

## **The Recognition of Co-Occurring Disorders and the Provision of Treatment**

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Prior to the late 1970s, treatment was geared to meet the needs of clients suffering from a dependence on illicit drugs such as opioids and cocaine, in particular. Alcohol abuse is not illegal since alcohol could be purchased, with legal impunity. But alcohol also presents a major problem similar in many ways to an addiction to heroin.

During the past twenty-five years, the federal agency known as the Substance Abuse and Mental Health Services Administration (SAMHSA) came to recognize that a reasonable percentage of male and female clients, in treatment for substance use and alcoholism, were suffering at the same time with mental disorders. SAMHSA, therefore, proposed treatment for substance use and mental disorders, simultaneously. Utilizing the know-how of its Center for Substance Abuse Treatment (CSAT), SAMHSA presented its Treatment Improvement Protocol 42 (TIP 42) in which treatment guidelines for substance use and mental disorders called Co-Occurring Disorders (COD) were documented in some detail. (TIP 42 revised the earlier TIP 9). Clients with lengthy histories of illicit drug use may also have had mental disorders to which very little or no attention was paid. It is now accepted in the field of behavioral health that more than 50 percent of clients referred to treatment have been suffering from Co-Occurring Disorders. COD treatment can no longer be ignored. As a result, COD treatment programs have emerged throughout the length and breadth of the United States.

The provision of COD treatment is somewhat costly and requires adequate funding. Relying entirely on funding sources such as insurance carriers, presents an obstacle to the provision of COD treatment. But COD treatment has to be provided for fear of the negative behavioral costs to society. Some states such as New York and Maryland, for example, have determined that funding for COD treatment is in the best interest of their individual states. Nevertheless, state funding has limitations in that it does not meet the treatment needs of an entire state. Consequently, hundreds of clients survive in their communities without any form of treatment.

In addition to funding limitations is the cost of hiring certified and licensed clinical staff capable of providing the specialized and qualitative care needed by COD clients. Also, the type of clinical staff hired must, of necessity, be able to cope with the behaviors of clients diagnosed with a mental disorder while, at the same time, experiencing unmanageable feelings caused by cravings. It is, therefore, imperative that recruiters are mindful of the unique type of treatment counselors capable and willing to accept that the concerns of COD clients require a great deal of tolerance, tact and, most importantly, sensitivity.

Based on ten years of hands-on experience as the director of a COD program in Maryland, it has been extremely difficult to recruit counselors appropriately trained and credentialed. The result has been a negative impact on treatment outcomes. The ability to recruit the quality of clinical staff as a means of providing the level of treatment services is largely dependent on the willingness of treatment agencies to provide the level of remuneration commensurate with a prospective candidate's educational qualifications, training and years of experience in the field. Thus treatment programs are presented with a dilemma.

Who are the clients generally referred to COD treatment? In Maryland, many of the state's clients suffering from co-occurring disorders have criminal histories. About ten years ago, the state implemented a program acceptable to its criminal justice system that allows a percentage of its incarcerated population to request treatment in lieu of imprisonment. Through an inmate's public defender a request is made to the judge responsible for the inmate's incarceration for the inmate to be evaluated for treatment. If the judge is amenable to the request, he or she would write an HGA 8-505 Order allowing a qualified therapist to evaluate the inmate. (The evaluator has to be approved by the state's criminal justice system). The recommendation of the evaluator is then submitted to the judge. If the judge is in agreement with the evaluator's recommendation, he or she would write an HGA 8-507 Order referring the inmate to treatment. The signed order is then sent to the state's Behavioral Health Administration (BHA), which is an arm of the state's Department of Health and Mental Hygiene (DHMH). The DHMH is responsible for the provision of funding for COD treatment. It is also responsible for the state's certification and licensing body known as the Maryland Board of Professional Counselors and Therapists (The Board). The Board is legally empowered to protect the safety of the citizens of Maryland by ensuring that treatment personnel meet stringent criteria for certification and licensing.

The inmate's evaluation submitted to the judge by the qualified therapist provides a recommendation that is underpinned by the Patient Placement Criteria (PPC) of the American Society of Addiction Medicine (ASAM). The placement criteria is based on the information provided by the inmate to the evaluator, who determines the level of care according to ASAM guidelines for placing a client into residential or outpatient care as the case may be. Residential care utilizes Levels 111.1, 111.3, 111.5 or 111.7 (ASAM Criteria). The program for which I am responsible accepts clients into COD treatment that are considered Level 111.3 or Level 111.5 candidates.

What is offered in terms of COD treatment? The COD treatment model considered equipped to meet all of the needs of the COD client is "The Integrated Model". But while it provides high treatment retention rates and outcomes, it requires resources that are often beyond the financial reach of some programs. The Integrated Model requires COD treatment to be provided in a setting capable of meeting the needs of clients with substance use and mental disorders in addition to physiological problems. The ideal treatment environment for COD treatment using The Integrated Model is a building housing not only the COD program but also the psychiatric and medical departments. In a facility where the most important needs of the client are met, communication with all of the treatment providers involved with any given client's treatment ensures that comprehensive treatment is accessible to the client. The COD program for which I am responsible utilizes all of the resources in the facility to which any client is entitled. In addition to the care provided by the COD program, the medical and psychiatric departments, the facility has an aftercare coordination department. It also has a small education program that is designed to help clients study for their General Educational Development (GED) Diploma. The facility has a vocational department that provides clients with help to secure gainful employment after they have successfully completed their individual treatment. For the record, based on actual experience, COD clients who have completed their treatment and have made changes to their thought process and their previous maladaptive behaviors often find employment in the local community starting their lives anew with moral support from their close relatives.

The basis of the treatment model used in the program is an intensive treatment schedule that requires therapeutic group sessions four times per day. Such group sessions utilize Cognitive Behavioral Therapy and Motivational Interviewing, among other treatment methods. Clients are required to meet with their individual counselors on a regular basis during the course of a seven-day week. The program

operates on a 24/7 schedule, and every treatment emergency is dealt with. Medical emergencies are referred to the local hospital located less than a mile away. The program relies on its part-time psychiatrists to monitor prescribed psychotropic medications. Because the program provides ASAM Criteria Level 111.3/111.5 residential treatment, clients are monitored, closely. While the program is designed to utilize The Integrated Model, it also relies on a modified version of the classic therapeutic community where clients are obligated to monitor the irrational behaviors of their peers.

What are some of the reasons for those irrational or maladaptive behaviors? Having lived lives in households where there were very little in terms of structure and discipline, where there were constant conflict among family members, some clients have found it difficult to adjust to what may be termed a normal way of life when they have been given the opportunity to make the necessary positive adjustment. There is also the question of households in communities where there is no visible progress. Abusing drugs such as heroin and cocaine for many years impacts negatively on communities. The contribution of addicts to economy and society is negligible and the cost to provide treatment is prohibitive. But treatment has to be made available.

What are the most common combination of substance use and mental disorders? Most clients present with the bipolar disorder and cocaine abuse. Others present with major depression and heroin abuse. There is no hard and fast rule in that some clients present with a variety of mental disorders and substance abuse. Some diagnoses suggest that some mental disorders are substance-induced. Recorded in TIP 42 are "The Quadrants of Care" developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD). Of the quadrants, COD treatment, utilizing the Integrated Model, works well with quadrants 2 and 3. Quadrant 2 is viewed as more severe mental disorder/less severe substance disorder while Quadrant 3 is seen as less severe mental disorder/more severe substance disorder. Both quadrants of care fall within the treatment capabilities of a Level 111.3 or a Level 111.5 COD program. Quadrant 1 requires very little COD treatment while Quadrant 4 is inappropriate for Level 111.3/111.5 programs.

The provision of COD treatment is no easy task but it is now established that co-occurring disorders are quite common in the male and female population. This paper is an attempt to support the view that treatment has to take into consideration the reality that the vast majority of clients that have been using illicit drugs and alcohol also have mental disorders for which COD treatment is an absolute necessity.

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