
Recovery and Relapse in Co-Occurring Disorders: Definitions, Dilemmas and Discrepancies

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Pretest Questions

Select and Circle the Best Answer:

1. Addiction and mental health systems often clash over:
 - (a) Viewing substance use problems as being caused by underlying mental health causes.
 - (b) Viewing mental health problems as being caused by underlying substance use problems.
 - (c) Whether medication should be used in a person who is also using alcohol or other drugs.
 - (d) Whether a person should be discharged or not for using substances while in treatment.
 - (e) All of the above.

2. Reasons for diagnostic confusion in addiction problems and psychiatric disorders are:
 - (a) Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity).
 - (b) Prolonged alcohol/drug use can cause short or long-term psychiatric illness.
 - (c) Alcohol/drug use can escalate in episodes of psychiatric illness.
 - (d) Addiction illness sometimes co-occurs with mental illness as an independent disorder.
 - (e) All of the above.

3. Assessment guidelines to distinguish between addiction illness and psychiatric disorders:
 - (a) Are not important as it is best to just treat symptoms and medicate whatever is present.
 - (b) Are always useless to pursue as all alcoholics and addicts lie and are unreliable.
 - (c) Should involve taking a good timeline history.
 - (d) Should not include questions about periods of time drug-free as addicts use all the time.
 - (e) None of the above.

4. Recovery in Co-Occurring Disorders Treatment:
 - (a) Applies to both addiction and mental illness.
 - (b) Is more than just stabilization of withdrawal and psychiatric symptoms.
 - (c) Involves pursuing personal goals and an identity beyond the person's illness.
 - (d) All of the above.

5. If treatment providers really embraced a recovery model:
 - (a) They would discharge any clients who used alcohol or other drugs in treatment.
 - (b) They would plan for continuing care rather than thinking of it as aftercare.
 - (c) They would emphasize the importance of graduating from the program.
 - (d) They would view prior treatment as an indication of poor prognosis.

6. To implement a recovery model:
 - (a) All programs should be rigidly separated to maintain group trust.
 - (b) There should be a fixed length of stay to ensure compliance to the program.
 - (c) Establish seamless movement through a flexible, broad continuum of care.
 - (d) Always initiate treatment in a residential program for at least 28 days.

7. Walking the Talk about Recovery means:
 - (a) Considering relapse in addiction no differently from relapse in mental illness.
 - (b) Having fixed program completion times for both addiction and mental illnesses.
 - (c) Placing people in long term residential if they have had three relapses.
 - (d) Holding clients accountable and discharging them if they miss five sessions.

Indicate True or False:

T F

8. Poor outcomes should result in early discharge to another program immediately. () ()

9. A mental health evaluation should not be done until the client is 30 days sober. () ()

10. Medication should not be used for people who have an addiction and mental illness. () ()

A. Recovery and Relapse; COD; Addiction – Definitions and Attitudes

- (a) How do you answer a client who asks: “How long do I have to be here?”
- (b) Does “recovery” mean different things for substance use versus mental health problems?
- (c) What does treatment completion mean? What does finishing the program and graduation mean?

Recovery in Addiction

- “Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-5* criteria for *substance use disorder*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.”

(White, W. & Kurtz, E. (2005). “The Varieties of Recovery Experience”. Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at <http://www.glattc.org> (* Updated to reflect DSM-5)

- The immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety.”

(McLellan A.T., McKay J.R., Forman R., Cacciola J., Kemp J. (2005) Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. Page 448 *Addiction* 100:447-458.)

Recovery in Mental Health

“Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness”
(Pat Deegan, a consumer leader and psychologist with schizophrenic disorder defines recovery from serious mental illness)

Co-Occurring Mental and Substance-Related Disorders

In “A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders”, SAMHSA defines people with co-occurring disorders as “individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person...at least one disorder of each type can be diagnosed independently of the other”. The report also states, “Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). There are no specific combinations of...disorders that are defined uniquely as co-occurring disorders.”

(www.samhsa.gov/reports/congress2002/foreword.htm)

Addiction Treatment	Mental Health Treatment
<u>Slip or Lapse</u> – A single incident of substance use that may or may not result in a relapse, depending on how the client (and practitioner) responds. A slip can be viewed productively as a mistake and an opportunity for further learning. (NIDA, 1993)	<u>Lapse</u> – Recurrence of a symptom of a disorder (Evans and Sullivan, 1990). Infrequent symptoms without significant interference in functioning
<u>Slides</u> – Slips and lapses that may be heading towards a full-blown relapse. Slides provide an opportunity to prevent treatment dropout and arrest further regression into relapse.	<u>Lapsing</u> – Continuing symptoms intermittently that may be heading towards a full-blown relapse. Lapsing provides and opportunity to prevent treatment dropout and stabilize further regression in to relapse
<u>Continued Use</u> – A person who has not committed to recovery may continue to use as they work through ambivalence and either try to control substance use or decide on abstinence.	<u>Continued Problems</u> – A person who has not committed to treatment may continue to have emotional, behavior or cognitive problems as they work through their ambivalence
<u>Relapse</u> – An unfolding process in which the resumption of substance use is the last event in a long series of maladaptive responses to internal or external stressors or stimuli. (NIDA, 1993). A full-blown relapse is not necessarily accompanied by the full resumption of a drug abuse lifestyle, but may result in a client’s seeking renewed treatment. For this reason, relapse must be further distinguished from a client’s total regression back to drugs. Some view “dry drunk” as a recovering person’s wanting total abstinence and sobriety, but still having cravings and attitudes that they consider to be still in relapse. Another definition is “any violation of a self-imposed rule regarding a particular behavior”. (Marlatt, 1995)	<u>Relapse</u> – (1) to exhibit again the symptoms of a disease from which a patient appears to have recovered; (2) recurrence of a disease after apparent recovery (“Mosby’s Pocket Dictionary of Medicine, Nursing and Allied Health”, Second Edition, 1994). <ul style="list-style-type: none"> Responding to lapses with old solutions likely to result in a return to pretreatment status (Evans and Sullivan, 1990)

Addiction

Addiction is a brain disease and biopsychosocial-spiritual in nature.

1. Revamped definition of addiction - American Society of Addiction Medicine (ASAM)

Definition:

ASAM: “Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

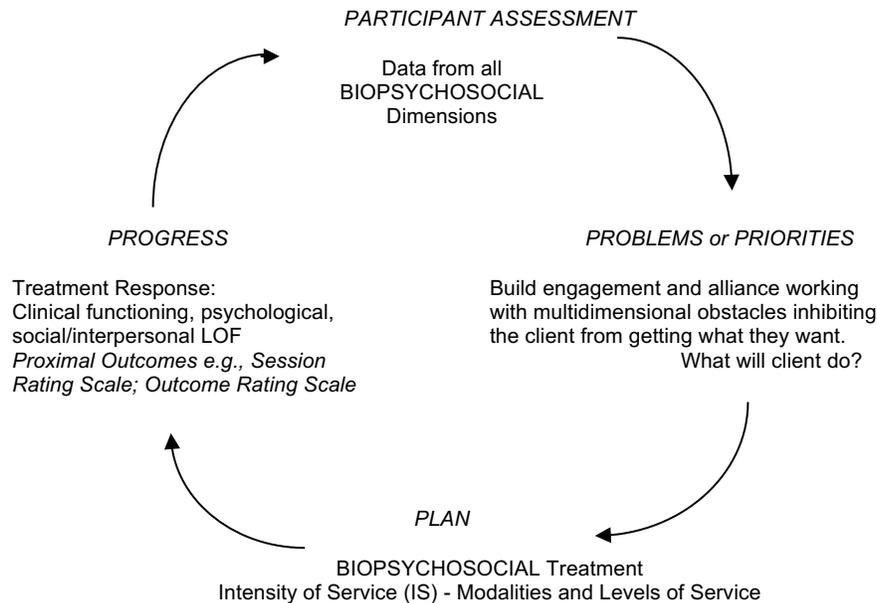
Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.”

<https://www.asam.org/resources/definition-of-addiction> September 15, 2019.

(b) Biopsychosocial in etiology, expression and treatment

Dilemmas: What to do about substance use while in treatment? Zero tolerance and discharge or allow client to remain in treatment? What to do in a relapse of depression, psychosis, mania or anxiety compared with substance disorder relapse?

B. Individualized, Outcomes-driven Treatment - The ASAM Criteria



(a) Assessment of Biopsychosocial Severity and Function (*The ASAM Criteria* 2013, pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths:

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

(b) Biopsychosocial Treatment - Overview: 5 M's

- * Motivate - Dimension 4 issues; engagement and alliance building
- * Manage - the family, significant others, work/school, legal
- * Medication – withdrawal management; HIV/AIDS; MAT - anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
- * Meetings - AA, NA, Al-Anon; SMART Recovery, Dual Recovery Anonymous, etc.
- * Monitor - continuity of care; relapse prevention; family and significant other

(c) Treatment Levels of Service (*The ASAM Criteria* 2013, pp 106-107)

- 0.5 Early Intervention
- 1 Outpatient Services
- 2 Intensive Outpatient/Partial Hospitalization Services
- 3 Residential/Inpatient Services
- 4 Medically-Managed Intensive Inpatient Services

C. Dimension 5: Relapse/Continued Use/Continued Problem Potential (*ASAM Criteria* 2013, pp 401-410)

A. Historical Pattern of Use

- 1. Chronicity of Problem Use
 - Since when and how long has the individual had problem use or dependence and at what level of severity?
- 2. Treatment or Change Response
 - Has he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity

- 3. Positive Reinforcement (pleasure, euphoria)
- 4. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity

- 5. Reactivity to Acute Cues (trigger objects and situations)
- 6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses

- 7. Locus of Control and Self-efficacy
 - Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?
- 8. Coping Skills (including stimulus control, other cognitive strategies)
- 9. Impulsivity (risk-taking, thrill-seeking)
- 10. Passive and passive/aggressive behavior
 - Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and Psychosocial Crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

- 1. Slip/ using alcohol or other drugs while in treatment.
- 2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs.
- 3. Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior.
- 4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.
2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.
3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.
 1. Acute intoxication and/or withdrawal potential
 2. Biomedical conditions and complications
 3. Emotional/behavioral/cognitive conditions and complications
 4. Readiness to Change
 5. Relapse/Continued Use/Continued Problem potential
 6. Recovery environment
4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.
5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.
6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and "doing time" rather than "doing treatment and change," explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.
7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder Enhanced services.. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.
8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.
9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute reoccurrence of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about "triggering" others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills. In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.
10. Document the crisis and modified treatment plan or discharge in the medical record.

D. Terminology and its Effect on Practice – Do you really believe in recovery?

- “Negative consequences” – In addiction treatment clinicians often say that if a person uses while in treatment there needs to be “negative consequences”. But if a person gets depressed again and cuts herself; or manic and spends a lot of money; or psychotic because of not taking medication, do we say there need to be “negative consequences”?
- “Graduation” – Clients and counselors talk of “graduation” from the program. But when does a person graduate from diabetes treatment? Or from Bipolar Disorder treatment? Or from hypertension or asthma treatment?
- “Complete the program” – Similarly, when does a person complete the depression program; or complete the Schizophrenic Disorder program? On what basis is the decision to discharge or transfer a person from successful treatment made? Is it based on a set time and/or number of sessions? Or do you focus on the level of function and the quality of the person’s recovery?
- “How long is your program?” or “How long do I have to stay?” – The same issue is raised here. Do we really believe we are managing long-term illnesses; or do we act more like there is a set of program expectations and monitoring compliance with rules and expectations.

E. Inconsistencies in Attitudes and Practice

Person’s Attitudes and Behavior	Recovery Process in 12 Step Programs and other Recovery Groups	Traditional Addiction Treatment Attitudes and Practice
1. Ambivalent about abstinence and recovery	1. “Keep coming back” – do the research; you don’t have to get the program; it will get you; stages of change and cognitive behavioral approach (SMART Recovery)	1. Client must agree to abstinence as a precondition of admission into treatment; or “come back when you are ready”
2. Reluctant to attend recovery meetings and groups	2. Outreach with 12-Step calls; offer to be a sponsor; assist with transportation; welcoming and “attraction not promotion”	2. Access to care is difficult; long waiting lists; recorded messages and complicated intake procedures
3. Shows up to a meeting after a few drinks	3. “Keep coming back” – “There but for the grace of God go I”; a good “remember when”	3. Leave and come back when you are sober. Sign a contract that you will not come to treatment if you have used
4. Feels will power will fix addiction and trouble accepting suggestions	4. “Powerlessness” and helping people understand the paradox of surrender and power; unmanageability and making amends	4. Counselors act as if powerful and able to confront and coerce recovery; work harder for recovery than client
5. Involves family and significant others in a web of pain and loss	5. “Detachment” – Al-Anon, Alateen; Naranon; help the family develop serenity and their personal recovery	5. Act as if we will stop addiction; work as hard as the family did to stop addiction; compassion fatigue and staff burnout

Person’s Attitudes and Behavior	Physical and Mental Health Recovery Approach	Addiction Treatment Recovery Approach
1. Relapse or re-occurrence of signs and symptoms of disorder	1. Viewed as a poor outcome or crisis requiring a timely response; assessment and treatment plan change	1. Viewed as willful misconduct with exclusion from treatment that day and possible discharge from treatment. “Punitively discharge clients for becoming symptomatic” (W.White, 2005)
2. Psychosocial crisis; treatment adherence problems; acute exacerbation of the disorder	2. Discussed as lack of progress and a poor outcome requiring a change in treatment strategies e.g., individual, group, family therapy, pharmacotherapy, case management	2. Discussed as the need for “consequences”, sanctions and possible discharge or transfer to another treatment team and setting

3. Persistent treatment adherence problems	3. Variety of proactive strategies – Assertive Community Treatment (ACT teams); Intensive Case Management (ICM); supported housing and employment; variety of “wet”, “damp” and “dry” shelters; mental health crisis teams to enhance natural and community supports	3. Blacklist client from readmission to the facility; discharge and send notice of case closed; refer to extended residential and inpatient care away from the person’s community with poor continuing care and reintegration into the community; invoke legal sanctions and remove from treatment
4. Severe and chronic illness	4. Utilize levels of care including acute hospitalization; day treatment; outpatient and community-based services; group and independent housing options. No fixed length of stay. Illness, disease and recovery management model.	4. Utilize predominantly fixed length of stay residential programs for those who can pay. Utilize predominantly low intensity outpatient services in the public sector. “Serial episodes of self-contained, unlinked interventions....Relegate post-treatment continuing care services to an afterthought” (W.White, 2005) Repeated episodes of acute care for detox; stabilization; discrete fixed program stay; “treatment completion”; “graduation”
5. Poor outcomes	5. Viewed as the need for more intensive case and care management and community outreach	5. Blame the client for denial and “stinking thinking”; non-compliance; stubbornness to take suggestions

F. Rename the Graduation or Treatment Completion Ceremony

Perhaps you could call it the RCA - the *Reflection, Celebration and Anticipation* ceremony or event.

- **Reflection** on what the client and family have learned, seen, gotten in touch with, changed since entering treatment. It can also be a reflection not just of positive things, but in all honesty (this is an honest program), reflection about things still not resolved or still not accepted. This is to model that this is about Progress not Perfection; about beginnings in recovery, not an end or completion of treatment; about reflecting on what might not yet be working, not just putting on a brave front to say everything is rosy
- **Celebration** of any accomplishments in this piece of recovery work done at this time in this program. Celebrating what has worked and what the program community has given the person; a time to be thankful for the challenging work the person has done so far in their recovery that is just beginning, not ending. Celebrating the hope that can be there for the client and family when there was only despair and hopelessness.
- **Anticipation** of what lies ahead in their recovery – plans on how to continue gains that have been made; but also how to keep working on doubts or ambivalences or challenges that still may be there or are even likely to be there. Anticipation of what needs to be done to keep progressing and if not "perfect" and there is a slip or relapse, what is plan B to get back on track – not with shame or a sense of failure, but with determination and commitment to keep moving forward – a day at a time with serenity.

Stephen

Stephen is 51 years old and is accompanied by his wife. He wants help, but is depressed. During his intake interview for this, his second DUI arrest, he looks disconsolate and he speaks in a monotone as he wonders if his wife will leave him. His alcohol use has resulted in alienation from his children, guilt feelings and his job may now be threatened, as he has been warned by his supervisor about his poor attendance and performance. Most of his friends drink, but none of them think he is an alcoholic.

He has not had any previous addiction treatment other than DUI classes after his first DUI four years ago. He attended AA for six months on and off and did have a sponsor, but felt more and more that he wasn't as bad as others at AA and gradually stopped going.

Stephen has been alcohol-free for three weeks. He has used cocaine (snorting) about three times per month over the past four years, but stopped two months ago. He has had no legal or financial problems related to cocaine. Stephen has continued on diazepam (Valium) 5 mg. qid which he has taken for five years to relax him because of mild hypertension. He has no other chronic physical problems but has lost 10 pounds weight over the past month and has been sleeping poorly. He wishes he could sleep and get away from all his problems but denies any organized suicidal plans and says he wants help.

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