Co-Occurring Disorders: A Basic Overview

What is meant by Co-Occurring Disorders (COD)? – Co-Occurring Disorders (COD) refers to two diagnosable problems that are inter-related and occur simultaneously in a person. The most common use of this term relates to co-occurring Substance Abuse (SA) and Mental Health (MH) disorders.

The prevalence of co-occurring disorders is evidently very high due to the close relationship between mental health and substance abuse issues:

"People with a mental disorder are more likely to experience a substance use disorder and people with a substance use disorder are more likely to have a mental disorder when compared with the general population." – SAMHSA

[All quotes for this overview are derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) webpage on co-occurring disorders] http://www.samhsa.gov/disorders/co-occurring

A Brief History of COD treatment:

- Early on in the substance abuse treatment field, mental health was often minimized if not totally ignored. The presence of mental health symptoms at that time could prevent admission to substance abuse treatment. Psychiatric medications were often not allowed and just seen as "using drugs to treat drugs" which was at times forbidden in both treatment and in the 12 step support group community. Often, the exact opposite situation was happening in mental health treatment settings as substance abuse was often minimized, overlooked or simply ignored in favor of focusing only on mental health as the primary issue. (Sadly, this one-sided viewpoint still occurs today in some mental health and substance abuse treatment settings)

  "In many cases, people receive treatment for one disorder while the other disorder remains untreated" – SAMHSA

- With time, it became increasingly evident that many individuals with more serious mental disorders needed additional substance abuse treatment because of the prevalence of substance abuse within the chronically mentally ill population. Programs were created for the treatment of the Mentally Ill, Chemically Addicted (MICA) population. Many of these MICA programs only catered to people with more serious, persistent and obvious mental illness. Higher functioning individuals with less chronic and severe mental health symptoms often did not fit in well to MICA programs. Overall, treatment options for co-occurring mental health and substance use disorders was still very limited.

- Eventually, it became evident that MICA programs were not enough. Many individuals with both mental health and substance abuse disorders still needed treatment services but were too high functioning for MICA programs designed specifically for the chronically mentally ill. Depending upon one's perspective however, often there was a divide with regard to how to treat these client's co-occurring mental health and substance abuse issues. The mental health field had the perspective of treating only the mental health with the view that substance abuse once mental health was stabilized. The substance abuse field had the opposite view, theorizing that sobriety itself would directly result in improved mental health. Therefore, the type of treatment setting usually dictated which issue was perceived as the primary concern and which disorders were overlooked.

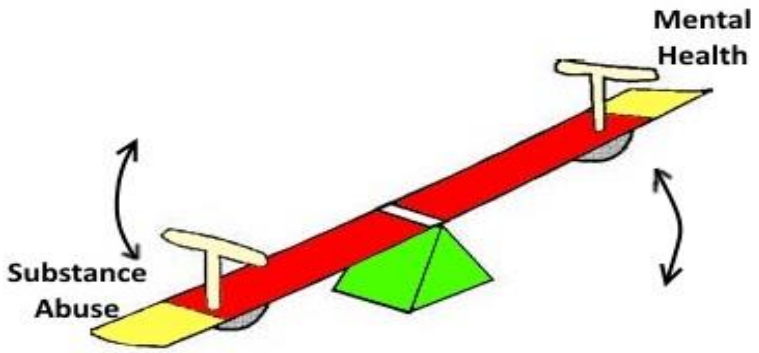
Question – *What problems may arise when only looking at one issue at a time when there are co-occurring mental health and substance abuse disorders?*

Answer: Sometimes the "one-sided" approach works. Sometimes a person goes through substance abuse treatment, stops abusing drugs and then mental health also improves. Also, there are instances when a person gets help for their mental health and with time they stop abusing drugs and alcohol as their mental health improves. These things do happen, but unfortunately when it comes to co-occurring disorders, these types of situations can be the exception as opposed to the norm.

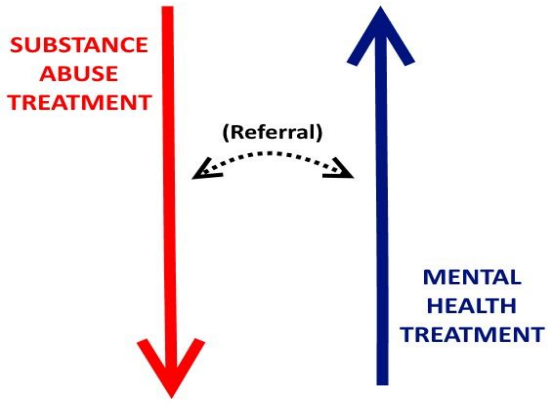
Quite often when mental health (MH) and substance abuse (SA) disorders are both present and co-occurring, these MH and SA issues can have a reciprocal relationship. For example, struggles with anxiety (MH) can trigger an increase in the use of illicit drugs (SA) as a means to try to cope. Conversely, for example, long term abuse of alcohol and other drugs (SA) can trigger a major depressive episode (MH). Therefore when treating co-occurring mental health and substance use disorders focusing on only one issue at a time can limit a person's capacity to effectively recover.

Treating just mental health alone while ignoring substance abuse or treating substance abuse alone while ignoring mental health can be futile when these issues are inter-related as they so often are.

To Illustrate: only focusing on one side at a time can end up having a "see-saw" like effect as the side focused on may start to improve yet the ignored, untreated aspect may get worse at times going back and forth. The obvious solution for these co-occurring disorders is to treat them both at the same time in a "balanced", integrated manner



- Next came the concurrent services approach (Parallel Treatment) which involved MH providers referring out to SA specialists for SA issues and SA providers referring out to MH specialists for MH issues. This was a move in the right direction because both MH and SA issues were being treated at the same time. However, they still were not being treated together.



Question: ***What problems & barriers are likely to occur with the parallel services approach?***

Answer – It is extremely difficult to treat people in two different settings. Communication and coordination of services between two sites is a constant obstacle to work around. Getting a client to comply with attending one treatment setting can be tough in itself, getting the client to attend two separate sites can be virtually impossible. Usually when faced with two counselors, most clients ended up sticking just with the one setting they felt most comfortable with and dropping out of the other setting.

Finally – **The Integrated Treatment Model** – This involves treating both mental health and substance use disorders simultaneously at the same facility.

What is needed for integrated substance treatment of co-occurring disorders?

- Psychiatrists who understand addiction who are willing to treat client's with COD's with psychotropic medication even at times when the client is not necessarily 100% sober
- Dual-trained clinicians and supervisors who have training and a working knowledge and understanding of both MH and SA treatment techniques and evidence-based practices
- Acceptance of medication assisted treatment for substance abuse
- Dual-focused, co-occurring group curriculum and treatment plans, fully integrating both MH and SA as interrelated issues throughout the entire course of treatment
- Recovery-oriented care: Using a client-centered approach that views recovery as an ongoing, multi-faceted process (as opposed to rapid discharges for "noncompliant" clients)

A common issue that can come up when working with COD's is the "Chicken/egg issue" - Which came first the chicken or the egg? Which issue is the "primary"? Is the substance abuse causing mental health problems or is an underlying mental health issue triggering substance abuse and self-medication; (Using alcohol and/or non-prescribed drugs as a means to cope with problems such as depression, anxiety, feelings, etc.) Time is often needed to improve understanding, but even with time there are no guarantees. There often are no easy answers as there can be a wide spectrum with regard to the relationship and prevalence of mental health vs. substance abuse. See diagram below:

The Four Quadrant Framework for Co-Occurring Disorders

A four-quadrant conceptual framework to guide systems integration and resource allocation in treating individuals with co-occurring disorders (NASMHPD,NASADAD, 1998; NY State; Ries, 1993; SAMHSA Report to Congress, 2002)

COD's can be extra challenging to diagnose and treat: Many symptoms that appear can be directly linked to a mental health condition, a substance use disorder, or both, so it can be difficult to tell.

"Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity" - SAMHSA

What are some examples of symptoms that can be linked with either MH or SA disorders?

- Depressed mood or sadness
- Isolation
- Feelings of worthlessness
- Feelings of helplessness
- Low self esteem
- Racing thoughts
- Paranoia
- Poor concentration
- Mood swings
- Anger issues
- Decline in work or school performance
- Difficulty focusing
- Family arguments
- Social problems and relationship problems
- Irritability
- Sleep disturbance
- Impulsivity
- Decrease in motivation
- Insomnia or hypersomnia
- Poor appetite
- Weight loss
- Overall life unmanageability
- Poor judgment, reckless behavior and poor decisions
- Anti-social or oppositional-defiant behavior/attitude

An Additional Challenge: Motivation and insight levels can vary with COD's

For example, a client may recognize and want help with his mental health but have no interest in changing his substance use. Conversely, someone may want to stop abusing substances but have no interest in addressing depression, anxiety or other mental health conditions present. Even more challenging, a person may have limited insight or motivation with regard to *both* MH and SA issues.

Brief overview of a few common MH disorders that may often co-occur with SA disorders in COD treatment:

- Depressive Disorders – Characterized by depressed mood, poor motivation, sleep and appetite problems, decreased motivation, suicidal thoughts, hopelessness or worthlessness
- Bipolar/Mood Disorders – Characterized by severe or unpredictable mood swings, both manic and depressive episodes, impulsivity, out of control pleasure seeking
- Anxiety Disorders – Racing thoughts, excessive worry, poor concentration, restlessness – Specific types: Generalized, OCD, Social Phobia, Panic Disorder
- Trauma – Posttraumatic Stress Disorder (PTSD), Abuse/Neglect history/victimization
- ADHD – poor attention, difficulty focusing, distractibility, restlessness

Integrated treatment for COD's doesn't end with just looking at MH and SA issues: Physical and medical conditions can be a critical element of treatment as well as any other persistent and difficult life challenge such as unemployment, family conflicts, homelessness, etc. Treatment of the whole person should be fully integrated into a comprehensive recovery-oriented system of care. Integrated treatment is advancing to include more and more issues to make sure to look at the whole person

"People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental and substance use disorders at the same time, often lowering costs and creating better outcomes." - SAMHSA

"Integrated Treatment programs help consumers develop hope, knowledge, skills, and the support they need to manage their problems and to pursue meaningful life goals." – SAMHSA

Coexisting Issues and Integration – The Escalator approach uses the term "Coexisting Issues" (COI) instead of Co-Occurring Disorders (COD) because coexisting issues implies inclusion of more than just mental health and substance abuse. The treatment world is continuously moving more and more toward full integration of a vast array of treatment services for the whole person. This includes providing integrated treatment for mental health, substance abuse, physical health, medical care, employment, housing, etc. as these issues are inter-related and better served in a cohesive and coordinated manner

For further explanation of the concept of Coexisting Issues click: **What are Coexisting Issues?**