advanced degrees. These forces have propelled changes in treatment delivery.

Daley, D. D. & Moss, H. B. (2002) highlight three approaches to dual disorders. They partially reflect chronological changes. The most primitive model is the Sequential one. It posits that an individual can't benefit from treatment of another disorder until one is under control. This is difficult to manage since they both interact. In fact, mental health symptoms can become triggers for substance abuse. From a levels-of-care perspective, neither entity benefits due to poor outcomes and follow up.

The parallel model is somewhat better. The client is able to address both issues at the same time. However, they see different counselors, often at different agencies. There remains the problem of linkage so that both counselors can work in concert. Often, this is more easily accomplished in large agencies where physical proximity and joint staffings can help. However, those with personality disorders can easily split staff, especially when multi disciplinary communication is not strong.

Finally, there is integrated treatment. Many substance abuse treatment facilities have therapists who specialize in behavioral disorders and can work with clients there. The same holds true for mental health centers that often offer substance abuse treatment as an adjunct. And, of course, there are many mental health professionals who have mastered both (regardless of which arena they began in). In this model, everyone benefits and relapse rates are lower.

The treatment methods that have been suggested to address Co-Occurring Disorders differ little from standard practices. However, they must be tailored to the special needs

of this population. These approaches include: Cognitive Behavioral Therapy, Family Therapy, 12-Step Facilitation, Expressive Therapy, Individual Counseling, Contingency Management, Skills Training and Case Management (Daley & Moss, 2002). This author finds that Dialectical Behavior Therapy is useful with all Substance Abuse Patients, although it was primarily designed to treat individuals with Borderline Personality Disorder (Linehan, 1993).

Contingency Mgmt is especially useful when working with Axis II disorders. Rewards seem more effective than sanctions. These need not be expensive and can be in the reach of the budget of most treatment centers. This author has used certificates of achievement (attending AA/NA meetings, no missed days, etc.), serving a meal once a week (pizza, food platters, etc.) and these have also been effective with groups. This author also rewards a member who is making progress by being given the opportunity to choose the menu; this not only boosts self-esteem, but earns thanks of other group members. Tangible rewards include: books, bookmarks, stickers, magnets, etc. Sanctions to address non-compliance or disruptive behaviors include both behavioral contracts and homework.

Because over 93% of treatment centers in America use the 12-step model (Peele, 1996), they will be reviewed. The role of mutual support groups (Alcoholics Anonymous and Narcotics Anonymous) is valuable in offering social support as well as role models. However, special care must be taken with individuals suffering from co-occurring disorders. This clinician takes time to coach people prior to their attendance at their first meeting. They are informed that it is not necessary to disclose sensitive issues because meeting are not therapy. Of course, it is necessary to individualize the client's experiences in the groups based on their disorder and level of vulnerability. Some clients are required to share while others are discouraged. It is often suggested that client's attend "open" meetings with family or friends at first in order to lend support.

There are more choices of support groups than there have ever been. Two secular ones are: SMART Recovery, Secular Organizations for sobriety. Celebrate Recovery is a Biblically based support group. More importantly, there are four that address persons with Co-Occurring Disorders: Double Trouble In Recovery Anonymous, Dual Disorders Anonymous, Dual Recovery Anonymous and Dual Diagnosis Anonymous (Coombs, R. & Howatt, W. 2005).

The last area to be addressed is medication. SAMHSA highlights the need for an on-site psychiatrist to prescribe (Substance Abuse Treatment For Persons With Co-Occurring Disorders, A Treatment Improvement Protocol Number 42, 2007). This author has worked in two outpatient treatment settings in the past several years that were exclusively substance abuse. They both had Psychiatrists who saw every client weekly, regardless of secondary diagnosis or whether or not the individual was prescribed medications. This practice seems to be driven by Managed Care. These doctors had a great deal of experience, had common practices and educated the clinicians a great deal. Conversations with other counselors has demonstrated that these guidelines seem to be similar in other settings as well.

Unfortunately, there still remains a stigma against medication use in some treatment programs, particularly those with a strong emphasis on 12-step and faith-based models. SSRIs have shown to be very effective in treating depression, ruminating thoughts as well as sleep and anxiety; often these symptoms are conjoined (Practical Management Options for Alcohol Dependence: Co-Occurring Mental Disorders, 2007). Two prescription drugs that are safe for recovering people to take and that address sleep are Trazadone and Seroquel (Benadryl helps many). Ambien and Soma are to be avoided (based on feedback from Psychiatrists that the author has worked with). Experience has shown this clinician that results have been mixed using the following drugs with persons with co-occurring disorders: Benzodiazepines, Opiate replacement (Methadone and Buprenorphine) and Stimulants (Adderall and Ritalin).

There are several recommendations to conclude and summarize the findings on recognition, diagnosis and effective treatment of persons with co-occurring disorders. Substance Abuse Counselors and Mental Health Counselors need to be cross-trained to recognize and assess dual disorders. Treatment settings should be integrated and provide not only counseling, and case management, but several levels of care. They should also provide a prescribing physician. Therapy needs to be tailored to the needs of the individual. As the substance abuse field becomes better at identifying individual with co-occurring disorders, it is likely that the need for specialized treatment will continue to increase.

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