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RECOVERY

The official newsletter of the RCORP Rural Center of Excellence on SUD Recovery at the Fletcher Group

UNDERSTANDING A CO-OCCURRING DISORDER

by Founder and Chief Medical Officer Dr. Ernie Fletcher

A dual diagnosis—the co-occurrence of a mental health condition and a substance use disorder—is especially challenging because the two conditions constantly feed off and mask one another, creating a complicated, compounding cycle that's difficult to assess and even harder to stop.

As COD expert Geoff Wilson pointed out in our July webinar, inadequate treatment can leave people with unresolved emotional distress that can lead to reuse.

Because of that danger, this issue of our newsletter highlights the key insights Geoff has gained over three decades of treating CODs, including a whole page of best-practice advice for recovery homes and programs in the rural communities we are dedicated to serving as an official RCORP Rural Center of Excellence on SUD Recovery.

The guidance herein won't make you a COD expert, but it will prepare you to react wisely when confronted by a condition that unfortunately afflicts millions of our fellow Americans.

Fletcher Group

IT'S EVERYWHERE

Co-Occurring Disorders—defined as the coexistence of both a mental health disorder and a substance use disorder—are far more prevalent than people imagine. In fact, when Geoff Wilson quotes SAMHSA's 2024 estimate that over 21 million America adults have a diagnosable COD, he quickly notes that the number accounts only for those officially diagnosed through insurance or treatment center billings. In other words, we really have no idea how many Americans are living with a COD.

"SAMHSA's number is just those we know about," says Wilson. "There are millions more out there who will never be diagnosed and therefore will likely never receive the professional help they need."

Equally difficult to assess is the personal effect of a COD. As children, we lack the cognitive development to understand what's happening. And, as adults, we too often lack the courage to look back and within even as the cycles of self-sabotage become increasingly difficult to ignore. None of us like thinking there's something wrong with us. That's why Wilson focuses not on what's *wrong* with clients, but what actually *happened* to them. Objective, rather than subjective, observation makes pulling back the curtain less frightening and more instructive.

So what are the specific challenges faced by those with a COD? Listed below are some of the complications that contribute to lower medication adherence, higher rates of reuse, and a greater need for intensive levels of care such as inpatient or residential treatment.

Enhanced Reinforcement from Substance Use
"People with a COD get a bigger pay-off than others from using opiates, methamphetamines, and alcohol," says Wilson. "That increased enhancement can make it significantly more difficult for them to enter into and sustain recovery."

Impaired Brain Functioning
Among other powerful psychic effects, childhood trauma can cause shrinkage of the prefrontal cortex, the part of the brain that controls our 'stop, think, and act' functions. "That can make you more impulsive which, in turn, makes it difficult to manage emotions and appreciate the consequences of your actions. And that, of course, can make recovery even more challenging."

WATCH THE VIDEO
of our July 2 webinar with clinician, supervisor, and trainer, Geoff Olsen.

CLICK HERE

Psychosocial Stressors
"Clients with a Co-Occurring Disorder often end up struggling with homelessness, joblessness, and chronic medical issues such as heart disease or hepatitis," says Wilson. "Significant psychosocial stressors like those can exacerbate matters even further, making recovery even more challenging."

A Deadly Loop
"The higher return to use rates caused by CODs," says Wilson, "can also intensify mood swings and depression that can lead to suicidal panic which, in turn, can lead to a spiralling and imprisoning fear-avoidance loop that's incredibly difficult to break free of."

SO MANY BARRIERS

Below are some of the barrier that contribute to a significantt treatment gap facing those with a COD.

Siloed Treatment Models
Two traditional approaches—one called Sequential Treatment and one called Parallel Treatment—prevent not only holistic care but even the sharing of essential information, such as medication changes or positive drug tests. "An example of Sequential Treatmentare is being referred to one service provider for a couple weeks, told, 'Just get sober and you'll feel better,' then referring to a different provider only to be discharged in the same way. People who put their faith in the system only to find out it's broken can easily become depressed and relapse. The same goes for what's called Parallel Treatment. That's when you go to this building to see the mental health therapist, another building to see the certified alcohol and drug counselor, and yet another building to see the medication practitioner with none of them talking to one another."

Lack of Trauma-Informed Care
Any member of a treatment team, from the person answering the phone to the clinician, can become a roadblock and re-traumatize clients if not properly trained in trauma-informed care.

Misdiagnosis
“It's not at all unusual,” says Wilson. "I've seen it happen again and again, particularly in the case of chronic or complex trauma. And without an accurate diagnosis it's impossible to make a proper intervention.”

Lack of Advocacy
Without assistance, clients with a COD may forget follow-up appointments or struggle to properly manage their own care. “Memory is not a strong point among those whose pre-frontal cortex has been damaged by childhood trauma and substance use,” says Wilson. “In recovery homes, for example, it's best to assign a staff member to fill the gap by making sure residents with a COD get to their appointments on time, adhere to the right medication schedule, and properly follow through with after-care.”

A Tendency to Burn Bridges
Clients with a Co-Occurring Disorder can also tend to burn bridges with fellow residents, treatment programs, even family members. "I have a couple clients right now," says Wilson, "who often stop taking their mood stabilizer and antidepressant, and not just because they forgot. Yes, it's frustrating because it makes them so vulnerable to reuse and negating all the hard work done up to that point."

Rural Challenges
Last but not least is the lack of mental healthcare, particularly in rural America. Running back and forth between siloed resources is one thing, but what if there's not even a single trained professional in your community to turn to? The Fletcher Group was in fact founded to address that lack and eagerly welcomes those in rural communities to partake of the considerable technical assistance we offer as an official RCORP Rural Center of Excellence on SUD Recovery.

WHAT WORKS BEST

So what can you do to help someone dealing with a COD? A lot, says Wilson.

Integrated Dual Primary Treatment
Any treatment provided must focus primarily, equally, and simultaneously on both the Mental Health Disorder and the Substance Use Disorder. Ideally, treatment should be administered from a single location by cross-trained clinicians. "I'm trained to treat both mental health and substance use," says Wilson. "I also have a nurse practitioner down the hall to assist me."

Adopting a Recovery Perspective
"It's wise to appreciate and never lose sight of the fact that treatment is a long and often unpredictable process," says Wilson. "Considerable patience, flexibility, and adaptability are required."

Phased Treatment
Clients typically move through a number of fairly predictable phases, from engagement and motivation to stabilization, active treatment, and continuing after care.

Multi-Problem Viewpoint
Clinicians should be prepared to address a wide array of psychosocial stressors, including housing, employment, and chronic medical issues such as hepatitis and wound care. "Helping clients resolve those real-life problems reinforces their engagement, especially if it can be done early in the process," says Wilson. "If you can help a client find housing or employment, for example, they're much more likely to stay involved."

Trauma-Informed Care
Traumatized people can be hyper-sensitive to their environment. "So much so," says Wilson, "that one's tone of voice, cadence, or even artwork on the walls can trigger anxiety and disengagement." But how do you gauge a person's sensitivity and know in advance what may or may not be stress-inducing?

"A great first step," says Wilson, "is to presume that every person in your environment has been exposed to abuse, neglect, and violence. That way you're far less likely to inadvertently provoke an adverse reaction."

On Neuroplasticity and Cognitive Impairments
Because substance use can cause the brain to atrophy and result in cognitive deficits, it's not safe to assume that traditional 'sitting and listening' therapy will be effective.

"If you think clients with a COD will sit attentively in a three-hour group session and retain everything that's said, you've got another thing coming," says Wilson.

"Retention of information presented that way is a huge challenge for people whose brains have been compromised by repeated substance use."

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WHAT WORKS BEST

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Active Learning
Instead of lengthy lectures that won't be retained, use visual aids and interactive tasks to communicate at a gradual, comfortable pace. "Don't be afraid of repetition," says Wilson. "Sometimes it's the only way for the most important information to sink in and be retained."

The Importance of Movement
Data indicates that brain plasticity can actually be improved through physical movement. "Mindfulness exercises and meditation help," says Wilson, "but one thing that I've seen make a real difference is daily physical exercise where clients actually break a sweat."

Executive Functioning and New Experiences
Jigsaw puzzles, crossword puzzles, and gardening can help to get the brain 'firing' again. "Keep in mind, too, that boring treatment is not treatment," says Wilson. "Clients need something that's new and unexpected, therefore more engaging."

Double Trouble Groups
Formally known as *Double Trouble in Recovery*, DTR Groups are peer support, 12-step programs that often work better than conventional AA and NA meetings because they encourage open discussion of both mental health and substance use.

Designated Advocacy
Recovery homes in particular should ask that an advocate (often a case manager) help clients manage appointments, ensure medication adherence, and communicate with healthcare providers.

The Dental Model
Because a one-time 'cure' is impossible, accept the fact that treatment requires long-term, periodic care that will vary in intensity in accordance with real-time symptoms, not unlike the care we receive year after year from a dentist."

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"It's not that there's something wrong with me, but that something happened to me.

That insight is so powerful because it helps clients see themselves in a completely new and different way."

WHAT WORKS BEST IN RURAL COMMUNITIES

Rural communities often face systemic and environmental challenges when trying to meet the treatment needs of those with a Co-Occurring Disorder. Below are Geoff Wilson's take on those challenges and how rural recovery homes and programs might overcome them.

Limited Access to Clinical Resources
Perhaps the most significant challenge in rural areas is the lack of on-site clinical staff, particularly in the fields of trauma-informed care and specialized psychiatric services. Wilson's recommendation: "Focus first on providing clients with a basic education regarding the impact of co-occurring disorders and trauma," says Wilson. "Fortunately, there are excellent free resources for this purpose, such as **SAMHSA's TIP 42 Manual** which can easily be taught and assimilated without the help of a master's-level clinician."

Medication Management
Going without prescribed psychiatric medications can exacerbate COD symptoms, leading to a risk of relapse and reuse. But how many rural recovery homes can afford to have a dedicated nurse or case manager on site to enforce medication adherence? Wilson's recommendation: Take the challenge seriously by establishing and observing detailed storage policies and meticulously monitoring time-critical dosing schedules. "Without some kind of monitoring," says Wilson, "clients can easily go four, five, or six days without their medicine."

Creat Your Own Support Group
As noted earlier, specialized support groups such as "Double Trouble" groups can be very helpful to those with a COD because they can openly discuss mental health and substance use challenges in a manner that may not be encouraged in other 12-Step meetings. If DTR groups are not available in your area, Wilson recommends reaching out to the National Alliance on Mental Illness (NAMI) for help in establishing a local group for your residents and clients.

Low-Cost Aids
According to Wilson, recovery homes in lack of clinical staff can still meet the needs of those with a COD by utilizing free and low-cost tools and activities that enhance neuroplasticity and brain recovery. They include:

Physical Activity: Walking, stretching, or watching and following along with free yoga videos on YouTube can work wonders.

Horticulture: Working a client garden encourages team-building as well as a strong sense of self-efficacy and pride while providing healthy nutrition at the same time.

Brain Exercises: Jigsaw puzzles, crossword puzzles, and interactive games an be very effective at getting the brain "firing" again.

Be Creative!
Creativity has many benefits. In addition to reducing stress, problem-solving thinking boosts cognitive health by stimulating neuroplasticity. "It can really be fun," says Wilson, "to get everyone together to do 20 minutes of yoga, exercise, gardening, or whatever other activity you can come up with that creates excitement and a more fulfilling connection with people and the outside world."

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