

Co-Occurring Disorders

INTRODUCTION

This chapter examines the complexities of people who are dealing with both addiction and mental illness. We will review how prevalent these issues are and some of the barriers experienced by people who suffer from co-occurring disorders. This chapter will provide an overview of treatment issues that may arise, as well as some approaches to therapy. Listed here are the Council for Accreditation of Counseling and Related Educational Programs (CACREP), Council on Social Work Education (CSWE), International Certification & Reciprocity Consortium (IC&RC), and Substance Abuse and Mental Health Services Administration (SAMHSA) standards associated with co-occurring disorders.

CHAPTER COMPETENCIES AND STANDARDS

CACREP—Standards 5, 8, 26

CSWE—Competencies 7 and 8

IC&RC—Domain I: Task 6; Domain II: Tasks 1–8; Domain IV: Task 4

SAMHSA—Competencies 4, 31, 52

PREVALENCE OF CO-OCCURRING DISORDERS

Estimating the number of individuals who have co-occurring substance abuse issues and mental health problems is a moving target—at best. SAMHSA estimates that 5.2 million people in the United States were dealing with co-occurring disorders (SAMHSA, 2007). In another publication, SAMHSA estimates that between 20% and 50% of people in mental health settings have

a co-occurring substance use and mental health disorder (SAMHSA, 2010c). The National Alliance on Mental Illness (2014) estimates that more than half of adolescents with a substance abuse disorder also suffer from a mental illness. Other research has corroborated the findings that a large percentage of the substance abusing population suffer from other, co-occurring mental disorders. For example Hasin et al. (2005) published results from the National Epidemiological Survey on Alcoholism and Related Conditions. They report that more than 5% of the population surveyed reported a major depressive disorder within the past 12 months, and more than 13% had a major depressive episode over the course of a lifetime. Cranford et al. (2011) found similar results using the same data set. In another study, Mericle et al. (2012) reported a correlation between ethnicity and psychiatric disorders, with Caucasians reporting the highest incidence of co-occurring disorders over the course of a lifetime. The authors conclude that 8.2% of whites, 5.4% of blacks, and 5.2% of Latinos self-reported a co-occurring disorder over the course of their lifetime. The issue of co-occurring mental disorders becomes even more complex

The issue of co-occurring mental disorders becomes even more problematic when we examine the issue of co-occurring disorders and prisoners. One study (Baillargeon et al., 2010) found that at least 50% of the prison population had a substance abuse problem, but among those with co-occurring disorders there was a much higher risk for reincarceration. In another study (Lynch et al., 2014), the researchers reported that 38% of the females who were included in the study reported a co-occurrence of mental health issues and substance abuse. But while it may be difficult to ascertain exactly how many individuals are dealing with co-occurring disorders, we do know how to deal with these issues. We will turn to that next.

PRIORITIZING TREATMENT OPTIONS

For many years, substance abuse counselors have grappled with the question, "If we have a client with a dual diagnosis, which problem should we treat first?" Some would argue that you deal with the substance abuse issue—then a clinician can know exactly what mental health issues are impacting the client (once they are detoxed from the drug of abuse). Others would argue that it is important to deal with the mental illness first. Today, the current thinking is to deal with both problems simultaneously (Drake et al., 2001). Drake and his co-authors recommend that a clinician (or team of clinicians) develop "integrated" services—seamless services provided by one provider that would treat both the substance abuse and the mental health issue. Others have argued for a simultaneous delivery of services that treat both the substance abuse and mental health issues (Smeelson et al., 2012; Suarez et al., 2012).

An American Distinction

It should be noted here that, ethically a counselor should not attempt to treat above his or her training or capability. Obviously, if a client has a mental illness that is beyond a person's ability to deal with, then a referral to another therapist is in order. Knowing when to refer is an important skill and doesn't mean that he or she is incompetent. It actually means just the opposite—that a person does have his own limitations and is putting the client's best interest first. By referring a person to her own limitations and is putting the client's best interest first. By referring a person to her own therapist for help, you create a situation where the client gets his or her needs (while still working on addiction issues).

RECOGNIZING AND ASSESSING MENTAL HEALTH DISORDERS

We are going to open this discussion about the recognition and assessment of mental health disorders with an assumption. This assumption is that you are working with a client who has already been detoxified (withdrawn) from what are psychoactive substances he or she have been using. If a client is still under the influence or in early stages of withdrawal, the mental state can often reflect that of someone who is experiencing mental illness (depression, anxiety, hallucinations, etc.). For a thorough discussion and clinical guide to detoxification of a client, we refer you to the *Detoxification and Substance Abuse Guide* (SAMHSA, 2006a). However, if your client is not actively using any drugs, then the following are markers to look for when there are signs of a change in mental functioning:

Symptoms and signs of conditions that require immediate medical attention:

- Change in mental status
- Increasing anxiety
- Hallucinations

Immediate mental health needs (mental health issues that require immediate attention):

- Suicidality (assess for suicidal ideation, plan, and past attempts)
- Homicidal thoughts (impulses to hurt themselves or someone else)
- Anger and aggression
- Lack of orientation (is the person oriented to person, time, and place? Do they know who they are, where they are, and what time/day it is)?
- Inability to carry on a conversation and exhibit logical, sequential thoughts

Any of these conditions suggest the need for further psychological screening. It is possible that the client is experiencing a serious psychological break with reality and may require medical intervention. There are some general questions that counselors can use to ascertain clients' level of functioning and their ability to track information. You may want to employ some of these questions if you have doubts about your client's orientation and alertness:

- Ask them to tell you what date and time it is.
- Ask them to tell you where they are.
- Ask them to tell you their first name and last name.
- Ask them why they are here.

These four simple questions should give you an indication of the client's mental orientation (or lack thereof). This is referred to as oriented times four (time, place, person and situation) and written O_x4. Inability to answer these questions suggests a need for further (more in-depth) screening. Let us return, for just a moment, to our discussion in earlier chapters regarding postacute withdrawal syndrome (PAWS). Recall that symptoms fall into three categories: physical, emotional, and mental. Physical symptoms can be as varied as headaches, nausea, inability to sleep, and physical discomfort including aches and muscle pain. Emotional symptoms include depression, anxiety, thoughts of suicide, and mood swings. Mental symptoms include confusion, difficulty in forming coherent thoughts, interference with short-term memory, difficulty in long-term memory.

One of the tasks of the therapist, then, is to determine if the symptoms and issues being displayed by the client are caused by PAWS or by an underlying mental condition. This can sometimes be difficult to determine, but here are some guidelines:

- When was the last time the client used any psychoactive substance (PAWS symptoms usually pass by the sixth month of abstinence)?
- Does the client have a history of mental illness?
- If yes, what has been the nature of the problem (depression, anxiety, etc.)?
- When did the problem first occur (age at onset)?
- When was the last episode?
- Has the client received treatment for the mental illness?
- Has the client taken medication?
- If yes, what medication?
- Are they still taking it? Dosage last taken?

These questions should help you to form a better picture of what is going on with your client. Depending on the answers to these questions, it may be necessary to make a referral for psychiatric help while helping the client with his or her substance abuse issues.

ADDRESSING MEDICATION IN RECOVERY

In the substance abuse treatment community, you will find a great deal of debate regarding the use of medications and recovery. First, a debate exists about the use of "harm reduction therapy" such as buprenorphine, methadone, and other drugs used to help opioid addicts to manage their addiction and lead responsible lives. Second, a debate exists as to whether dually diagnosed recovering substance abusers should use medications to help them manage their mental illness. The question is, "If an addict is taking a drug for mental illness, are they truly in recovery?" (Ginter, 2012; White, 2009; Woods & Joseph, 2012).

Today, this debate almost sounds ludicrous. If a person was a diabetic and needed insulin to live, we would not question their recovery because they were dependent on insulin, but as laughable as it sounds, the debate still continues. People who are dependent on medications (for depression, anxiety, bipolar disorders, schizophrenia, and a host of other mental illnesses) are still having their recovery called into question by other recovering addicts (and even some treatment professionals) (Redden et al., 2013; Zweben & Ashbrook, 2012).

This leaves the recovering addict with the question, "Can I be in recovery and be taking medication?" The answer needs to be a resounding, "Yes." Yes, a person can be recovering from alcohol and other mood-altering substances and still be taking prescription medications to help them manage their mental health issues. The operative word here is "mood-altering substances." If an individual is using a compound or behavior (food, drugs, sex, gambling, etc.) to alter his or her mood (and escape reality) then recovery must be called into question. They are simply exchanging one addiction for another—much like the alcoholic who quits drinking but begins smoking marijuana on a regular basis. But when an addict is using a prescription medication (prescribed by their physician or psychiatrist) to manage a mental health issue, then they are acting responsibly and should be considered actively in recovery. Recovery means that the individual is working to meet the challenges of daily living without the coping mechanism of mood-altering drugs or behaviors, and they are actively seeking to improve themselves and their relationships with others. The fact that they are dependent on medication to help them manage does not change the fact that they are seeking to recover from the addiction.

CONCLUSION

This chapter takes up the sometimes hotly contested debate of co-occurring disorders (substance abuse and mental health issues) and recovery. Several different debates arise over this subject. The first question is what issue to treat first (the substance abuse or the mental illness). The second question asks if a person who is “in recovery” from alcohol, other drugs, or other behaviors (such as gambling addiction) be in recovery if he or she is actively taking medication for a mental illness. Another question that arises is, if a person is on a harm reduction therapy regime (such as taking buprenorphine for opiate addiction), can they still be considered in recovery? Though these questions have been debated for decades, most treatment professionals today are beginning to modify their stance (on at least some of these questions). Most professionals would accept a client taking medication for a mental illness while simultaneously participating in a recovery program for alcohol and other substances. And many professionals are beginning to accept harm reduction models as a legitimate means of treatment (because of the potential for allowing the client to lead a normal, healthy, and productive life while in treatment), though this is still a matter of some debate.