Integrated Dual Disorder Treatment for Co-occurring Disorders (COD: IDDT)

An Evidence-Based Practice

The Presenter

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What We Will Cover Today

1. Definition of evidence-based practices
2. Substance and Mental Health Disorders
3. What co-occurring disorders are, how prevalent they are, and how serious they are
4. How co-occurring disorders have been approached in the past and how beneficial the different approaches have been
5. Common problems faced by consumers with co-occurring disorders

6. A description of integrated care
7. Categories of treatment programs
8. Principles and practice standards
9. Medication issues
10. Examples of EBPs for CODs
11. Recovery
12. Questions and comments

Evidence-Based Practices (EBPs)

- A clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting consumers achieve their desired goals or outcomes
- 3 components:
  - The highest level of scientific evidence
  - The clinical expertise of the practitioner
  - The choices, values and goals of the consumer

- **Promising practices** - show potential for positive results and or have significant evidence or expert consensus for their use
- **Emerging practices** - innovative practices that deal with specific needs, but are not supported by the strongest scientific evidence

Defining Mental Illness

Clinical definition :

- Clinically significant behavioral problems
- Associated with distress (painful symptoms)
- Causes disability (impairment in functioning)
- A biological illness that responds to treatment
- Not to be confused with weakness of character

Facts about Mental Illness

- Has nothing to do with intelligence
- Can happen to anyone
- Chronic but not contagious
- Difficult to diagnose and to treat
- Treated but not cured
- People with mental illnesses are not all dangerous
- Should not be confused with terms psychopath or sociopath

Substance-Related Disorders

- The taking of a drug of abuse
- The side effects of a medication
- Toxin exposure
- Substance Use Disorders
  - Substance Dependence
  - Substance Abuse
- Substance-Induced Disorders

Substance Abuse Criteria

1 or more in same 12-month period, significant impairment or distress

- A. Maladaptive pattern of use:
  - Recurrent substance use resulting in failure to fulfill major role obligations at work, school, home
  - Recurrent use in situations of physical hazard
  - Recurrent substance-related legal problems
  - Continued use despite persistent or recurrent social/interpersonal problems related to use
- B. Never met criteria for dependence for this class of substance

Substance Dependence Criteria

3 or more in 12-month period

- Tolerance
  - more or diminished effects
- Withdrawal
  - characteristic syndrome
- Taken in larger amounts/longer time intended
- Persistent efforts to cut down or control use
- Much time spent obtaining, using, recovering
- Important activities given up to use
- Continued use despite negative effects

Neurological Effects of Substance Use

- Chemical changes in neurotransmitters
- Physical effects
- Affective responses

View DVD Disc 2

Common Factors of Mental Illness and Substance Abuse

- Brain disorders
- Lack of insight
- Chronic
- Impacts family
- Shame and guilt
- Require treatment

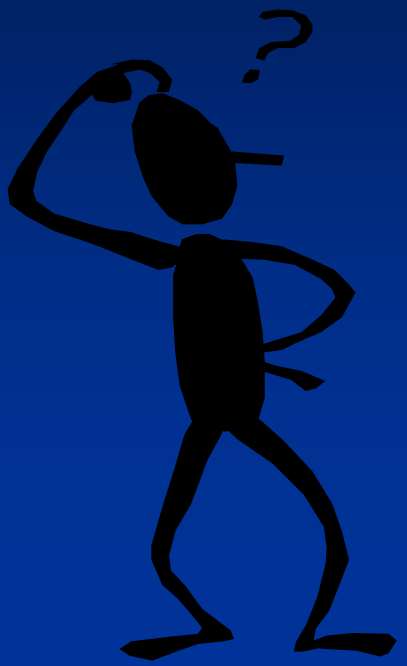
What are co-occurring disorders?

- Mental illness and substance use disorder occurring together in one person
- The term “Co-occurring Disorders” refers to *substance use* (abuse or dependence) and *mental* disorders occurring *together* in one person.
- Consumers who have co-occurring disorders
  1. one or more disorders relating to the use of alcohol and/or drugs of abuse *and*
  2. one or more mental disorders

- At least *one* disorder *of each type* must be established *independently of the other* and is not simply a cluster of symptoms resulting from one disorder (or one type of disorder).

Why focus on dual disorders?

- Substance use disorders are common in people with severe mental illness
- Mental illness is common in people with substance use disorders
- Dual disorders lead to worse outcomes and higher costs than single disorders



Adverse Outcomes

- Numerous health and social problems requiring costly care
- Risk for homelessness and incarceration
- Women are at risk of being victims of sexual abuse and domestic violence
- Parents with co-occurring problems risk encounters with child welfare

Outcomes Related to CODs

- More rapid progression from initial use to substance dependence
- Poor adherence to medication
- Decreased likelihood of treatment completion
- Greater rates of hospitalization
- More frequent suicidal behavior
- Difficulties in social functioning
- Shorter time in remission of symptoms

Trauma/Abuse & Co-Occurring Disorders

(*NEDS, National Treatment Improvement Evaluation Study)*

- 74% of consumers were victimized prior to substance abuse treatment
- 65% committed violent acts
- 72% of men and 50% of women committed acts of violence
- 74% of men and 73% of women were victimized prior to treatment

Offenders with Co-Occurring Disorders

- Persons with CODs repeatedly cycle through the criminal justice and treatment systems
- Likely to experience problems when not taking medication, not in treatment, experiencing mental health symptoms, using alcohol or drugs
- Use of even small amounts of alcohol or drugs may trigger recurrence of mental health symptoms

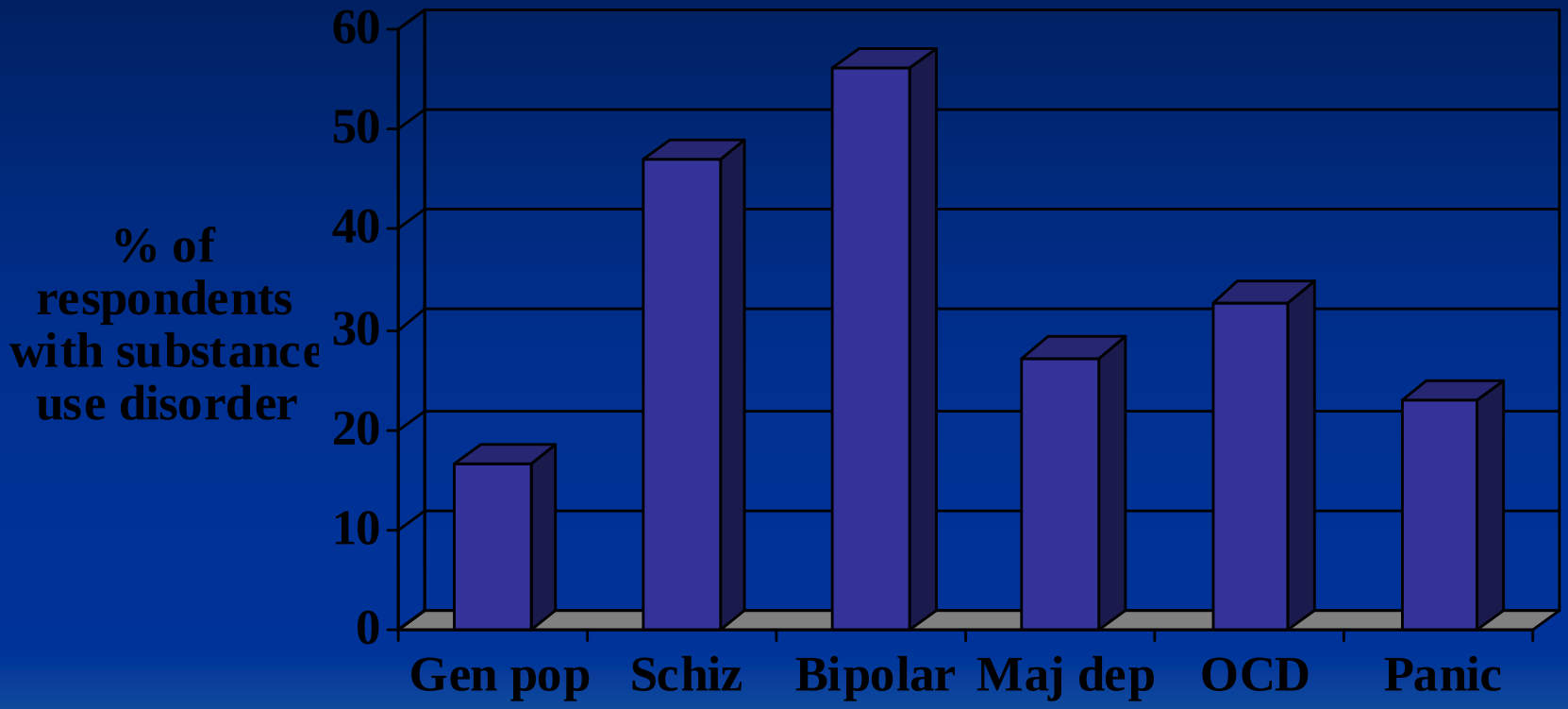
Prevalence of CODs in treatment Settings

- Studies in substance abuse settings have found that from **50% to 75%** of consumers had some type of mental disorder
- Studies in mental health settings have found that between **20% 50%** of their consumers had a co-occurring substance use disorder
- Experts in this field assert that co-occurring disorders should be ***the expectation, not the exception*** in any behavioral health care setting

Substance abuse is common in people with mental illness

- Over 50% of people with schizophrenia, bipolar disorder and other severe mood disorders have a substance use disorder at some time in their life
- About one third of people with anxiety and depressive disorders have a substance use disorder at some time in their life

Prevalence of CODs



How Serious are Co-occurring Disorders?

- Consumers with co-occurring disorders require more *complex* and *expensive* care
- Consumers with co-occurring disorders tend to have more problems of *all* kinds (medical, legal, social, interpersonal, homelessness, etc.), and more (and more expensive) contacts with agencies and providers (mental health, drug & alcohol, law enforcement, courts, emergency rooms, social welfare, shelters, etc.)
- Consumers with co-occurring disorders tend to “fall through the cracks” of the traditional treatment system and develop even worse and more expensive problems

Dual disorders lead to worse outcomes than single disorders

- Relapse of mental illness
- Treatment problems and hospitalization
- Violence, victimization, and suicidal behavior
- Homelessness and Incarceration
- Medical problems, HIV, & Hepatitis risk behaviors and infection
- Family problems
- Increase service use and cost

Adverse Childhood Experiences

Growing up (prior to age 18) in a household with:

- Recurrent physical abuse
- Recurrent emotional abuse
- Sexual abuse
- A family member who abuses alcohol or drugs
- A household member who has been incarcerated
- Someone who has chronic depression, suicidality, has been institutionalized or has a mentally illness
- A Mother who has been experienced violence
- One or no parents
- Emotional or physical neglect

- Many studies link childhood trauma to both mental illness and addiction

What Approaches to Treating Co-occurring Disorders Have Been Tried?

Four general approaches have been tried:

1. **Not at all**—referred out to treatment for the other problem or refused care entirely
2. **Serial Treatment**—one type of disorder treated at a time, in separate settings
3. **Concurrent** or **Parallel Treatment**—treatment for both types of disorder offered at the same time but in separate settings and by separate providers
4. **Integrated Treatment**—both types of disorder assessed and treated together in specialized settings by providers possessing competency in the treatment of both types of disorder *and* integrated treatment

How Beneficial Are These Approaches?

- **No Treatment At All:**
  - Denial of treatment is, of course, ineffective. It is also unethical and could result in legal liability.

- **Serial Treatment:**
  - Serial Treatment can worsen problems or create new ones:
    - Confusion due to conflicting treatment philosophies held by different providers
    - Confusion due to conflicting treatment recommendations or priorities
    - Treatment gaps arising due to communication problems between/among providers
    - Practical considerations such as scheduling, transportation, etc.

- **Concurrent or Parallel Treatment:**
  - As with serial treatment, this approach can worsen problems or create new ones:
    - Confusion due to conflicting treatment philosophies held by different providers
    - Confusion due to conflicting treatment recommendations or priorities
    - Treatment gaps arising due to communication problems between/among providers
    - Practical considerations such as scheduling, transportation, etc.
    - High drop-out rates
    - Less than 10% get both services

Consumers often fall between the cracks

Integrated Treatment

- A relatively recent development
- Essential for consumers who are significantly impaired by both kinds of disorder
- Essential for consumers whose mental disorder interferes with treatment of their substance use disorder
- Essential for consumers whose substance use disorder interferes with treatment of their mental disorder
- Beneficial for *all* consumers with co-occurring disorders due to its ability to avoid problems seen with other models (provider conflicts, poor provider communication, consumer confusion, scheduling or transportation problems, etc.)

Integrated Dual Disorders Treatment (IDDT)

- Treatment of substance use disorder and mental illness together
  - Same team
  - Same location
  - Same time

IDDT

- The consumer participates in *one* program that provides treatment for *both* disorders
- The consumer's mental and substance use disorders are treated by the *same* clinicians
- Clinicians are trained in psychopathology, assessment, and treatment strategies for *both* mental *and* substance use disorders
- Clinicians offer substance abuse treatments tailored for consumers who have severe mental disorders

Integrated Treatment

- The focus is on preventing anxiety rather than breaking through denial
- Emphasis is placed on trust, understanding, and learning
- Treatment is characterized by a slow pace and a long-term perspective
- Providers offer stage-wise and motivational counseling

- Supportive clinicians are readily available
- Twelve-Step groups are available to those who choose to participate and can benefit from participation (e.g., Double Trouble)
- Neuroleptics and other pharmacotherapies are indicated according to consumers' psychiatric and other medical needs

Categories of COD Programs

- Dual Diagnosis *Capable* (DDC-CD or DDC-MH).
  - DDC-CD Welcomes individuals with chemical dependency (CD) whose conditions are stable; makes provision for comorbidity in program mission, screening, assessment, treatment planning, staff training, etc.
  - DDC-MH is similar to the above in a mental health (MH) treatment setting.
- DDE=Dual Diagnosis *Enhanced* (DDE-CD or DDE-MH).
  - DDE-CD is a CD program that is enhanced to accommodate individuals with subacute symptomatology or moderate disability; enhanced MH staffing and programming, etc.
  - DDE-MH is similar to the above in a MH setting.

COD Program Models

- Continuous Integrated Case Management
- Continuous Recovery Support
- Emergency Triage/Crisis Intervention
- Crisis Stabilization Beds
- Psychiatric Inpatient Unit or Partial Hospital
- Detoxification Programs
- Psychiatric Day Treatment
- Addiction Intensive Outpatient (IOP), Partial, Residential
- Psychiatric Housing Programs:
  - Abstinence-expected (dry)
  - Abstinence-encouraged (damp)
  - Consumer-choice (wet)

Principles and Standards of Care (Minkoff)

The Nine Principles:

1. Dual diagnosis is an *expectation*, not an exception.
2. The population of individuals with co-occurring disorders can be organized into *four subgroups* based on high and low *severity* of each type of disorder.
3. Treatment success involves formation of empathic, hopeful, integrated treatment relationships.

4. Treatment success is enhanced by maintaining integrated treatment relationships providing disease management interventions for *both* disorders *continuously* across multiple treatment episodes, balancing case management support with detachment and expectation at each point in time.
5. Integrated dual primary diagnosis-specific treatment interventions are recommended.
6. Interventions need to be matched not only to diagnosis, but also to phase of recovery, stage of treatment, and stage of change.

7. Interventions need to be matched according to level of care and/or service intensity requirements, utilizing well-established level of care assessment methodologies.
8. There is no single correct dual diagnosis intervention, nor single correct program. For each individual, at any point in time, the correct intervention must be individualized, according to subgroup, diagnosis, stage of treatment or stage of change, phase of recovery, need for continuity, extent of disability, availability of external contingencies, and level of care assessment.
9. Outcomes of treatment interventions are similarly individualized, based upon the above variables and the nature and purpose of the intervention. Outcome variables include not only abstinence, but also amount and frequency of use, reduction in psychiatric symptoms, stage of change, level of functioning, utilization of acute care services, and reduction of harm.

The Eight Practice Standards

1. **Welcoming Expectation**
   - Expect comorbidity and engage consumers in an empathic, hopeful, welcoming manner.
2. **Access to Assessment**
   - Access to services should not require consumers to self-define as MH or SUD before arrival; eliminate barriers; deny no consumer treatment based on disorders.
3. **Access to Continuing Relationships**
   - Initiate and maintain empathic, hopeful, continuous treatment relationships—even if treatment recommendations are not followed.
4. **Balance Case Management and Care with Expectation, Empowerment, and Empathic Confrontation**

5. Integrated Dual Primary Treatment

- Each disorder receives appropriate diagnosis-specific and stage-specific treatment, regardless of the status of the comorbid condition

6. Stage-Wise Treatment:

- Acute Stabilization
- Motivational Enhancement
- Active Treatment
- Relapse Prevention
- Rehabilitation and Recovery

7. Early Access to Rehabilitation

- Consumers who request assistance with housing, jobs, socialization, and meaningful activity are provided access even if they are not initially adherent to MH or SUD treatment recommendations.

8. Coordination and Collaboration

- Consistent collaboration between all treaters, family caregivers, and external systems is required.
- Collaboration with families should be considered an expectation for all individuals at all stages of change.

Scientific Evidence for Integrated Treatment

- More effective than separate treatment
- Studies show integrated treatment is more effective than traditional separate treatment
  - IDDT improves abstinence
    - Abstinence leads to improvements in other outcomes:

- Reductions in institutionalization
- Reductions in symptoms, suicide
- Reductions in violence, victimization, legal problems
- Improved physical health
- Improved functioning, ability to work
- Improved relationships and family functioning

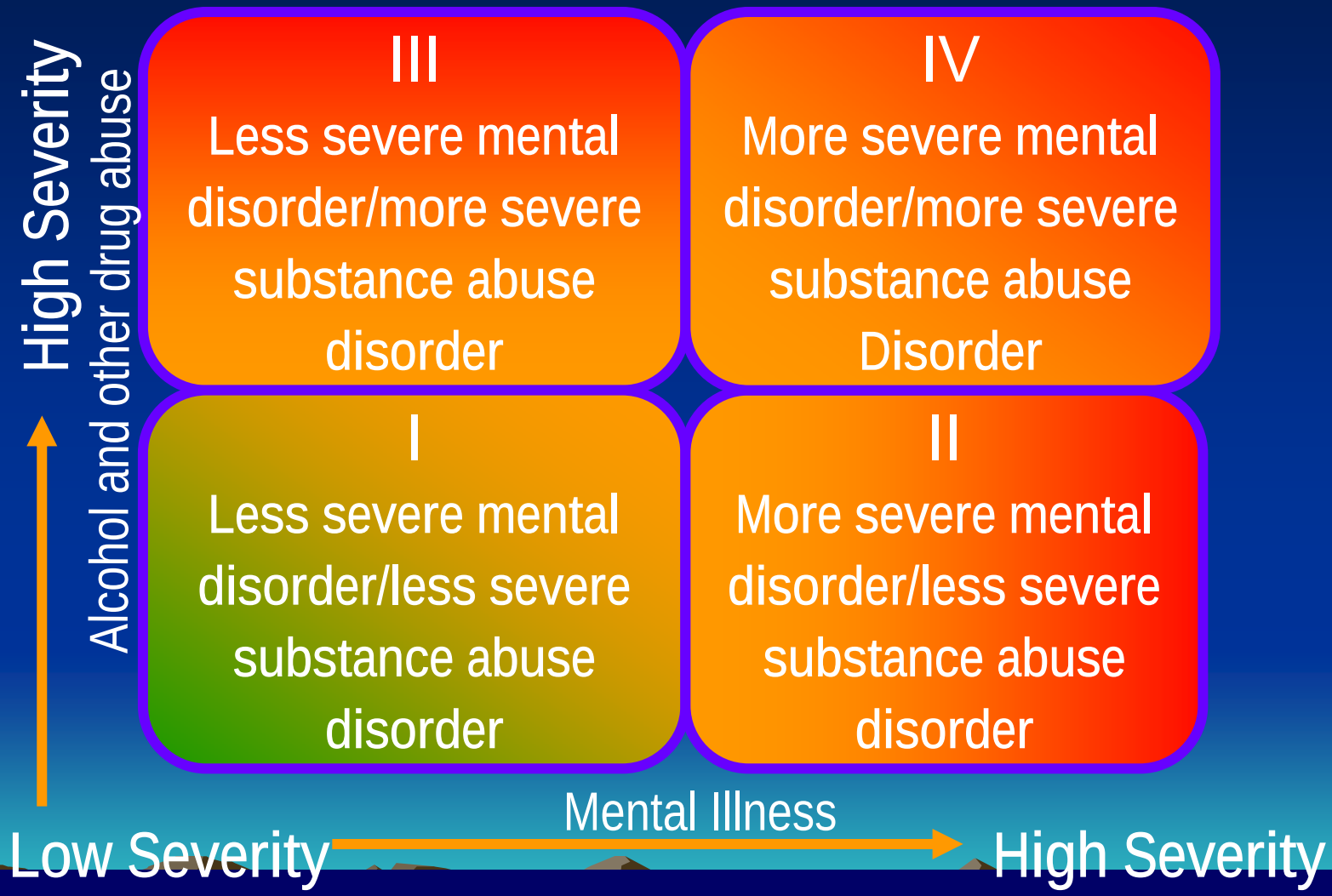
System Goals

- To create a clinical delivery system in which there is **“no wrong door”** to the most appropriate treatment and recovery supports for people with co-occurring mental illness and substance use conditions who present for treatment
- To develop **enduring linkages** between service providers or treatment units with a key system, or **across multiple systems**, to facilitate the provision of services to individuals at the local level

- Establish an integrated approach to service delivery for persons with co-occurring mental illness and substance use disorders
- Create an integrated treatment system in which mental health treatment and substance abuse treatment are brought together by two or more clinicians/support workers working for different treatment units or service providers

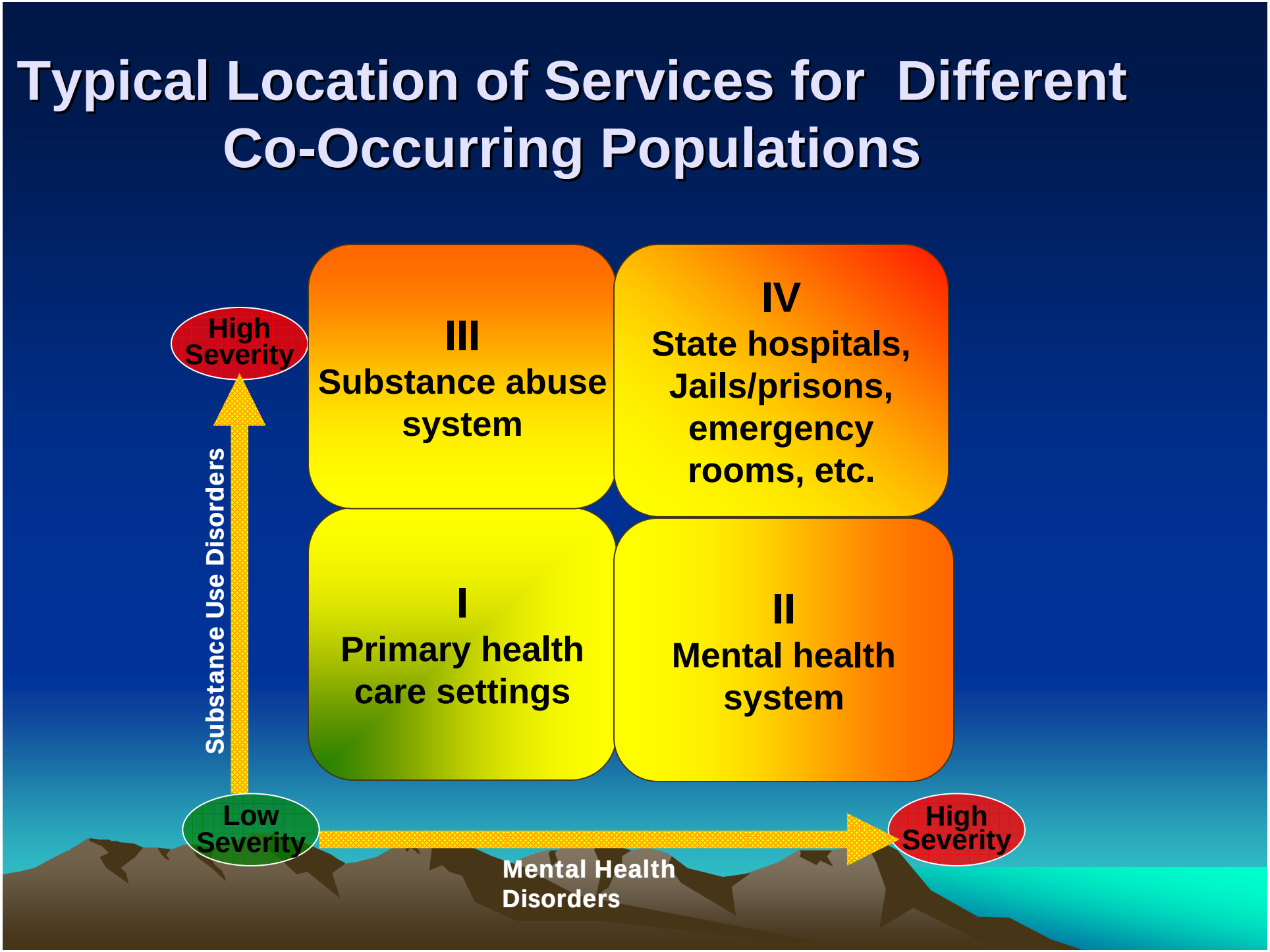
- Screen all individuals who present for treatment in partner agencies for the presence of co-occurring disorders
- To improve Clinical outcomes of consumers with CODs in both systems through:
  - Improved communication
  - Training in the areas of screening, admission and referrals
  - Treatment planning
  - Continuum of care

The Four Quadrants

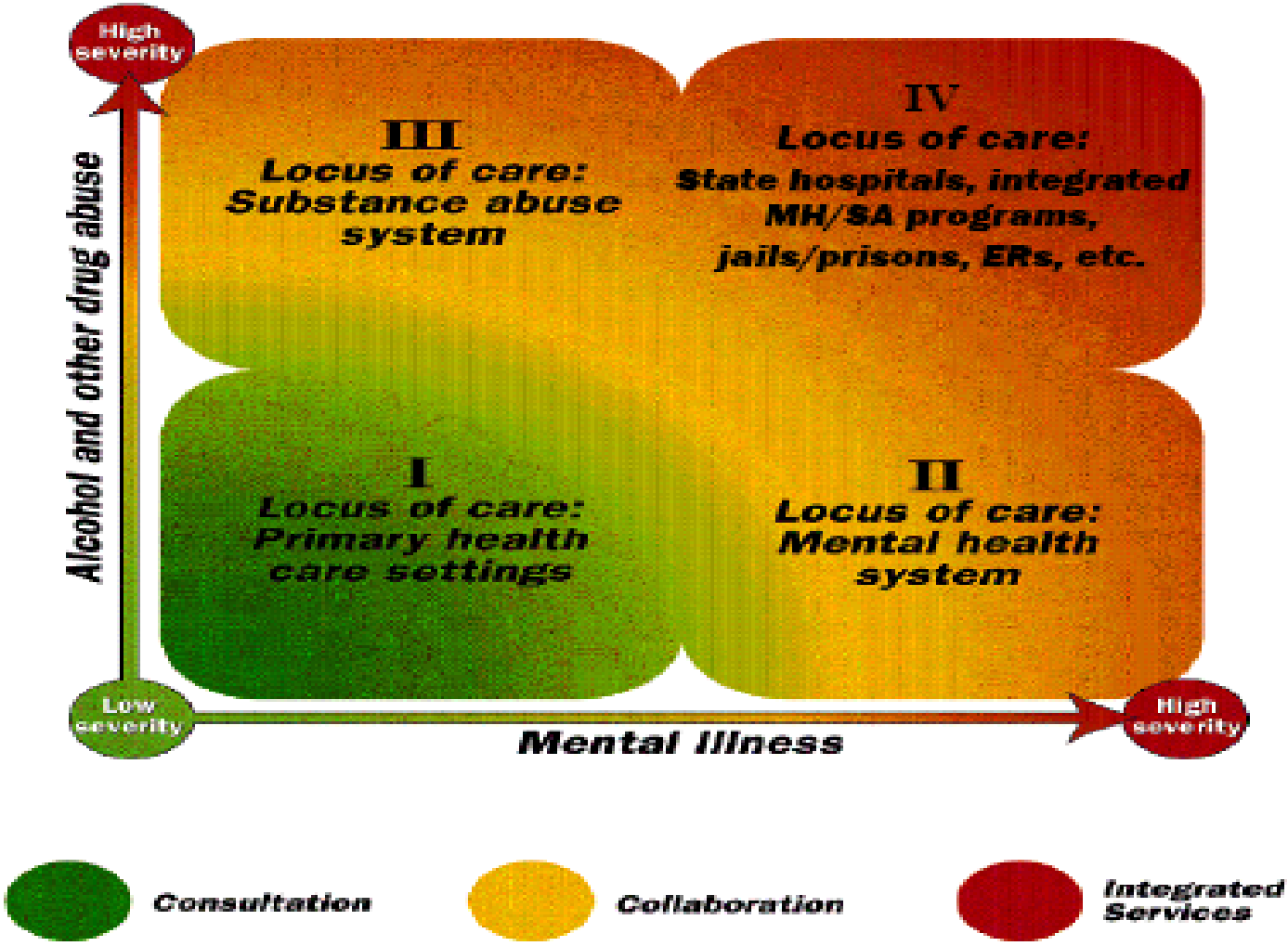


NASMPHD/NASADAD (1999).

Typical Location of Services for Different Co-Occurring Populations



Service coordination by Severity



Service Coordination by Severity

- **Level I Consultation:** Informal relationships among providers that ensure both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention, and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.
- **Levels II/III Collaboration:** More formal relationships among providers to ensure both mental illness and substance abuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co-occurring disorders and contribute to service delivery.
- **Level IV. Integrated Services:** Relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen.

Principles of IDDT

- Integrated
  - Same team of dually trained people
  - Same location of services
  - Both disorders treated at the same time
- Long-term perspective
  - Goal: sustained abstinence
  - Occurs over a period of years for most people
  - Vulnerability to relapse
- Comprehensiveness
  - Recovery → Meaningful life
  - Different interventions for:
    - Specific outcomes
    - Specific stages
    - Specific subgroups

- Algorithms
- Assertiveness
  - Outreach
  - Services delivered in community, jail, homeless shelters, hospitals
  - No terminations; algorithms instead
- Stage-wise services
  - Different services offered at different stages of treatment

Components of IDDT

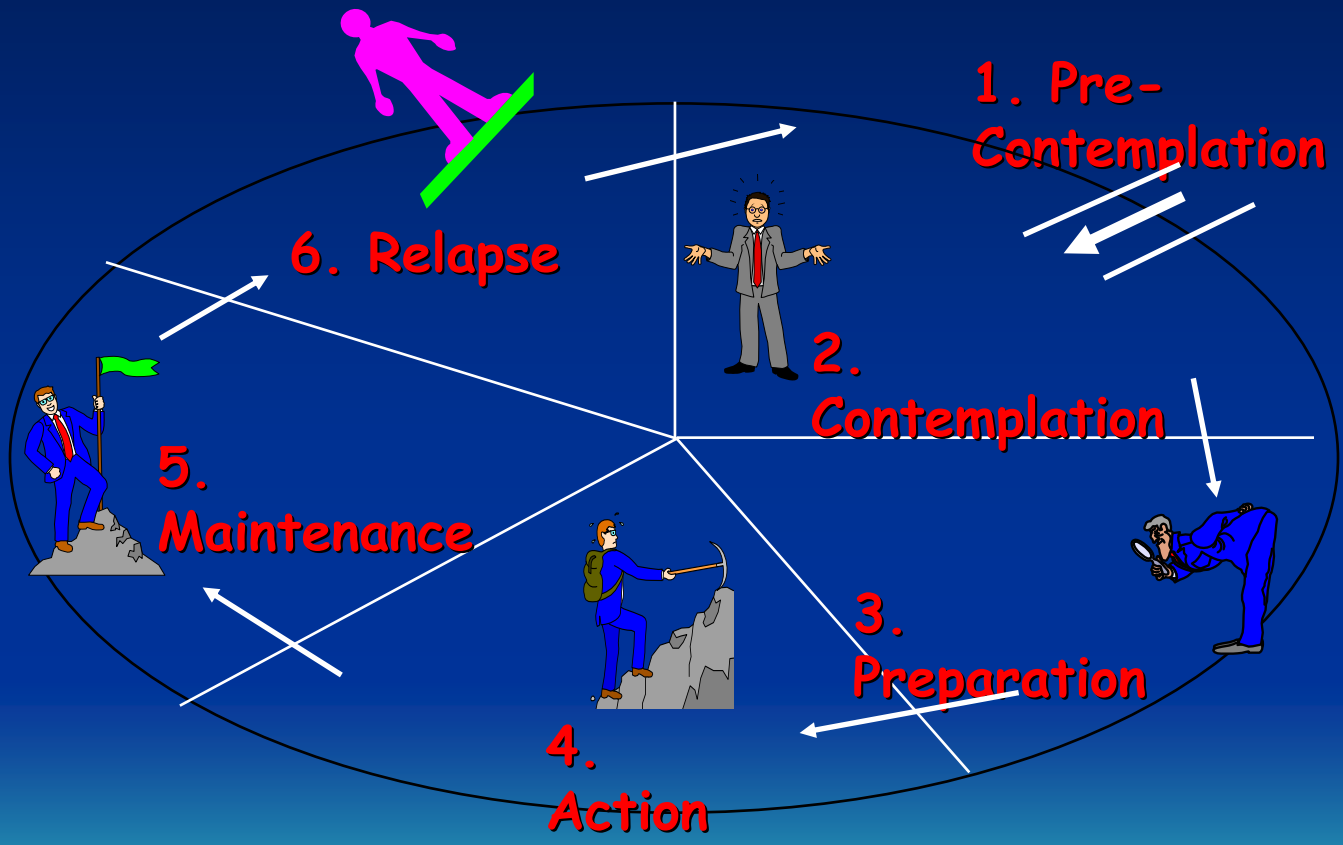
- Multidisciplinary Team
- Stage-Wise Interventions
- Access to Comprehensive services
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interviewing
- Substance Abuse Counseling

- Group Treatment
- Family Psychoeducation
- Participation in Alcohol and Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Non-Responders to Substance abuse Treatment

Principles of Stage-wise Treatment

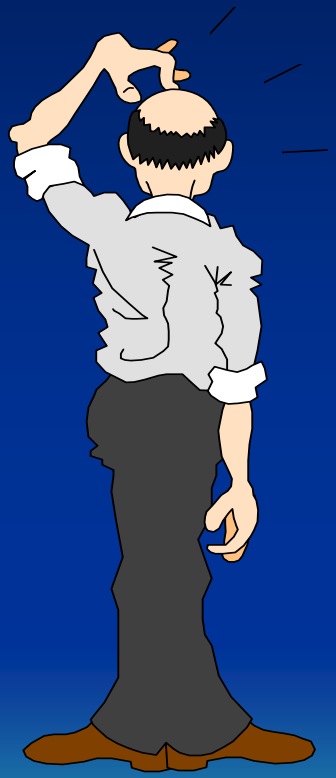
- Precontemplation – Engagement
  - The person has no intention to change in the foreseeable future and may not be aware of problems.
  - Outreach, practical help, crisis intervention, develop alliance, assessment
- Contemplation & Preparation – Persuasion
  - The person is aware that a problem exists and is thinking seriously about overcoming it, but has not made a commitment to take action. During this stage the person is weighing the pros and cons of the problem and its solution.
  - Education, set goals, build awareness of problem, family support, peer support,
- Action - Active Treatment
  - Intention and behavior are combined: action is planned within the next month.
  - Substance abuse counseling, medication treatments, skills training, family support, self help groups
- Maintenance - Relapse prevention
  - The individual is actively working to prevent relapse and consolidate gains achieved during the Action stage. The person is remaining free from addictive behavior and is consistently engaging in a new incompatible behavior for more than six months.
  - Relapse prevention plan, continue skills building in active treatment, expand recovery to other areas of life

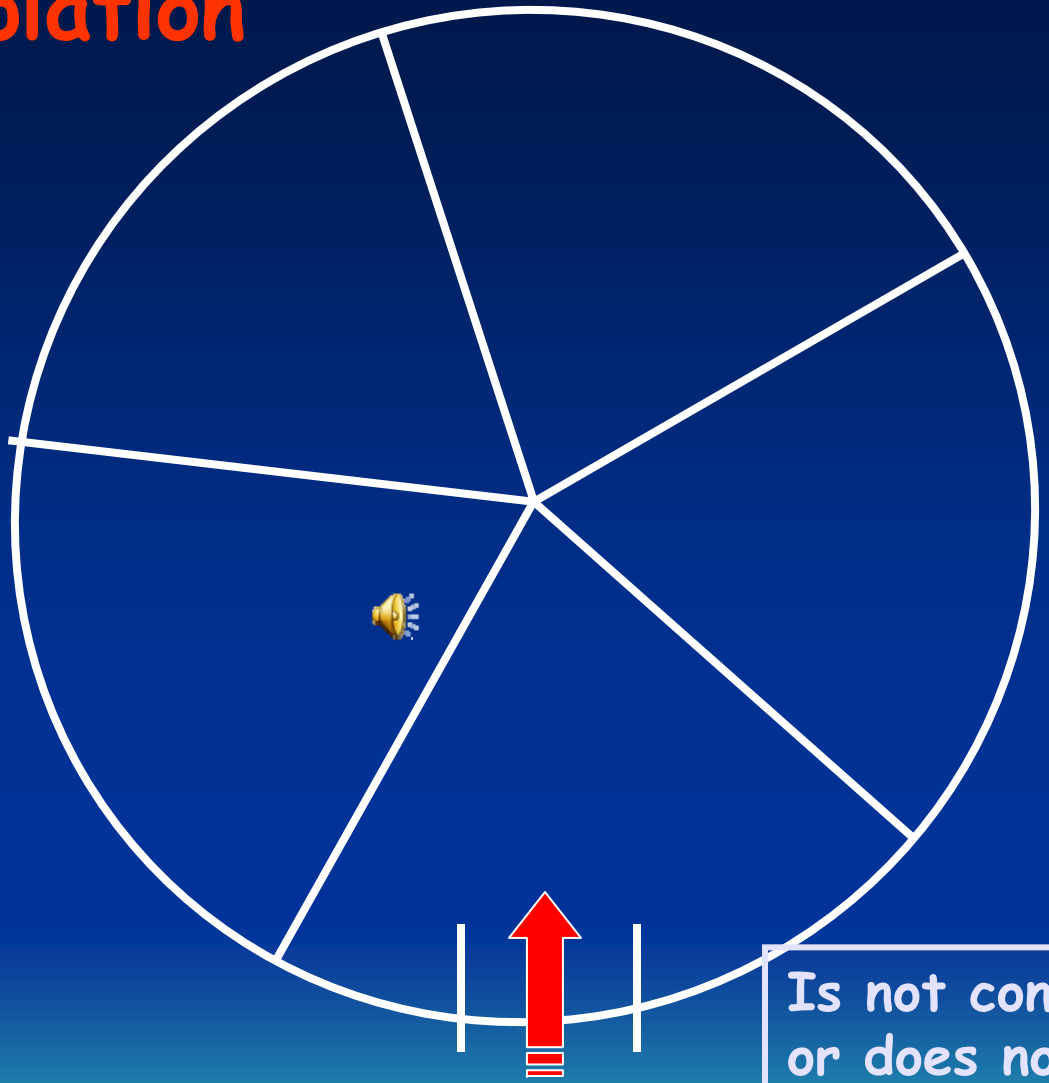
STAGES OF CHANGE



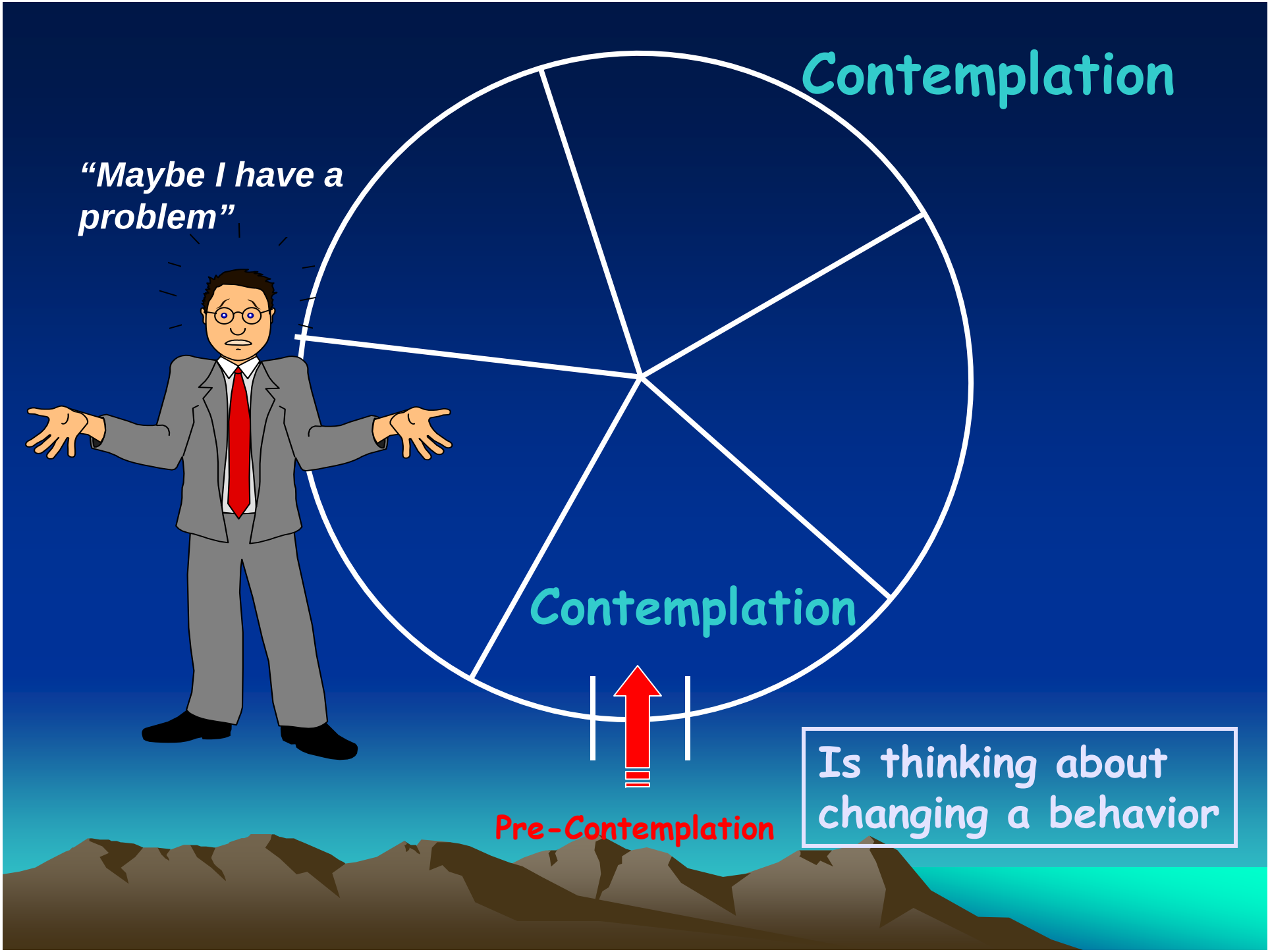
Pre-Contemplation

"I don't have a problem"



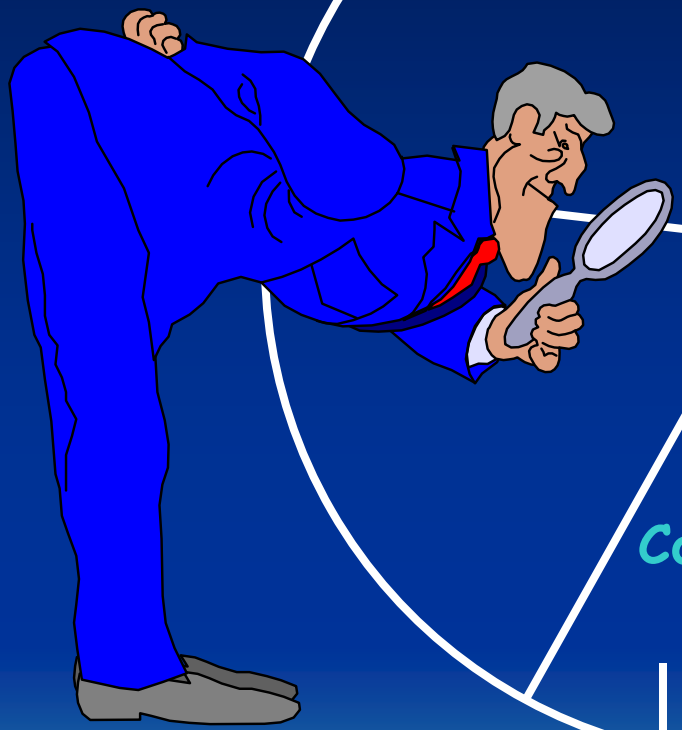


Is not considering or does not want to change a particular behavior

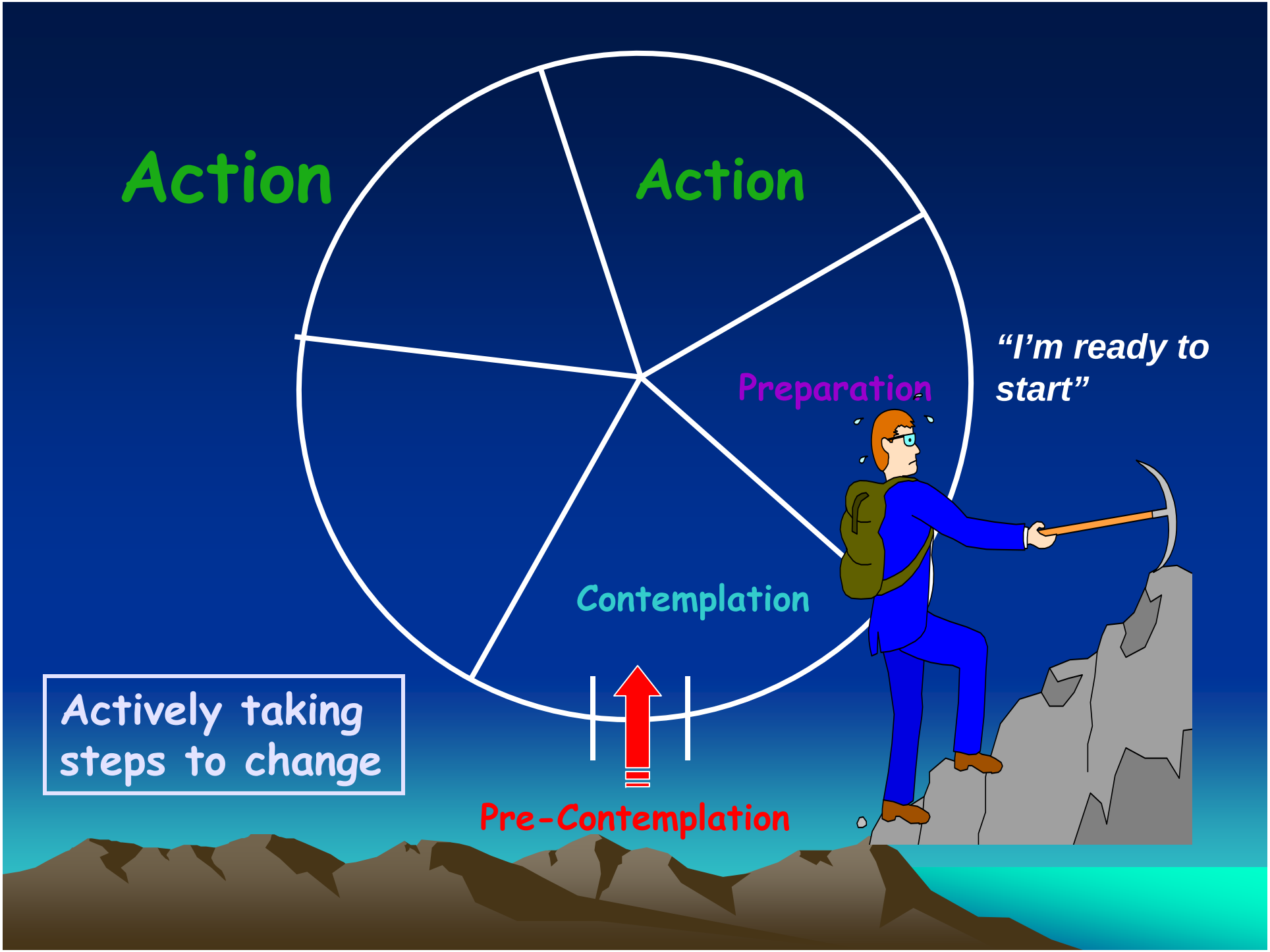

Contemplation
"Maybe I have a problem"
Contemplation
Pre-Contemplation
Is thinking about changing a behavior

Preparation

"I've got to do something"

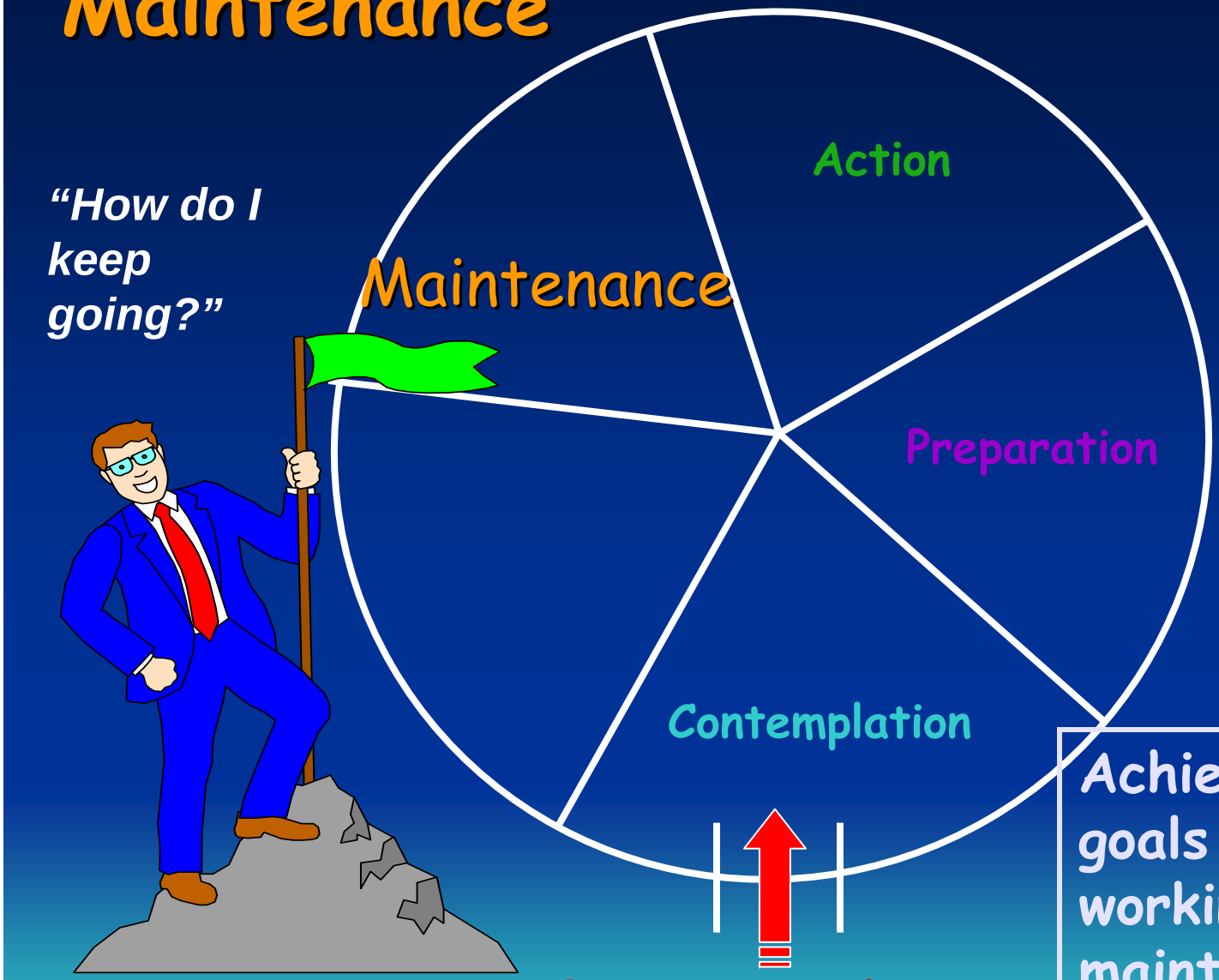


Is planning to change & has taken steps toward change.


Action
Action
Preparation
"I'm ready to start"
Contemplation
Actively taking steps to change
Pre-Contemplation

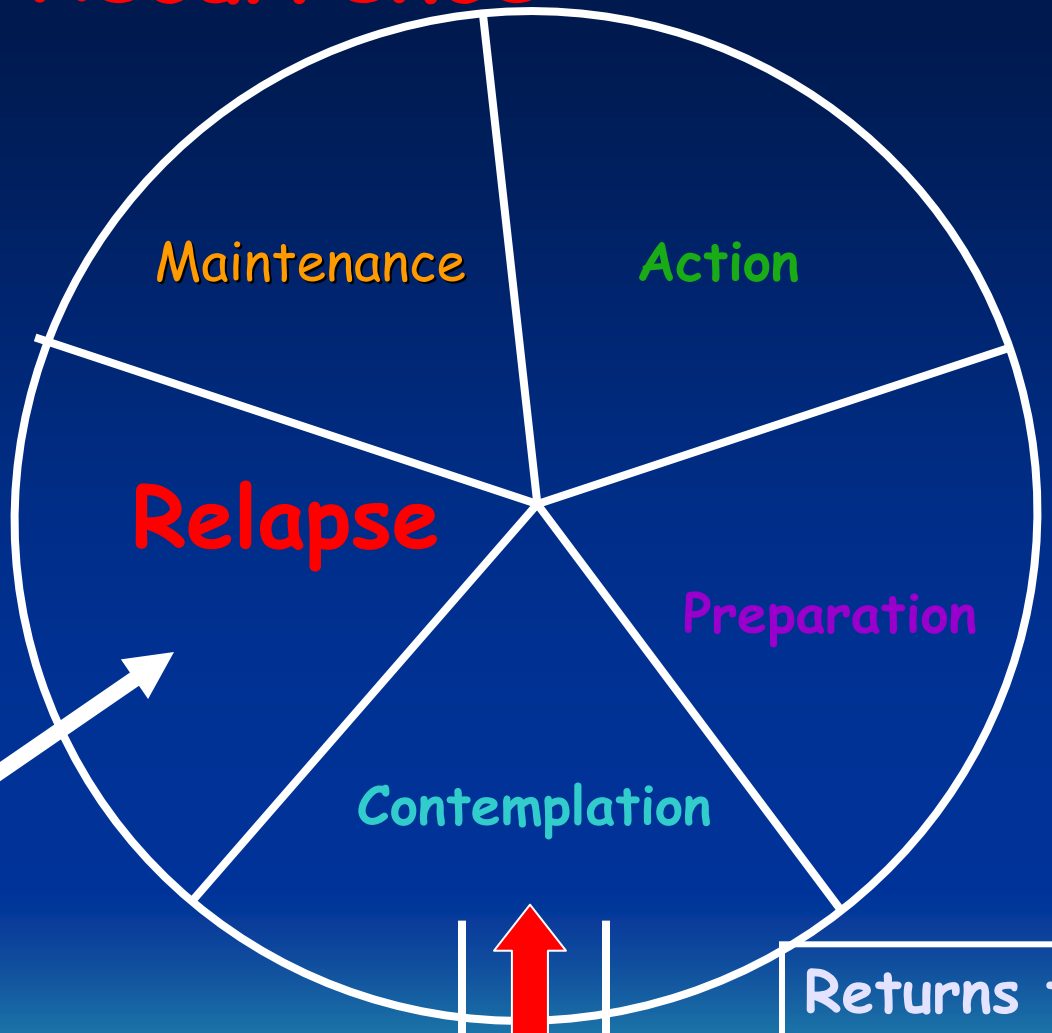
Maintenance

"How do I keep going?"



Achieved initial goals and is working to maintain gains

Relapse/Recurrence



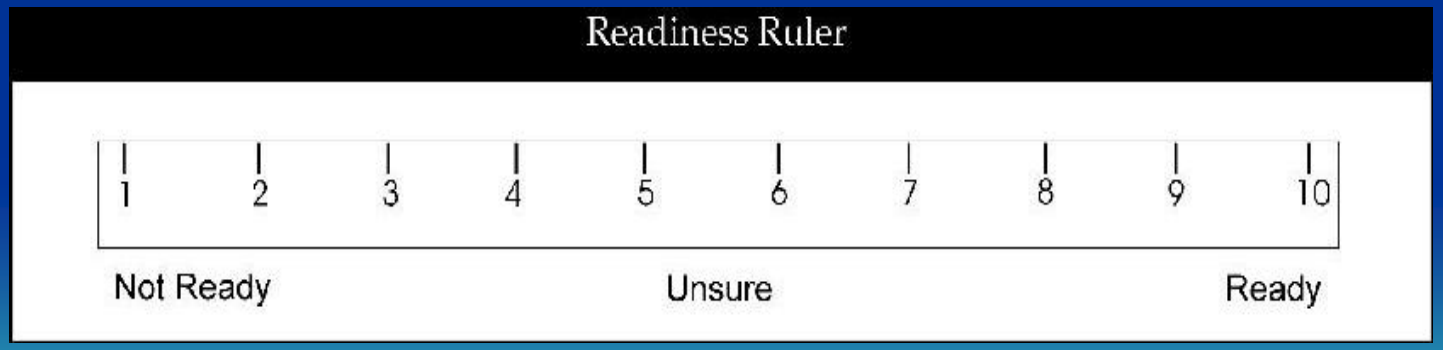
"What went wrong?"

Returns to behaviors and deciding what to do next

Motivational Interviewing

Changing:
Benefits / Costs

Not Changing:
Benefits / Costs



Motivational Interviewing

- **Precontemplation**
  - Establish rapport, ask permission, and build trust.
  - Raise doubts or concerns in the client about substance-using patterns by
    - Exploring the meaning of events that brought the client to treatment or the results of previous treatments
    - Eliciting the client's perceptions of the problem
    - Offering factual information about the risks of substance use
    - Providing personalized feedback about assessment findings
    - Exploring the pros and cons of substance use
    - Helping a significant other intervene
    - Examining discrepancies between the client's and others' perceptions of the problem behavior
    - Expressing concern and keeping the door open

- **Contemplation**
  - Normalize ambivalence
  - Help the client tip the decisional balance scales toward change by:
    - Eliciting and weighing pros and cons of substance use and change
    - Changing extrinsic to intrinsic motivation
    - Examining the client's personal values in relation to change
    - Emphasizing the client's free choice, responsibility, and self-efficacy for change
  - Elicit self-motivational statements of intent and commitment from the client
  - Elicit ideas regarding the client's perceived self-efficacy and expectations regarding treatment
  - Summarize self-motivational statements

- **Preparation**
  - Clarify the client's own goals and strategies for change
  - Offer a menu of options for change or treatment
  - With permission, offer expertise and advice
  - Negotiate a change - or treatment - plan and behavior contract
  - Consider and lower barriers to change
  - Help the client enlist social support
  - Explore treatment expectancies and the client's role
  - Elicit from the client what has worked in the past either for him or others whom he knows
  - Assist the client to negotiate finances, child care, work, transportation, or other potential barriers
  - Have the client publicly announce plans to change

- **Action**
  - Engage the client in treatment and reinforce the importance of remaining in recovery
  - Support a realistic view of change through small steps
  - Acknowledge difficulties for the client in early stages of change
  - Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these
  - Assist the client in finding new reinforcers of positive change
  - Help the client assess whether she has strong family and social support

- **Maintenance**
  - Help the client identify and sample drug-free sources of pleasure (i.e., new reinforcers)
  - Support lifestyle changes
  - Affirm the client's resolve and self-efficacy
  - Help the client practice and use new coping strategies to avoid a return to use
  - Maintain supportive contact (e.g., explain to the client that you are available to talk between sessions)
  - Develop a "fire escape" plan if the client resumes substance use
  - Review long-term goals with the client

- **Recurrence**
  - Help the client reenter the change cycle and commend any willingness to reconsider positive change
  - Explore the meaning and reality of the recurrence as a learning opportunity
  - Assist the client in finding alternative coping strategies
  - Maintain supportive contact

Outcomes

IDDT reduces:

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

IDDT increases:

- Continuity of Care
- Consumer quality-of-life outcomes
- Stable housing
- Employment
- Independent living

Some Evidence-Based Practices

- Stages of Change/Motivational Interviewing
- Harm Reduction
- Mutual Self-Help Programs
- Consumer-Delivered Services
- Specialty Courts (Drug Court, Mental Health Court, Co-occurring Disorders Court)
- Specialized Services for Homeless Populations
- Group Treatment
- Family Treatment

Peer Support Interventions

- Traditional 12-step programs have **not always meshed well** with the needs of individuals with co-occurring disorders
- 12-step models such as AA and NA have been **adapted for co-occurring disorders**
- **"Double Trouble"** and similar groups have been developed throughout the U.S.

Medication Guidelines
(Minkoff)

Maximize outcome of two *primary* disorders:

- For diagnosed psychiatric illness, the most clinically effective psychopharmacologic strategy available, *regardless of the status of the comorbid substance disorder*.
- For diagnosed substance disorder, appropriate psychopharmacologic strategies may be used as ancillary treatments to support a comprehensive program of recovery, *regardless of the presence of a comorbid psychiatric disorder* (although taking into account the individual's cognitive capacity and disability).

Pharmacological Interventions

- Medications are routinely and effectively prescribed for individuals with CODs
- Medications serve to successfully:
  - Decrease drug **cravings**
  - Reduce **reinforcing effects** of drugs
  - Assist in **acute withdrawal**

Pharmacological Interventions

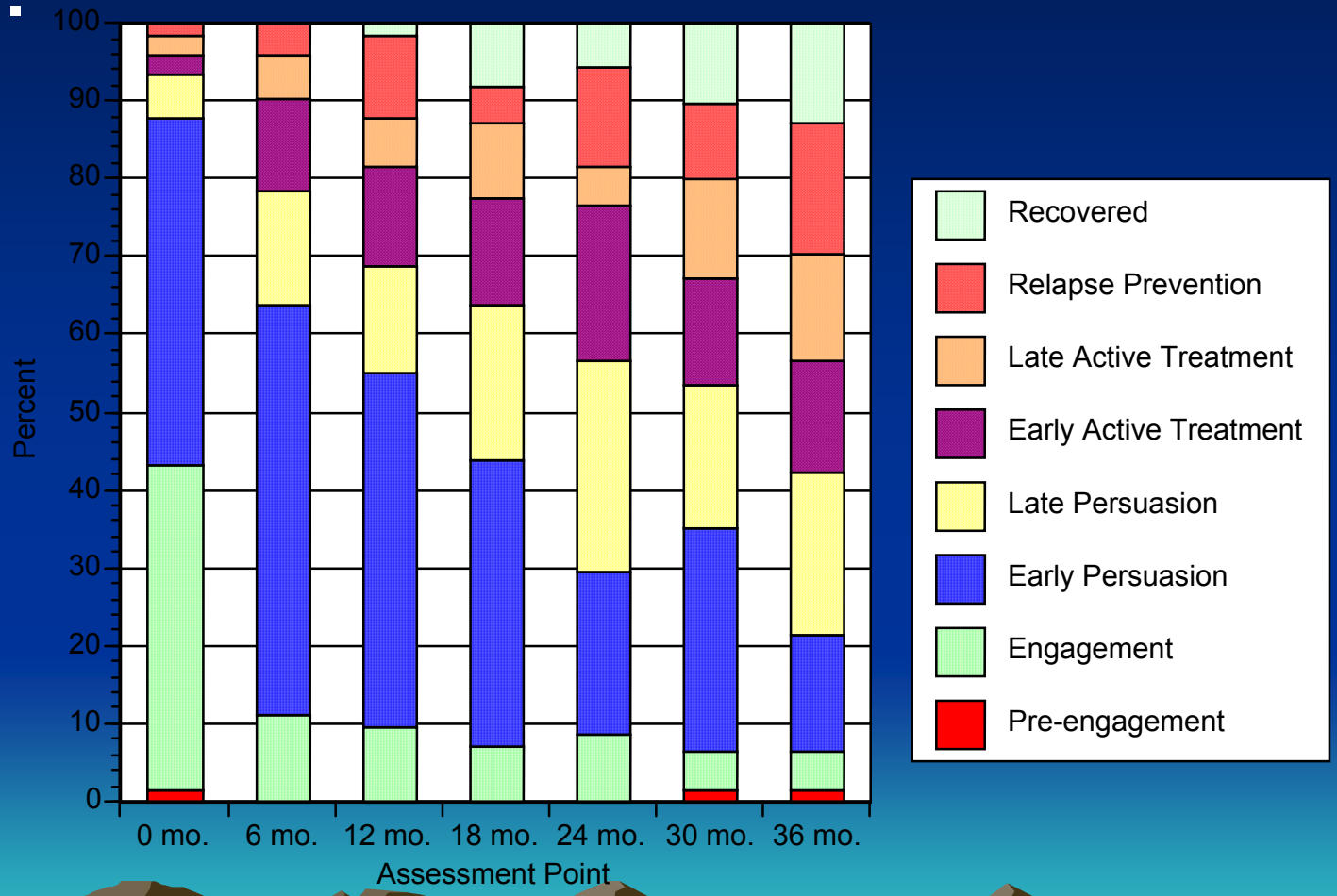
- Abuse of illicit drugs and alcohol can **impair the action of medications**
- **Toxic effects** can occur if alcohol or illicit drugs are used while taking certain medications (e.g., lithium, tricyclic antidepressants, MOI inhibitors)
- Medications with **addictive potential** should be avoided, or used with caution

Diagnosis-Specific Recommendations

- Schizophrenic Disorders:
  - Atypical neuroleptics; clozapine may reduce substance abuse.
- Bipolar Disorders:
  - Second and third generation mood stabilizers (valproate, lamotrigine).
  - Gabapentin and topiramate may also be useful.
  - A significant population will still respond to lithium.
- Depressive Disorders:
  - No particular category of antidepressant is specifically recommended or contraindicated.

- Anxiety Disorders:
  - Benzodiazepines for acute situations and detox only.
  - For anxiety: clonidine, venlafaxine, SSRIs, gabapentin, valproate, topiramate, atypical neuroleptics, buspirone.
- Attentional Disorders:
  - Bupriprion, SSRIs, Strattera (atomoxatine).
- Addictive Disorders:
  - Disulfiram, naltrexone, acamprosate, methadone, LAAM, buprenorphine.

Attaining remission occurs in stages



How do people obtain remission from dual disorders?

- Stable housing
- Sober support network/family
- Regular meaningful activities
- Trusting clinical relationship

Stable remission improves other aspects of life

- Objective: living situation, victimization
- Subjective: overall satisfaction with life, housing, family, health

Recovery

- Independent living
- Control of symptoms
- Active remission of substance abuse
- Competitive employment
- Socialization with peers who do not use substances
- Expression of life satisfaction

Recovery is a long-term process

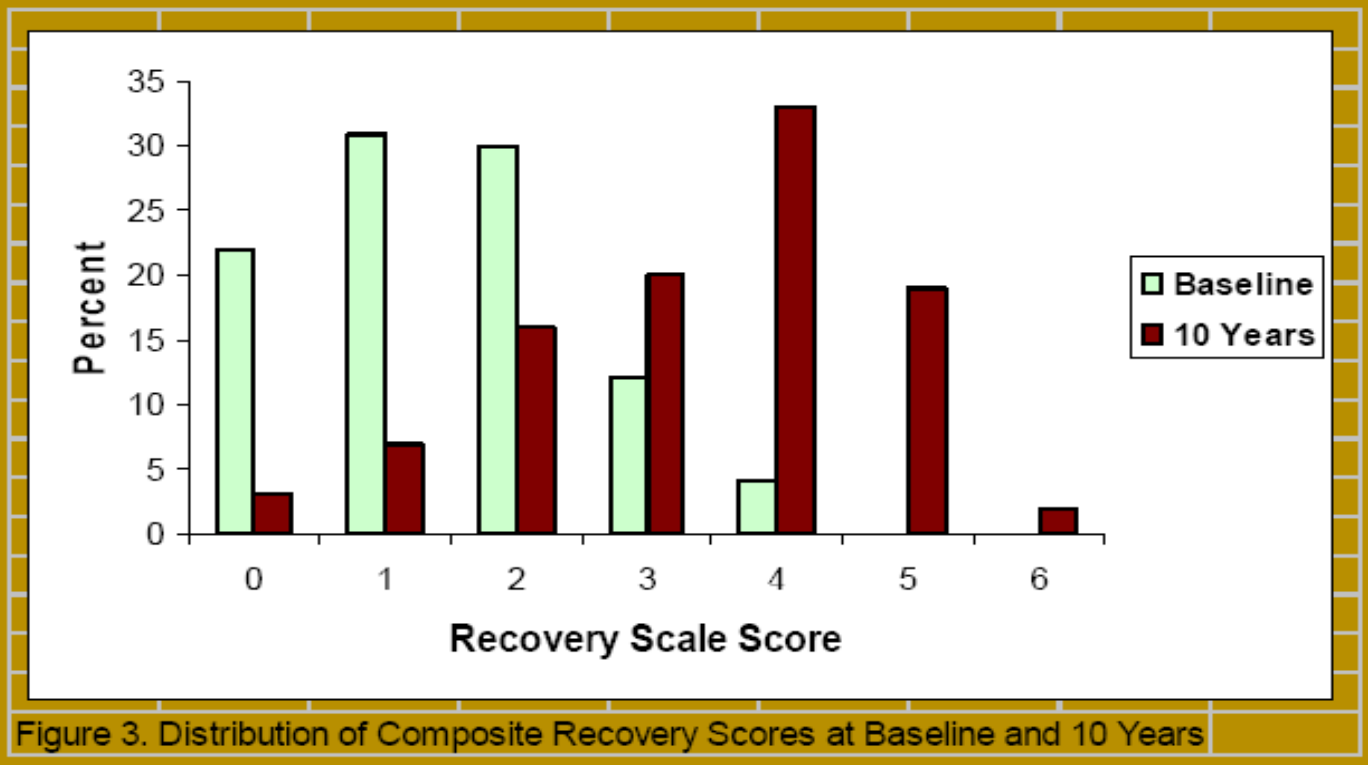


Figure 3. Distribution of Composite Recovery Scores at Baseline and 10 Years

Treatment factors for recovery

- Integration of mental health and substance abuse treatment
- Stage-wise interventions
- Assertive outreach
- Motivational counseling
- Substance abuse counseling

More treatment factors for recovery

- Social support interventions
  - (groups, self help, family)
- Long term perspective
- Rehabilitation of skills
  - (coping, social, leisure, work)
- Cultural sensitivity and competence
- Program fidelity

Recovery model

- Consumer-driven
- Unconditional respect and compassion
- Clinician responsible for helping consumer with motivation for treatment
- Focus on consumer goals and functioning not on adherence to treatment
- Consumer choice and shared decision-making are important

Questions/Comments

Thank You!