# Co-Occurring Mental Health and Substance Use Disorders

# Richard's Story

Growing up in Philadelphia, the only contact that Richard Drain had with white people was with police, judges, and probation officers. Richard's world started to expand when he went into the military. It was during the war in Vietnam, and the world was tumultuous. And though Richard wasn't sent to Southeast Asia, his inner world was beginning to become tumultuous also. He began hearing voices. He became violent. He began to use drugs.

Once Richard was discharged from the military, he moved into his mother's house with his girlfriend and their children. His mother passed away not long after, and things began to spiral out of control.

Richard's girlfriend moved out. Incapacitated by his own paranoid delusions, which he tried to control with drugs and alcohol, Richard could not provide for the children. He sent them to the Virgin Islands to be raised by their grandparents.

He could no longer pay the mortgage on the home his mother had left him. He returned from work one day to find an officer from the Sheriff's Department who had come to evict him. Richard slept in playgrounds. He survived on the streets however he could.

One night, staying with friends in a crack house, Richard had had enough and tried to kill himself. Rather than provide him badly needed love and support, his friends kicked him out, afraid he would scare off their business.

During those years, Richard also began dealing drugs to survive. He was arrested and went before numerous courts; but the process took a long time, and before he could be convicted, he disappeared from the criminal justice system. "I was a fugitive," Richard says, "running from pillar to post, from street to street."

While living on the streets, Richard went into a soup kitchen one day and met Brenda Cooper-Kuttz of the Philadelphia Health Management Corporation. At her suggestion, he tried staying in the shelters, but they were not great. He found himself sleeping on the floor, sleeping in vomit.

Brenda had also referred him to the Access Project, a drop-in center in West Philadelphia that provided support for people with the co-occurring disorders of mental illness and addiction. There he met Bill Miller.

Brenda and Bill saw in Richard what no one had seen in a very long time—a human being with great potential. Almost everyone else had written him off long ago, including his family and old friends from the neighborhood. But Brenda and Bill told him about Horizon House, a program that could help Richard with vocational training and other support, including subsidized housing.

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It was 1995. Richard stopped using drugs and began attending 12-step meetings so that he could get into the Horizon House program. He got an apartment and began taking vocational classes. He was told about potential employment as a departmental aide with the City of Philadelphia's Office of Behavioral Health. Although he wanted the job, Richard was still running from his old legal charges, and could not go to work for the city until they were cleared.

Though he was facing 7½ to 15 years in prison, Richard knew he could not get on with his future until he had faced his past. Describing his emotional state at the time, Richard says that he "stepped out on faith and turned myself in to the courts." He stood before the same judge he had seen years earlier and told his story. Moved by Richard's courage and determination, the judge sentenced him to two years parole and one year probation—no jail time.

All told, Richard was homeless for 11 years. Now he was beginning a job with the City's Office of Behavioral Health, a job he has now held since 1997. Richard also became involved in many other community programs, serving on the Philadelphia Health Care for the Homeless Consumer Advisory Board and as the Financial Secretary of a community development corporation that brings low-income housing and after-school programs into Richard's neighborhood. He is also a member of the District Attorney's Youth Aid Panel, a program intended to divert troubled youth away from the traditional criminal justice system. He is constantly using his own story to help others along their journeys.

Richard says that when he got clean, he "began to see things in color." He was aware of things he had not noticed in years. On one winter day, he turned to a friend and said, "It's snowing. That's the first time I've ever seen snow." The friend told him he was crazy, that it snows every winter. Richard responded, "Yeah, but this is the first time I've ever *seen* it."

Once he started in his new job, he also became friends with people of all backgrounds and all skin colors. For the first time, he wasn't looking at white people from across the desk or across a courtroom. Instead, he was working next to them in the same office—equals.

After Richard had been in his Horizon House apartment for a year, an amazing thing happened. He was reunited with his "childhood sweetheart," Cassandra. They were married five years ago and now have their own house. He has reconnected with his children. "I'm joyous, happy, and pretty free," Richard says, with a voice full of a contentment that cannot be contained.

Of course, Richard is aware daily that his illnesses do not just go away. He suffers from chronic back pain and bouts of depression. "My mental illness crept up on me again last summer," he says in resignation. But he is sober. And he is content.

When I ask Richard about his experience living without a home, he says that "homelessness can happen to anyone at any time. Homelessness is an epidemic…it should be listed on the CDC's list of epidemics down there in Atlanta."

*Interview by Jeff Olivet. Originally published in* Olivet, J. & Horn, A. (2005). *Every success story is a great story*. Nashville, TN: National Health Care for the Homeless Council.

# Co-Occurring Disorders and Homelessness

Richard's story in the preceding pages illustrates the complexity and tremendous difficulties one faces in living with mental illness, substance use disorders, and being homeless. Yet, his story also demonstrates amazing personal resilience, as well as the hope and promise offered by caring providers who work with a person-centered, trauma-informed, recovery-oriented frame of reference.

Below is some basic information about co-occurring mental health and substance use disorders:

- Of all people experiencing homelessness on a given day, approximately 25 to 30% have a mental illness.
- As many as one-half of all people experiencing homelessness who live with a serious mental illness also have a substance use disorder.
- Compared to individuals with a primary mental or substance use disorder, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including inpatient hospitalization.
- The presence of co-occurring mental and substance use disorders is complex, as the illnesses interact with and exacerbate one another.
- Emerging research suggests that mental disorders often precede substance abuse. It is also the case that alcohol and drug abuse and withdrawal can cause or worsen symptoms of mental illnesses.
- Substance use also can mask symptoms of mental illness, particularly when the person uses alcohol or drugs of abuse to "medicate" the mental illness.
- Individuals with untreated mental illness are at increased risk for substance abuse. Similarly, individuals who abuse alcohol and other drugs are at increased risk for experiencing mental illness.
- While there is a good deal of variability from person to person and no single set of co-occurring disorders, experts now agree that co-occurring disorders should be the expectation among persons with serious mental illness, not the exception. Thus, providers must design treatment systems with their needs in mind.

*Excerpted from:* U.S. Department of Health and Human Services. (2003). Co-Occurring Mental and Substance Abuse Disorders: A Guide for Mental Health Planning + Advisory Councils. Retrieved from http://download.ncadi.samhsa.gov/ken/pdf/NMH03-0146/NMH03-0146.pdf

# What Works

Listed below are selected approaches and practices that are particularly effective in addressing the needs of people with serious mental illness and/or substance use disorders living on the streets and in shelters.

**Belief in recovery**
People can and do recover from problems related to substance use disorders, mental illness, and homelessness—recovery of hope, meaningful activities and relationships, and self-esteem and self-worth.

**Person-centered values**
The person's own needs and preferences are the primary focus of attention. The helping relationship is collaborative and invitational, offering support, information, and options. Tailor services to the individual.

**Outreach and engagement**
This approach involves going out into the community and meeting people where they are—on the streets, under bridges, and in shelters and drop-in centers. Workers seek to develop trust with individuals and to provide or connect them with needed services.

**Flexible, low-demand services**
Services provision is in an individualized manner, varying in frequency, duration, and scope depending on changing needs and wishes. Participation in treatment is not a requirement as a condition for receiving services, such as accessing entitlements or housing.

**Housing with appropriate supports**
The emphasis is on placing people as early as possible into permanent housing units with appropriate supportive services offered by an interdisciplinary team of health, behavioral health, and social service providers. Housing itself is a form of treatment.

**Interdisciplinary care teams**
Teams—composed of various health, behavioral health, and social service providers—work together to ensure that they address the needs of an individual or family experiencing homelessness in a holistic and coordinated manner.

**Integrated treatment for co-occurring mental illness and substance use disorders**
This approach implies concurrent, coordinated clinical treatment of both mental illnesses and substance use disorders provided by the same clinician or treatment team. Research indicates that integrated treatment is more effective than a parallel or sequential treatment approach.

**Motivational interventions/stages of change**
Motivational interventions include a range of clinical strategies to help individuals resolve ambivalence and move in the direction of change. Match these strategies to the client's level of readiness to change.

**Self-help programs**
The basis of these programs is typically the Alcoholics Anonymous (AA) 12-step method. The focus is on developing personal responsibility within the context of peer support. Participation decreases substance use and inpatient treatment, and improves self-esteem and community adjustment.

**Involvement of consumers and recovering persons**
Consumers can play an important role in outreach, supporting peers in recovery, staffing agency programs, and contributing as active members of planning councils, advisory boards, and community advocacy groups.

**Long-term follow-up support**
The recovery process is neither a linear nor a short-term process for most people. Relapse is common. Individuals require long-term follow-up support from an interdisciplinary team of care providers.

**Prevention services**
Examples of prevention include appropriate discharge planning from institutions, hospitals, and treatment programs; short-term intensive support upon re-entry into the community; and provision of subsidized housing and adequate income support.

*Adapted from:* Department of Health and Human Services, Pub. No. SMA-04-3870. (2003). *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders.* Retrieved from http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/default.asp

# Tips for Responding to People with Psychiatric Diagnoses, Substance Use Disorders, and Histories of Trauma

By Laura Prescott

| Do | Do Not |
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| ❖ Assume people are doing the best they can at any given time | ❖ Assume people are "acting out" or that "attention-seeking" is a bad thing or that people are attempting to get attention for no reason |
| ❖ Increase tolerance for emotions, particularly anger in women and sadness in men | ❖ Attempt to shut down emotions that may appear frightening or outside the usual gender-specific parameters |
| ❖ Provide separate placements for women and men when possible | ❖ Set up closed, locked, or unmonitored spaces with men and women (mixing men with histories of assault with women can be highly problematic) |
| ❖ Take time to be present—be honest and ask questions if you do not understand | ❖ Assume someone is too "fragile" to hear what you have to say—survivors are usually very adept at figuring out what is going on anyway and if you are indirect you can lose trust |
| ❖ Ask if someone is "safe" in his or her "home environment" (wherever that is) or if he/she is currently at risk for being hit, kicked, punched, slapped, having money taken away, or being the subject of unwanted sexual advances | ❖ Assume that because someone has a diagnosis or is struggling with substance use that the person is not *currently* subject to violence |
| ❖ Educate about trauma, post-traumatic stress, and outcomes | ❖ Assume people understand what post-traumatic stress is or know what to do |
| ❖ Use people-first language | ❖ Refer to people by their labels (i.e., "she's a borderline" or "he's a schizophrenic"); these terms are demeaning |
| ❖ Speak with people directly | ❖ Speak about someone in the third person while the person is in the room or to others when the person is present |

| Do | Do Not |
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| ❖ Understand that the use of metaphor may be someone's attempt to communicate something difficult to express | ❖ Assume that because someone is hard to understand that they make no sense |
| ❖ Attempt to decrease isolation by offering peer support groups, use peer mobile outreach teams, encourage natural support systems and connections to community—people who have direct experiences of healing can provide hope, encouragement, and personal connection that are important to build authentic relationships | ❖ Refer people to places/services that are going to further segregate them from the community |
| ❖ Have people who have been in the system come back and run groups, providing important role modeling and encouragement for others | ❖ Prevent people who have been out of the system for awhile (to be determined by policy, usually 6 months) from returning |
| ❖ Watch body language, sit/stand at an angle | ❖ Cross your arms, stand over someone, sit or stand face-on, block entry or exits |
| ❖ Provide privacy to protect dignity | ❖ Interview people in public areas, in front of others (including family members), or use family members to interpret |
| ❖ Use a strengths-based focus | ❖ Assess for and address only deficits |
| ❖ Treat people who are adults like adults | ❖ Treat people who are vulnerable like children (assume it means lack of strength) |
| ❖ Insist that people take part in the development and assessment of their treatment plans, even if they are not technically "competent" to consent or refuse treatment | ❖ Exclude people from treatment team meetings or meetings where treatment plans are developed and progress is assessed |

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| ❖ Repeat more than once in empathetic, affirming statements | ❖ Assume that people understand at first when the environment is chaotic and their internal worlds are as well |
| **Do** | **Do Not** |
| ❖ Address issues relevant to loss: grief, shame, despair, battering, reproduction, parenting, health conditions, self-injury, custody, and other legal issues | ❖ Provide groups that are purely behavioral and not relational, or do not address relevant issues for those receiving services. (there are too many "coping groups" in the world) |
| ❖ Be patient—people have good reasons not to trust those in power and will connect as they can | ❖ Assume people will or should trust you right away |
| ❖ Measure successes incrementally and longitudinally because recovery is a messy process that is long-term and not necessarily linear | ❖ Measure recovery as though it is a linear process that can be demarcated by changes in behavior in the short term |
| ❖ Support self-determination: allow (and even encourage) people to make mistakes and have successes so they can learn from them on their own | ❖ Tightly control what people can and cannot do in the name of "best interest" through the use of restrictive behavioral plans |
| ❖ Provide alternatives to medication such as hypnosis, relaxation, meditation, yoga, and other physical outlets for anxiety, grief, rage, etc. | ❖ Assume medication is the only way to help someone with rage, anxiety, grief, and other responses to compounded and cumulative loss |
| ❖ Be consistent and provide information; the more consistent you can be the easier it is to build trust | ❖ Skip over providing information to people about services and your role within these services—the more information people have, the more they can make informed choices and feel in control (like a partner) of the process |
| ❖ Be individualized and flexible | ❖ Insist that rules fit everyone the same way—there is often a need for flexibility in order to meet individual needs—flexibility does, however, need to be balanced with consistency |

| Do | Do Not |
|---|---|
| ❖ Assume that power and symbols of power are potential triggers for people who have been hurt, dominated by force and coercion | ❖ Display security uniforms, badges, weapons, and other symbols of power in locked environments where people have no means of escape |
| ❖ Assume there are many reasons why someone self-injures—often it is the only way to cope with unbearable feelings and memories—sometimes it is a way to speak about the unspeakable | ❖ Assume people are hurting themselves to "get attention," be "manipulative," or simply because they are people with "borderline personality disorder" |
| ❖ Cultivate a curiosity about the people you serve | ❖ Assume you know what people are about even if you have seen them over a long period of time |
| ❖ Be tenacious about hoping and encouraging people to move on with their lives, defining their own goals even if their definition of recovery is not what you would like it to be | ❖ Give up on people no matter how vulnerable or how impossible the odds seem to be that they will find their own way |
| ❖ Use same-gender staff when doing any kind of crisis intervention such as one-to-one, asking someone to disrobe, doing searches, etc. | ❖ Use opposite-gender staff at night (a time of particular vulnerability for women with histories of sexual abuse), during one-to-one (as people tend to need to use the bathroom and having someone watch is particularly intrusive), etc. |

# Resources on Homelessness and Co-Occurring Disorders

We recommend the resources listed below to enhance your knowledge and skills in working with people with co-occurring mental health and substance use disorders. Several of these resources relate specifically to people experiencing homelessness.

**Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders (2003).** Access this publication electronically at http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/default.asp For free copies of this document, contact SAMHSA's National Mental Health Information Center at 800-789-2647.

**Co-Occurring Disorders Initiative.** Launched by SAMHSA in 2003, COCE is the first national resource for the field of co-occurring mental health and substance use disorders. Online at http://www.samhsa.gov/co-occurring/.

**Co-Occurring Dialogues—Electronic Discussion List.** This list provides a forum for communication, idea exchange, brainstorming, and the sharing of exciting current publications and opportunities. The List also makes announcements and broadcasts information. Subscribers are free to ask questions of their peers, to seek information, and to respond to each other's needs. A subscription to the Co-Occurring Dialogues Discussion List is free and unrestricted. Subscribe by simply sending an e-mail to dualdx@treatment.org.

**Co-Occurring Disorders: A Training Series.** This free online training series offers a comprehensive overview for counselors on topics related to assessing and treating persons with co-occurring disorders. Each topic is a self-directed learning module. Participants can take a "competency quiz" and download a certificate of completion. Continuing Education Units (CEUs) are available for certain licensed professionals. http://cmhwbt.fmhi.usf.edu/co-occurring/intro_00_title.cfm.

**SAMHSA Issue Brief: Promising Approaches to Treatment with Persons with Co-occurring Disorders (2003).** For more information or additional copies, contact SAMHSA, Center for Mental Health Services, National Resource Center on Homelessness and Mental Illness 800-444-7415. Online at http://www.nrchmi.samhsa.gov.

**Strategies for Reducing Chronic Street Homelessness: Final Report (January 2004).** Prepared for U.S. Department of Housing and Urban Development, Office of Policy Development and Research by Walter R. McDonald & Associates, Inc. and the Urban Institute. Online at http://www.huduser.org/portal/publications/homeless/chronic_homeless.html.

**Substance Abuse Treatment for Persons with Co-Occurring Disorders: A Treatment Improvement Protocol TIP #42 (January 2005).** Copies available free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), 800-729-6686 or electronically at www.ncadi.samhsa.gov.