MODULE 5:
CO-OCCURRING CONDITIONS AND RECOVERY

Changing the view from "dual diagnosis" to recovery of the whole person

Introduction

The whole is greater than the sum of its parts.
--Aristotle

The goal of this module is to become aware of the signs that someone may be experiencing addiction issues, how those issues have been treated in the traditional system, and how to move from treatment of symptoms of illness and addiction to recovery of the whole person.

Objectives

The learning objectives for this assignment are for you to be able to:

- Define co-occurring conditions and *at least* two types of addictions
- Describe traditional methods of treatment for addiction and how they differ from integrated recovery-oriented approaches
- Give examples of peer support practices that help to shift the focus away from the illness or addiction to recovery of the whole person
- Locate *at least* three resources for further study

What to complete

Your assignment is to read this workbook module and complete the self-check questions prior to coming to the training for this topic.

Plan about one hour to complete this section of the workbook.

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Addiction and co-occurring conditions

Addiction[1] is the continued use of psychoactive substances or the repetition of a behavior despite adverse consequences. Addictions can include, but are not limited to, drug and alcohol abuse, food addiction, exercise addiction, sexual addiction, computer addiction, work, and gambling.

Mental health and addictions (substance use) conditions often co-occur. In other words, individuals with an addiction (also known as a substance use condition) often have a mental health condition at the same time and vice versa.

- Approximately 8.9 million adults have co-occurring disorders; that is they have both a mental and substance use disorder
- Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all

Source: *SAMHSA Co-Occurring Disorders website:* http://www.samhsa.gov/co-occurring/

Signs of addiction

"Universal Precautions" as discussed in the module on trauma can also be applied when considering if someone may have co-occurring conditions.

Start with the idea that every person you meet (including staff) may be experiencing some form of addiction. If a person is struggling with an addiction issue, one way to learn more is to ask the person about the four "C's:"

- Is there a loss of **Control?** Can the person stop? Can the person describe the consequences of not stopping?
- Is the use **Compulsive**? What does the person believe will happen if they try to stop? Does the person have to use the substance to feel "normal," even if it is at odd times or places?
- Is there intense **Craving?** What happens if the substance is not available? What will the person do to satisfy the craving?
- Is there a disregard for **Consequences?** What happens if the level of substance use becomes destructive enough to cause loss of self-respect, loss of family and important relationships, or problems with jobs, home, freedom (e.g.: arrest and incarceration) or health?

[1] Wikipedia (08/16/2013) http://en.wikipedia.org/wiki/Addiction

If you discover someone is facing an addiction issue, listening and asking motivational support questions, like those practiced in the training, can help the person to decide for themself whether they are ready to make any changes.

Addictions and co-occurring disorders are complex conditions. Each may have multiple causes that are unknown or hard to determine. *As peer supporters it is important for us to avoid over-simplifying situations or making assumptions about what a person can or cannot do. When we "meet people where they are," without making judgments or trying to "fix" them, we create an environment where trust can grow and a peer relationship can thrive.*

Assignment #1: Practicing the "C's" (optional)

1) *Consider a personal habit that has been hard for you to break. Ask yourself about the four "C's" and consider whether there are any negative consequences associated with the habit that you might want to work on changing. Think about how a peer supporter might be able to help you.*

2) *Find a practice partner that you feel safe talking with. Explain that you want to practice asking people about sensitive subjects like bad habits and then ask the person about the four "C's." Think about how you, as a peer supporter, might be able to help with anything the person identified.*

ACE and addictions

Excerpts from *The Origins of Addiction*[2] by Vincent Felitti, MD.

If a substance like heroin is not inherently addicting to everyone, but only a small minority of users, what determines the selectivity? Is the substance intrinsically addicting, or do life experiences actually determine its compulsive use? Surely its chemical structure remains constant.

Our findings indicate that ***the major factor underlying addiction is adverse childhood experiences*** that have not healed with time and that are overwhelmingly concealed from awareness by shame, secrecy, and social taboo. The compulsive user appears to be one who, not having other resolutions available, unconsciously seeks relief by using materials with known psychoactive

[2] Felitti, V. (2004) The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study. http://www.nijc.org/pdfs/Subject%20Matter%20Articles/Drugs%20and%20Alc/ACE%20Study%20-%20OriginsofAddiction.pdf

benefit, accepting the known long-term risk. The ACE Study provides population-based clinical evidence that unrecognized adverse childhood experiences are a major, if not the major, determinant of who turns to psychoactive materials and becomes addicted.

Conclusion: The current concept of addiction is ill-founded. Our study of the relationship of adverse childhood experiences to adult health status in over 17,000 persons *shows addiction to be readily understandable through largely unconscious attempts to gain relief from well-concealed prior life traumas by using psychoactive materials*. Because it is difficult to get enough of something that doesn't quite work, the attempt is ultimately unsuccessful, apart from its risks.

Assignment #2: Questions for reflection

1) Do you agree with Dr. Felitti's conclusion? Why or why not?
2) Could adverse childhood experiences explain why some people are more vulnerable to addictions or mental health issues or both?
3) Based on your own experience or the experience of people you support, is childhood trauma ever considered or addressed as part of the treatment plan?

Be prepared to share your thoughts at the training.

Traditional vs. integrated approaches

The following key points are taken from Recovery in Mental Health and Addiction, Answers to Frequently Asked Question #6 by Larry Davidson, Ph.D., and William L. White, M.A. from *Recovery to Practice Weekly Highlight*, Issue No. 14, 8/13/2010. Highlight any of the following key points that help you better understand how these systems of care evolved.

Key points:

- Mental health and addiction fields have different historical roots and traditions.
- Two distinct groups of practitioners have different training and approaches.
- People with co-occurring conditions have traditionally had their care segregated by primary and secondary conditions.

- Both fields (mental health and addiction) have come to recognize the prevalence of co-occurring disorders.
- Research has consistently shown that integrated care is most effective.
- Integration has been difficult because of political, fiscal, structural, and attitudinal influences that have been hard to overcome.
- Focus on deficits, dysfunction, illness, and treatment has hindered integration.
- The recovery movement in both the mental health and addiction fields has brought the two worlds together with a focus on building upon strengths.
- In both fields, an integrated vision of recovery begins with the idea that recovery is an individual process of growth for which there are multiple pathways.
- Recovery is a process of healing and community inclusion that offers hope.
- For some, recovery is a transformational process (sudden, unplanned, and permanent).
- For some, recovery is an incremental process (marked by multiple phases).
- Recovery stories often include elements of both transformation and incremental change.
- People in recovery are active agents of change in their own lives – not simply passive recipients of care.
- Recovery stories often include new perspectives and insights, important decisions, critical actions taken, and the discovery of previously hidden healing resources within and beyond the self.
- Recovery stories often give prominence to the role of diverse religious, spiritual, and secular frameworks in the recovery process.
- Recovery stories often describe the role of family and peer support in making a difference in their recovery.
- Whether living with a mental health condition, an addiction, or both, people need to have hope.
- People in recovery want to manage symptoms, increase capacity to participate in valued social roles and relationships, embrace purpose and meaning in life, and make worthwhile contributions to their communities.

- With this shared vision, differences that have historically separated the fields of mental health and addictions can now provide opportunities for synergy and growth in both.

Assignment #3: For further study (optional)

Read the full article*, Recovery in Mental Health and Addiction, Answers to Frequently Asked Question #6* by Larry Davidson and William L. White.

- What is the hope for the future of integrated care?
- How does peer support fit in that future?

Source:
www.dsgonline.com/rtp/WH%202010/Weekly%20Highlight%20August%2013.pdf.

Harm reduction

A fundamental difference between mental health and substance use treatment is abstinence as a prerequisite to receiving or keeping services. Harm reduction (which offers alternate or safer methods for working through an addiction) is an approach that recognizes it is not always realistic for people living with an addiction to be abstinent. Even when an addiction seems to be under control, recovery, for most people, is not a clean or linear process, especially when there are co-occurring conditions present. Harm reduction offers some tolerance for substance use while someone is in treatment. It does not demand abstinence before treatment. It does not kick someone out if there is a relapse.

Examples of harm reduction include *"wet houses"* that provide shelter to those still actively drinking, "*needle exchanges*" that provide clean needles to those who are actively using, or "*withdrawal support*" that provide methods to help people who are still actively smoking or abusing prescription drugs to go through the withdrawal process if they chose to reduce their use and/or quit.

In the traditional addiction treatment field, active substance use has been grounds for discontinuing or terminating services. In other words, abstinence is required **before** treatment.

But what about traditional mental health care? In this system, emphasis is on protection from harm and consequences (up to and including seclusion and restraint).

Under integrated treatment, there is greater recognition that active use may be a "call for help" and not something to automatically punish. Harm reduction is a way to give an individual extra time to arrive at his or her *own* conclusion that something needs to change – and to establish relationships with people who can offer support to make the change happen.

Harm reduction for psychiatric medications

Many people experience negative, sometimes life-threatening, effects from psychiatric medications. As a person in recovery, we may have strong feelings based on personal experience about whether psychiatric medications have been helpful or harmful. In our role as a peer support provider, we do not tell people what to do—or not do—as they figure out their unique recovery journey, but we can help people make more informed decisions based on additional information.

The following introduction is from a self-help guide for those taking psychiatric medications who are seeking alternatives.

> *Harm Reduction Guide to Coming Off Psychiatric Drugs*[3]
> *This guide brings together the best information we've discovered and lessons we've learned at Icarus Project and Freedom Center. It is not intended to persuade anyone to stop taking psychiatric medications, but instead aims to educate people about their options if they decide to explore going off their medication.*
>
> *In a culture polarized between the pro-medication propaganda of pharmaceutical companies on the one hand, and the anti-medication agenda of some activists on the other, we offer a harm reduction approach to help people make their own decisions. We also present ideas and information for people who decide to stay on or reduce their medications.*
>
> *Many people do find psychiatric medications helpful and choose to continue taking them, even with the risks, as this may be a better option given someone's situation and circumstances. At the same time, psychiatric drugs carry great dangers and can sometimes do terrible harm, even becoming bigger problems than the conditions they were prescribed to treat.*

[3] Harm Reduction Guide to Coming Off Psychiatric Drugs. *Published by The Icarus Project and Freedom Center*. www.theicarusproject.net | www.freedom-center.org

Too often, people who need help getting off psychiatric drugs are left without guidance, and medication decisions can feel like finding your way through a labyrinth. We need honest information that widens the discussion, and we hope this guide helps people trust themselves more and (helps people to) take better care of one another.

Assignment #4: Questions for reflection (optional)

(1) What are your thoughts about the concept of harm reduction?

(2) What are your thoughts about the use of psychiatric medications? For yourself? For others?

(3) As a peer supporter, what can you do to support people who make different choices in their recovery than you would?

Bridging the gap between traditional and integrated practices

The traditional medical model is illness-based. The premise is to cure or fix what's wrong. For physical issues, this approach is appropriate and often life-saving. When you think about someone with acute appendicitis, focusing on what's wrong and performing surgery to remove that part of the body–in isolation of all the other parts–can be essential to restoring health. For illness or injury of the physical body, the medical model has proven to be efficient and effective.

However, when applied to a person with a psychiatric (or co-occurring) condition the medical model approach is less effective and has often proven to be harmful. Whole people are categorized by symptoms and labeled according to what's wrong with them.

Those labels stick. And they hurt people.

Because symptoms are the focus of treatment, often without regard to other issues that may impact the quality of the person's life, treatment tends to rely on the use of psychotropic medications. Sometimes the iatrogenic (medication-induced) side effects, like uncontrolled weight gain and diabetes are far more harmful, potentially life-threatening, than the symptoms that are being treated.

People who provided services in the medical model historically assumed those with psychiatric (or co-occurring) conditions were incapable of being educated to make informed choices and sound decisions about their care.

This tendency people in professional roles had to devalue and dehumanize those with psychiatric conditions is what led members of the disability rights and consumer/survivor/ex-patient movements to adopt the mantra, "*Nothing about us without us."*

Recovery of the whole person

As peer supporters, one of our most important jobs is to focus on the ***whole*** person first. Our unique ability to connect and develop relationships with people, seeing more than the diagnoses or stigmatizing labels, allows us to guide people to reconnect with their own abilities, strengths, talents, and lessons learned from their own stories of survival.

People First Language: Dignity, Not Semantics

By Yvette Sangster[4] Founder, Advocacy Unlimited, Inc.

Language is power. Our words have the power to teach, inspire, motivate, and uplift people. Words also have the power to hurt, isolate and oppress individuals or entire segments of society. It is not about semantics, it is about dignity and a right for people to be treated with respect.

Many labels used for people with disabilities in our society have negative connotations or are misleading. Using labels contributes to negative stereotypes and devalues the person they attempt to describe. It is only important to refer to the person's disability if it is relevant to the conversation or situation. Often times, throughout our history, it has become necessary to change our language and the way in which we refer to individuals and groups to avoid further oppressing those members of society. The time has come to reshape our language once again so that we may refer to people with disabilities and the disability community in a respectful and inclusive manner. When a stigmatized group of people, such as persons with mental illnesses, is struggling for increased understanding and acceptance, attention to the language used in talking and writing about people is particularly important.

[4] http://www.mindlink.org/people_first_language.html

Generic reference to "the mentally ill" or "the consumer" conveys a lack of appreciation for the individuality of those referred to. It communicates and reinforces the discriminatory notion that "the mentally ill" are a special and separate group that is fundamentally unlike the rest of "us."

The use of people first language such as "a person with schizophrenia," "an individual with bipolar disorder," or "people with mental illnesses," on the other hand, recognizes and communicates that the people being referred to are first and foremost multidimensional human beings like everyone else but who, secondarily, have a disability with which they are dealing. Use of such language, although sometimes awkward, is important. Not only does it challenge the existing tendencies of the public to view and treat those individuals with psychiatric disabilities in dehumanizing ways, it also helps those individuals with mental illnesses feel respected as human beings rather than disparaged as diseased and dysfunctional.

Who are the people?

When we begin to think that people with mental illness are human beings first, with hopes, dreams, goals and value, everything we do and say after that reflection is more meaningful, and respectful to that person. As a result of our actions, and thoughts, we assist the public at large to remove the barriers of discrimination that devalue individuals with disabilities.

Simultaneously we provide an environment in which people with mental illness are valued and motivated to gain hope for their future and reach their goals.

How peer supporters can help

> "The difference between the right word and the almost right word is the difference between lightning and a lightning bug." — Mark Twain

As peer supporters, whenever we use person first language, we honor the ***whole*** person. We remember that the person has other roles – such as son/daughter, brother/sister, student/teacher, father/mother, boy-/girl-scout, sponsor/mentor, dreamer, artist, musician, poet, song-writer, photographer, advocate, friend.

When we refer to someone as a "*person, just like everyone else, with multiple challenges"* (rather than labels based in fear, like "dangerous depressed addict" or "angry alcoholic manic" or "lazy schizophrenic user") we restore the person to his or her rightful place in the human race.

After all, as peers we know we are all **whole** people with multiple challenges in multiple areas of our lives.

Assignment #5: Use of language (optional)

Download and read, *Language Matters in Mental Health: The Power of Language about Mental Health* by the Hogg Foundation.

Source: http://www.hogg.utexas.edu/initiatives/language_matters.html

(1) When you encounter stigmatizing language, what do you do about it?
(2) Consider the way you use language when you are with non-peer co-workers, other peer support providers, or the people you support. Is there something more you can do to raise awareness about stigmatizing language?

Antonio's Story: Turning Adversity into Opportunity

At the age of 17, Antonio Lambert had been shot nine times and was sentenced to 22 years in prison. After 16 years in incarceration, Antonio emerged severely depressed, confused and uncertain. A life of severe depression and substance abuse had taken a toll. There was one thing he was sure about - he had to change his life or he would end up dead or spend the rest of his life behind bars.

With the help of a mentor, Antonio found hope and a new direction for his life. He began work as an ACT peer specialist in 2001 and became a respected trainer for peer specialists and mental health professionals. He learned he could turn adversity into opportunities and set about building a life full of meaning not only for himself but others he saw in similar circumstances.

Now, Antonio is back on the streets to help others with co-occurring mental health and addiction conditions. He has emerged as a respected community leader. His most popular presentation: *From Streets to Prison to Streets: Recovery Comes Full Circle*, is an inspiring story about his challenges and, most important, how and why he changed his life.

Assignment #6: Case study (optional)

As a result of his remarkable journey and contributions to mental health and substance abuse services, Antonio was the subject of a feature story in the New York Times series - LIVES RESTORED: *After Drugs and Dark Times, Helping Others to Stand Back Up*, by Benedict Carey.

Source: http://www.nytimes.com/2011/12/20/health/20lives.html?_r=0

Video: http://www.nytimes.com/interactive/science/lives-restored-series.html?_r=0#/antonio-lambert

(1) After reading Antonio's story and/or viewing the video, consider elements of your own recovery story that you would share with a reporter for the New York Times, if you had the chance. What can you say about your life that would give hope to others?

Be prepared to share the key elements of your story at the training.

Recovery Capital

According to William White, recovery capital is an unlimited resource. We find it within us, in fellow travelers on the recovery journey, in family members and friends. We find it in our social, spiritual, and work lives, and through positive involvement in our community – including service work. While we all have access to abundant reserves of recovery capital, we don't always use that capital to further our recovery. Unused recovery capital is of no value.

Categories of Recovery Capital[5]

Recovery capital is sometimes divided into three broad categories:

> ***Social Capital -*** includes the support, guidance, and sense of belonging, purpose, and hope that comes from relating to others. It is also the connections that one can access through relationships and membership in groups or communities. Social capital can be viewed as the web of supportive social relationships and networks that surround an individual in recovery.
>
> ***Physical Capital -*** includes the tangible resources such as income, assets, vehicles, housing, food, clothing, computers and related technology.
>
> ***Human Capital -*** includes both internal and external resources. Internal resources include specialized knowledge and skills. External resources include individuals who are instrumental in the healing journey.

As peer supporters, we are always looking for strengths for people to build upon. Looking at strengths as "recovery capital" can be an effective way of helping someone out of the darkness of what's wrong by shining a light (perhaps, start with a flashlight) on what's strong in a person's life, and then help the person to discover ways to use and increase those strengths and make an investment in building new ones.

[5] Adapted from the Recovery Coach Manual – McShin Foundation, 2010.
http://mcshinfoundation.org/sites/default/files/pdfs/Recovery%20Coach%20Manual%20-%207-22-2010.pdf

Assignment #7: Identifying your recovery capital (preparation for class)

Download and read pages 7-9, in the Recovery Coach Manual by the McShin Foundation. List examples from your own life (things you are grateful for) of each type of recovery capital: Social, Physical, and Human. ***Be prepared to share your list at the training and describe how it relates to recovery of the whole person.***

Source: http://mcshinfoundation.org/sites/default/files/pdfs/Recovery%20Coach%20Manual%20-%207-22-2010.pdf

My Social Capital

My Physical Capital

My Human Capital

SUMMARY CHECKLIST

After completing this workbook assignment are you able to…

- ☐ Define co-occurring conditions and *at least* two types of addictions.
- ☐ Describe traditional methods of treatment for addiction and how they differ from integrated recovery-oriented approaches.
- ☐ Give examples of peer support practices that help to shift the focus away from the illness or addiction to recovery of the whole person.
- ☐ Locate *at least* three resources for further study.

Based on what you've learned in this workbook assignment, what questions would you like to have answered at the training?

Thank you for completing this workbook assignment! We look forward to your participation at the training!

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RESOURCES FOR FURTHER STUDY

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Videos and Webinars

Antonio Lambert (Presenter): From Streets to Prison to Streets (DVD 42 min.)
Recover Resources: www.recoverresources.com

Association for Addiction Professionals (NADAAC): http://www.naadac.org/education/webinars

Faces and Voices of Recovery:
http://www.facesandvoicesofrecovery.org/resources/multimedia.php

Magellan Resiliency and Recovery E-Learning Center: http://www.magellanhealth.com/training

SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS):
http://samhsa.gov/brss-tacs/webinars.aspx

SAMHSA Center for Integrated Health Care: http://www.integration.samhsa.gov/about-us/webinars

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APPENDIX 5-A: TRAINING HANDOUTS

Signs of Addiction

- Is there a loss of **Control?**
- Is the use **Compulsive**?
- Is there intense **Craving?**
- Is there a disregard for **Consequences?**

Recovery Capital

- Social Capital
- Physical Capital
- Human Capital

Social Capital - includes the support, guidance, and sense of belonging, purpose, and hope that comes from relating to others. It is also the connections that one can access through relationships and membership in groups or communities. Social capital can be viewed as the web of supportive social relationships and networks that surround an individual in recovery.

Physical Capital - includes the tangible resources such as income, assets, vehicles, housing, food, clothing, computers and related technology.

Human Capital - includes both internal and external resources. Internal resources include specialized knowledge and skills. External resources include individuals who are instrumental in the healing journey.