Definitions and Terms Relating to Co-Occurring Disorders

Overview Paper 1

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment
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The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's misson is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials online, by telephone, and through in-person consultation.

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SUMMARY

This paper provides definitions of terms associated with substance-related disorders, mental disorders, co-occurring disorders, and programs. The purpose for which a definition is used and the context in which it is used will affect its meaning, dimensions, and precision. Thus, context and purpose should be made explicit in any policy, initiative, financing mechanism, or system in which a definition is used.

INTRODUCTION

It is essential to employ a common language in order to develop consensus on how to address the needs of persons with co-occurring disorders (COD). Over time, numerous terms have been used to describe co-occurring disorders and their treatment. To avoid confusion in terminology and provide a starting point for dialogue among service providers, administrators, financing agencies, and policymakers, this overview paper compiles definitions consistent with state-of-the-art science and treatment practices relating to COD.

TERMS ASSOCIATED WITH SUBSTANCE-RELATED DISORDERS

Substance Abuse, Substance Dependence, and Substance-Induced Disorders

The standard use of these terms derives from the DSM-IV-TR, within which substance-related disorders are divided into substance use disorders and substance-induced disorders. Substance use disorders are further divided into substance abuse and substance dependence.

There are 11 categories of substance use disorders (e.g., disorders related to alcohol, cannabis, cocaine, opioids, nicotine) (see Table 1), which are separated by criteria into abuse and dependence. The term "substance abuse" has come to be used informally to refer to both abuse and dependence. By and large, the terms "substance dependence" and "addiction" have come to mean the same thing, though debate exists about the interchangeable use of these terms. Finally, the system of care for substance-related disorders is usually referred to as the substance abuse treatment system.

Substance-induced disorders are important to consider in a discussion of COD. Although they actually represent the direct result of substance use, their presentation can be clinically identical to other mental disorders. Therefore, individuals with substance-induced disorders must be included in COD planning and service delivery.

Substance abuse, as defined in the DSM-IV-TR, is a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (American Psychiatric Association [APA], 2000, p. 198). Individuals who abuse substances may experience harmful consequences such as

- Repeated failure to fulfill roles for which they are responsible
- Use in situations that are physically hazardous
- Legal difficulties
- Social and interpersonal problems

Table 1: Classes of Substance Use Disorders

- Alcohol
- Amphetamine or similarly acting sympathomimetics
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opioids
- Phencyclidine (PCP) or similarly acting arylcyclohexylamines
- Sedatives, hypnotics, or anxiolytics

Source: APA, 2000, p. 191.

Substance dependence is "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (APA, 2000, p. 192). This maladaptive pattern of substance use includes all the features of abuse and additionally such features as

- Increased tolerance for the drug, resulting in the need for ever-greater amounts of the substance to achieve the intended effect
- An obsession with securing the drug and with its use
- Persistence in using the drug in the face of serious physical or psychological problems

Substance-induced disorders include substance intoxication, substance withdrawal, and groups of symptoms that are "in excess of those usually associated with the intoxication or withdrawal that is characteristic of the particular substance and are sufficiently severe to warrant independent clinical attention" (APA, 2000, p. 210). Substance-induced disorders ***present as*** a wide variety of symptoms that are

characteristic of other mental disorders such as delirium, dementia, amnesia, psychosis, mood disturbance, anxiety, sleep disorders, and sexual dysfunction.

To meet diagnostic criteria, there must be evidence of substance intoxication or withdrawal, maladaptive behavior, and a temporal relationship between the symptoms and the substance use must be established. Clients will seek care for substance-induced disorders, such as cocaine-induced psychosis, and COD systems must be able to address these conditions.

TERMS ASSOCIATED WITH MENTAL DISORDERS

The standard use of terms for non–substance-related mental disorders also derives from the DSM-IV-TR. These terms are used throughout the medical, social service, and behavioral health fields. The major relevant disorders for COD include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and personality disorders (see Table 2). While several disorders listed in the DSM-IV-TR may (and frequently do) co-exist with COD, they are excluded from the definition of co-occurring disorders because other service sectors have traditionally been responsible for caring for persons with these disorders (e.g., developmentally disabled) or the qualities of the disorder are not typically responsive to behavioral health interventions (e.g., dementia). In these instances, the costs of providing care typically come from sources outside the behavioral health system. For example, the elderly person with Alzheimer's dementia and alcohol abuse will typically have service authorized by medical care organizations, while the adolescent with developmental disability and cannabis abuse will have services financed through State disability monies.

Table 2: Major Relevant Categories of Mental Disorders for COD

- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse-control disorders
- Adjustment disorders
- Personality disorders
- Disorders usually first diagnosed in infancy, childhood, or adolescence

Source: APA, 2000.

Distinctions Between Mental Disorders and Serious Mental Illnesses

Normal, and even exaggerated, responses to stressful experiences should not be confused with a diagnosable mental disorder. Only when intense emotions, thoughts, and/or behaviors occur over extended periods of time and result in impairment in functioning are they considered mental disorders. Nonetheless, clients with substance use disorders will seek services for severe or acute symptoms that do not meet diagnostic criteria for a mental disorder. Like persons with substance-induced disorders, these individuals must be included in COD planning and service delivery because their symptoms require screening, assessment, and treatment planning. Mental disorders are characterized by:

- The nature and severity of symptoms
- The duration of symptoms
- The extent to which symptoms interfere with one's ability to carry out daily routines, succeed at work or school, and form and keep meaningful interpersonal relationships

The Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992 (Public Law 102-321) required SAMHSA to develop definitions of serious emotional disturbance for children and adolescents and serious mental illness for adults. These definitions are used to establish Block Grant target populations and prevalence estimates for States but also have an application in the design and delivery of services for persons with COD. Despite efforts at standardization, each State has its own definition of these terms and its own definition of its "priority populations." These definitions have implications for access to public mental health services.

Children with a ***serious emotional disturbance*** (SED) are defined as "persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities" (CSAT, 1998, p. 266). Such roles or functioning include achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

Adults with a ***serious mental illness*** (SMI) are defined by SAMHSA as "persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], resulting in functional impairment which substantially interferes with or limits one or more major life activities" (CSAT, 1998, p. 265). Such activities can include:

- Basic daily living skills (e.g., eating, maintaining personal hygiene)

- Instrumental living skills (e.g., managing money, negotiating transportation, taking medication as prescribed)
- Functioning in social, family, and vocational or educational contexts

Two features of these definitions should be considered:

- Persons with SMI and SED include people with any mental disorder listed in the DSM-IV (or the equivalent *International Classification of Diseases, Tenth Revision*) with the exception of substance-related disorders, developmental disorders, dementias, and mental disorders due to a general medical condition, which are excluded unless they co-occur with another diagnosable SMI or SED.
- Adults or children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have SMI or SED.

TERMS ASSOCIATED WITH CO-OCCURRING DISORDERS

Co-Occurring Disorders

The term ***co-occurring disorders*** (COD) refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders. The definition of a person with COD (individual-level definition) must be distinguished from a person who requires COD services (service definition).

At the *individual level*, COD exist "when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from [a single] disorder" (CSAT, 2005, p. 3).

Some clients' mental health and substance abuse problems may not, at a given point in time, fully meet the criteria for diagnoses in DSM-IV-TR categories. While conceptually ideal, diagnostic certainty cannot be the sole basis for system planning and program implementation. For these purposes, COCE encourages the use of a *service definition* of COD. A service definition reflects clinical realities and constraints and/or programmatically meaningful descriptions of "at-risk" populations targeted for prevention and early intervention.

A service definition of COD includes:

- Individuals who are "prediagnosis" in that an established diagnosis in one domain is matched with signs or symptoms of an evolving disorder in the other.
- Individuals who are "postdiagnosis" in that either one or both of their substance-related or mental disorders may have resolved for a substantial period of time.
- Individuals with a "unitary disorder and acute signs and/or symptoms of a co-occurring condition" who present for services. Suicidal ideation in the context of a diagnosed substance use disorder is an excellent example of a mental health symptom that creates a severity problem, but by itself does not necessarily meet criteria for a formal DSM-IV-TR diagnosis. Substance-related suicidal ideation can produce catastrophic consequences. Consequently, some individuals may exhibit symptoms that suggest the existence of COD, but could be transitory (e.g., substance-induced mood disorders). While the intoxicated person in the emergency room with a diagnosis of a serious mental illness will not necessarily meet abuse or dependence criteria, he or she will still require COD assessment and treatment services.

For system planning and program design purposes, COCE recommends inclusion of the prediagnostic, postdiagnostic, and unitary disorder with acute signs and/or symptoms of a co-occurring condition in a service definition of COD.

Careful assessment to take all present and past signs and symptoms into account is necessary to distinguish among these three COD service subpopulations. Depending on the severity of their symptoms, these individuals may require the same full range of services needed by those who meet the individual criterion for COD (both conditions established independently).

Every initiative must clarify the purpose of defining COD. For a *system* to be responsive to the range of acute and long-term needs of persons with COD, the COD service definition is appropriate. At the *program* level, a narrower subgroup of persons with COD might be proposed that is consistent with the program's license and staff expertise and credentials. Program definitions may also reflect fiscal realities concerning the COD subpopulations for whom payors are willing to fund services (see nicotine discussion below). Some *research hypotheses* may be better tested using the individual COD definition that excludes the pre- and postdiagnosis subpopulations, or specific diagnostic groups may be targeted.

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The inclusion or exclusion of specific addictive substances in COD definitions has considerable implications for service systems and program planning. Nicotine dependence is a disease of high prevalence, with extraordinarily high rates of morbidity and mortality, and frequently co-occurs with other addictive and mental disorders (Grant et al., 2004). While posing less severe health risks, caffeine dependence is likewise highly prevalent as a co-occurring disorder. These

addictive disorders are included within the individual and service definitions of COD, yet most programs will not target caffeine dependence for treatment, and most payors will not reimburse programs for caffeine interventions. Nicotine dependence will be a critical component of comprehensive assessment and treatment planning for all COD. However, COD service initiatives may choose not to include it as part of their COD service definition unless it co-occurs with an additional substance-related disorder.

Similar issues arise with the DSM-IV category of "impulse-control disorders not elsewhere classified." This category includes kleptomania, pyromania, and pathological gambling. These disorders share features with substance-related disorders, and some similar intervention strategies have been used to treat them. The person with schizophrenia who routinely spends most of his discretionary income on lottery tickets would benefit from COD interventions. As such, impulse-control disorders should be screened for and assessed, and can be paired with mental disorders to meet COD criteria.

Caffeine dependence, nicotine dependence, and pathological gambling highlight the need to recognize two practical continua. The first is a continuum in the assignment of a COD diagnosis. Whether an individual has crossed the diagnostic threshold for COD ultimately is governed by clinical judgment and determined by multiple factors in addition to diagnoses. These include level of disability, effectiveness of available interventions, financing for interventions, and community and consumer values. Thus, for example, most persons with a mental disorder and caffeine addiction might not reasonably be diagnosed with COD. However, excessive caffeine use that triggers panic attacks in an individual with agoraphobia may qualify as a COD requiring integrated services.

The second continuum refers to eligibility criteria for specific programs or interventions. For example, public health goals would be well served by treating nicotine dependence in all persons with schizophrenia. However, providers may have a difficult time getting reimbursed for such treatment and may choose not to offer it.

Any COD definition should be consistent with the ultimate goal of alleviating the considerable pain and suffering associated with COD. Definitions that exclude vulnerable individuals from effective care should be reconsidered.

Terms for the Course of Co-Occurring Disorders

- ***Remission*** refers to the absence of distress or impairment due to a substance use or mental disorder. An individual in remission no longer meets DSM-IV criteria for the previously diagnosed disorder but may well benefit from relapse prevention services.
- ***Recovery*** consists of "gaining information, increasing self-awareness, developing skills for sober living, and following a program of change" (Lowinson et al., 1992, p. 533). As defined in the President's New Freedom Commission on Mental Health (NFCMH), recovery is "the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms" (NFCMH, 2003, p. 5). When people with COD are in recovery, it is implied that they are abstinent from the substance causing impairment, are able to function despite symptoms of mental illness, and participate in life activities that are meaningful and fulfilling to them.
- ***Relapse*** is the return to active substance use in a person with a diagnosed substance use disorder or the return of disabling psychiatric symptoms after a period of remission related to a nonaddictive mental disorder. Relapse is both an anticipated event in the course of recovery and a process in which warning signs appear prior to an individual's actual recurrence of impairment.

Quadrants of Care and the Integration Continuum

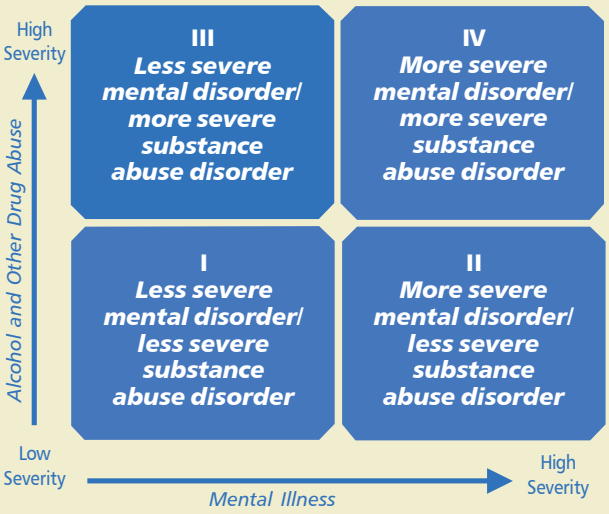
The *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* was cosponsored and facilitated by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Meeting participants created a conceptual framework that classifies clients into four quadrants of care based on relative symptom severity, not diagnosis. The four quadrants are:

I. Low addiction/low mental illness severity
II. Low addiction/high mental illness
III. High addiction/low mental illness
IV. High addiction/high mental illness (IV) (NASMHPD and NASADAD, 1998) (see Figure 1, page 5).

This model provides a framework for understanding the range of co-occurring conditions and the level of coordination that service systems need to address them. Someone with acute mental illness symptoms and a substance use disorder can be assigned to Quadrant IV for a brief time, then drop back to a less severe quadrant. Although the four-quadrant model is not yet validated, COCE materials and technical assistance will use it to guide discussion and further conceptual development.

The four-quadrant model also provides a structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every client with COD. Coordination, consultation, collaboration, and integration are not discrete points. Rather, they reside upon a continuum. It is important to note that coordination, consultation, collabo-

Figure 1: Co-Occurring Disorders by Severity



Source: NASMHPD and NASADAD, 1998.

The four-quadrant model provides a structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every client with COD.

ration, and integration refer to organizational and provider *behavior*, and not to service systems structure or the location in which services are provided. The application of these approaches will be discussed in more detail in the COCE Paper titled "Services Integration for Persons With Co-Occurring Disorders."

- ***Minimal coordination*** exists if a service provider either (1) is aware of a co-occurring condition or treatment but has no contact with other providers or (2) has referred a person with a co-occurring condition to another provider with little or no followup.
- ***Consultation*** is a relatively informal process for treating persons with COD, involving two or more service providers and requires the transmission of medical or clinical information or occasional exchange of information about the person's status and progress. The threshold for "consultation" relative to "minimal coordination" is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended treatment service.
- ***Collaboration*** is a more formal process of sharing responsibility for treating a person with COD, involving regular and planned communication, sharing of progress reports, or entry into a memorandum of agreement. In a collaborative relationship, different disorders are treated by different providers yet the roles and responsibilities of the providers are clear. The threshold for "collaboration" relative to "consultation" is the existence of formal agreements and/or expectations for continuing contact between providers.
- ***Integration*** requires the participation of providers trained in both substance abuse and mental health services to develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. The threshold for "integration" relative to "collaboration" is the shared responsibility for the development and implementation of a treatment plan that addresses the COD. Although integrated services may be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be provided by a single individual, if he or she is qualified to provide services that are intended to address both conditions. Different levels and types of integration are possible, and there is no one way to achieve integrated treatment. Further, not all agencies have the same capacity or resources for achieving treatment integration. Recognizing an organization's capabilities and providing for both substance and mental health services within those capabilities can enhance treatment effectiveness.

Integrated Screening, Assessment, and Interventions

- ***Integrated screening*** is the determination of the likelihood that a person has a co-occurring substance use or mental disorder. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment. Integrated screening is a formal process that typically is brief and occurs soon after the client presents for services.
- ***Integrated assessment*** consists of gathering information and engaging in a process with the client that enables the provider to establish the presence or absence of co-occurring disorders, determine the client's readiness for change, identify client strengths or problem areas that may affect the processes of treatment and recovery, and engage the client in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the client to develop a treatment and service plan.
- ***Integrated interventions*** are specific treatment strategies or therapeutic techniques in which interventions for all COD diagnoses or symptoms (if one is using a broad definition of COD) are combined in a single contact or in a series of contacts over time. These can be acute interventions to establish safety, as well as ongoing efforts to foster recovery.

TERMS ASSOCIATED WITH PROGRAMS

A ***program*** is a formally organized array of services and interventions provided in a coherent manner at a specific level (or levels) of care in order to address the needs of particular target populations. Each program has its own staff competencies, policies, and procedures. Programs may be operated directly by public funders (e.g., States and counties) or by privately funded agencies. A single agency may operate many different programs. Some agencies operate only mental health programs; some operate only substance abuse treatment programs, and some do both.

Program Types

The American Society of Addiction Medicine Patient Placement Criteria, Second Edition, Revised (ASAM PPC-2R) describes three types of programs for people with COD. These definitions should be used within mental health as well as addiction programs.

- ***Addiction- or mental–health-only services*** refers to programs that "either by choice or for lack of resources [staff or financial], cannot accommodate patients" who have co-occurring disorders that require "ongoing treatment, however stable the illness and however well-functioning the patient" (ASAM, 2001, p. 10).
- ***Dual diagnosis capable*** (DDC) programs are those that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (ASAM, 2001, p. 362). Even where such programs are geared primarily toward treating substance use or mental health disorders, program staff are "able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change—as well as relapse and recovery environment issues—through individual and group program content" (ASAM, 2001, p. 362).
- ***Dual diagnosis enhanced*** (DDE) programs have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health treatment to clients who are, compared to those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder" (ASAM, 2001, p. 10). Enhanced-level services "place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content" (ASAM, 2001, p. 362). The Integrated Dual Disorders Toolkit describes a particular type of dual diagnosis enhanced program for adults with SMI (CMHS, 2003).

Given the high prevalence of COD within all behavioral service settings, it is reasonable to expect programs to move toward dual diagnosis capable.

These program types can be established at any level of care. Given the high prevalence of COD within all behavioral service settings, it is reasonable to expect programs to move toward dual diagnosis capable. While standards for DDC and DDE program licensure or certification have not been established at the national level, States are beginning to develop some core standards.

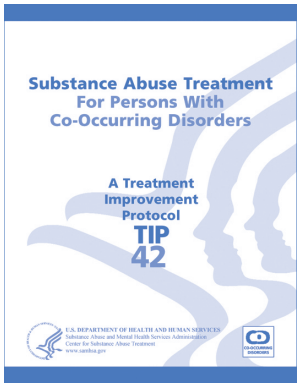
CONCLUSION

The substance abuse and mental health fields have made considerable progress in addressing the needs of persons with co-occurring substance-related and mental disorders. To the extent that they can share a common language to improve clarity of communication, clinical and programmatic advances will continue. This COCE Overview Paper is an effort to ground these fields in such a common language, to provide a conceptual framework for developing definitions, and to support integrated substance abuse and mental health approaches to persons with COD. Definitions, informed by research and translated by clinical, economic, and political forces, must change over time. As such, this overview paper will be routinely updated to reflect COCE's effort to bring consensus to the terms we use.

RECOMMENDED REFERENCES

The definitions in this paper draw heavily on the work of SAMHSA consensus panels and consultants and are derived primarily from a select number of recent or forthcoming publications. It is our hope and expectation that readers of this overview paper will use these references to contextualize terms for their unique circumstances.

It is not the intent of this paper to provide a comprehensive inventory of language relating to COD, but rather to define the most common terms currently in use. A more complete catalog of COD-related terminology can be found in the glossary (Appendix C) of the TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005).



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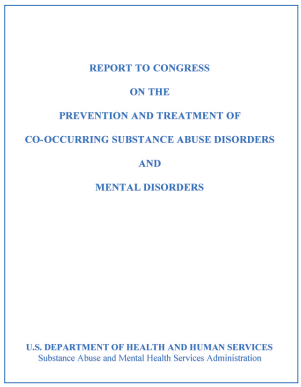

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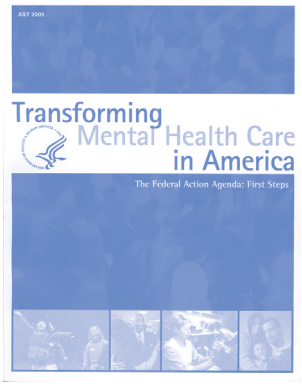

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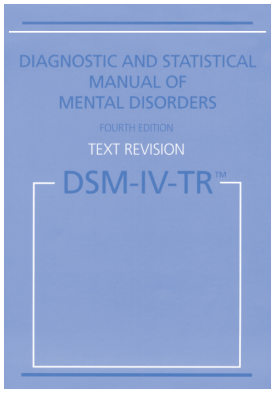

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