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JANUARY 2014 • PRACTICE BRIEF No.3:

Co-occurring Mental Health and Substance Use Disorders: GUIDING PRINCIPLES AND RECOVERY STRATEGIES IN INTEGRATED CARE (Part 1)

Our January Brief

This practice brief is the first of a two-part series in which we introduce eight core principles that have been proven to be essential to providing comprehensive and integrated treatment for co-occurring substance abuse and mental health disorders. Outcome studies have shown that programs providing integrated treatment have several common components associated with good outcomes. In this first brief, we focus on four of those components. Each evidence-based practice component is reviewed with suggestions for strategies and tools followed by a case example demonstrating how the principle can be used in treatment.

Individuals with co-occurring mental health and substance use disorders (CODs) have complex treatment needs. Historically, these issues were treated separately, as competing discreet needs. Barriers in access to integrated care for substance related and mental health disorders prevented many individuals from finding relief from their COD. The structures in place that prevented integrated care were many. Public and private funding, research, and public policy all created troughs between disciplines of care. Researchers and practitioners have noted how the separation of mental health and substance abuse treatment has created additional barriers and obstacles for clients with CODs:

> *Parallel treatment results in fragmentation of services, non-adherence to interventions, dropout, and service extrusion, because treatment programs remain rigidly focused on single disorders and individuals with dual disorders are unable to negotiate the separate systems and to make sense of disparate messages regarding treatment and recovery (Osher, Drake, 1996; Drake, Mueser, Brunette, and McHugo. 2004).*

Mental health services and treatment structures for substance related disorders were on divergent paths and many professionals considered one another with skepticism. Today, some, but not all, of those barriers have been eliminated.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2011 National Survey on Drug Use and Health, Mental Health Findings, more than 8 million adults in the United States have CODs. Only 6.9% of individuals receive treatment for both conditions and 56.6% receive no treatment at all (SAMHSA, 2012).

Continued inside

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Principles of Integrated Care for CODs

This is the first of two practice briefs that will explore eight principles of integrated care for CODs (Mueser et al., 2003). This brief will examine the first four of the following principles:

Principle 1
Integration of mental health and substance use services

Principle 2
Access to comprehensive assessment of substance use and mental health concerns

Principle 3
Comprehensive variety of services offered to clients

Principle 4
An assertive approach to care/ service delivery

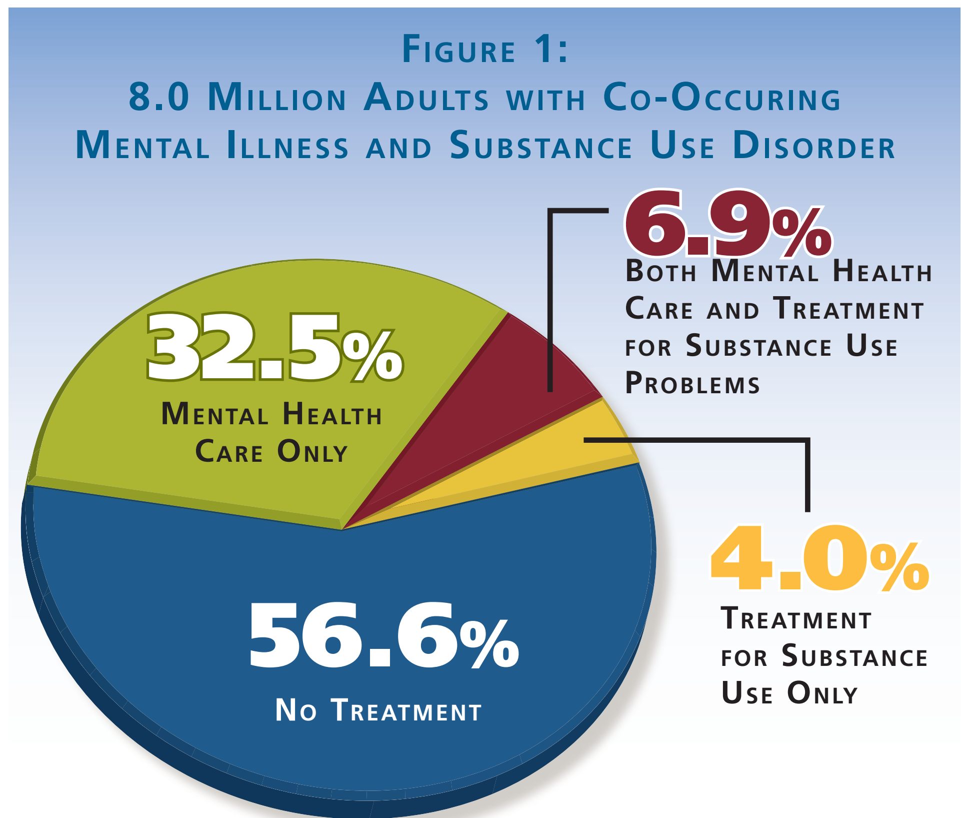
Principle 5
Using a harm reduction approach to care

Principle 6
Motivation-based and stage wise interventions

Principle 7
Long-term perspective of care

Principle 8
Providing multiple psychotherapeutic modalities

Mental Health Care and Treatment for Substance Use ProblemsAmong Adults Aged 18 or Older 2011



After a brief review of each principle, an illustrative case study will be provided and suggestions for implementing each of the principles in a client session will be offered (SAMHSA, 2009a; 2009b).

Principle 1: Integration of Mental Health and Substance Use Services

Multidisciplinary teams provide integrated services and relevant care that is client centered and longitudinal in nature. Agency policies and practices recognize the relapse potential with CODs and do not penalize clients for exhibiting symptoms of their mental health or substance related disorders. Team members may include the client and their family members or supportive persons, practitioners who are trained in substance abuse and mental health counseling, and a combination of physicians, nurses, case managers, or providers of ancillary rehabilitation services (therapy, vocational, housing, etc.) such as social workers, psychologists, psychiatrists, marriage and family therapists and peer support specialists. Based on their respective areas of expertise, team members collaborate to deliver integrated services relevant to the client's specific circumstances, assist in

making progress toward goals, and adjust services over time to meet individuals' evolving needs (Mueser, Drake, & Noordsy, 2013). The team members consistently and regularly communicate with the client to discuss progress towards goals, and they work together to meet the individual treatment needs of each client.

Case Study: *Penny, 43, experienced her first depressive episode in her mid teens. During her first treatment for substance use (marijuana and alcohol) at age 17, Penny was diagnosed with attention deficit hyperactivity disorder (ADHD). However, over the next few years, she became increasingly edgy and irritable with intermittent periods of euphoria, accelerated energy and impulsive behaviors followed by periods of despair. She had repeated hospitalizations and concurrent and sequential contact with both mental health and substance abuse treatment systems over the years. Penny was labeled with a variety of diagnoses, including bipolar disorder, ADHD, major depression, anxiety disorder, borderline personality disorder, and chemical dependence.*

Penny's multi-disciplinary team consisted of her primary practitioner who held LADC/LPCC dual licenses, a primary care physician, a psychiatrist, a family therapist, a peer recovery support specialist, and a vocational specialist. Penny participated in individual therapy as well as recovery skills groups with her primary practitioner. Her primary care physician monitored Penny's physical concerns including her diabetes and hypothyroid disorder. Penny's psychiatrist prescribed and monitored Penny's mood-stabilizing medications and provided case consultation to Penny's team. The family therapist provided ongoing support to Penny and her boyfriend Don, and helped Penny and her team decide if and when to begin reparations in her relationship with her children. In addition, the family therapist provided feedback to the team about how Penny's relationships impacted her recovery status and overall stability. The vocational specialist acted as a resource for Penny once she expressed a desire to return to work, helped Penny and her team identify resources for employment, and acted as liaison with Penny's employer. The peer recovery support specialist helped Penny identify recovery support groups and helped Penny and her team identify barriers and resources to overcome those barriers to recovery success.

MULTIDISCIPLINARY TEAMS PROVIDE INTEGRATED SERVICES AND RELEVANT CARE THAT IS CLIENT CENTERED AND LONGITUDINAL IN NATURE.

Principle 2: Access to Comprehensive Assessment of Substance Use and Mental Health Concerns

Integrated care recognizes that CODs and the resulting consequences of those conditions are commonplace. Therefore, practice protocols that standardize comprehensive biopsychosocial assessments are essential to identifying major mental illnesses and substance use. A comprehensive assessment includes screening, and when needed, further examination of substance use and mental health concerns. Practitioners utilize information collected from the comprehensive assessment to provide recommendations for When feasible, the practitioner gathers information from the client's family and other professional resources who might have relevant information regarding symptom severity, substance use, and role functioning. Information gathered during the initial assessment can assist in a collaborative goal setting process. Ongoing assessment is critical in the treatment of co-occurring disorders and involves evaluation of changes in circumstances, substance use, stability and symptom expression, and goal attainment. Conducting a comprehensive integrated assessment helps define areas that can be addressed in treatment and

> PRACTICE PROTOCOLS THAT STANDARDIZE COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENTS ARE ESSENTIAL TO IDENTIFYING MAJOR MENTAL ILLNESSES AND SUBSTANCE USE.

treatment –such as the role one condition has on the efficacy of particular treatment strategies for the other condition(s). Screening tools for substance related disorders can include the CAGE-AID (Brown & Rounds, 1995), the Michigan Alcohol Screening Test (MAST) (Selzer, 1971), the Drug and Alcohol Screen Test (DAST) or the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993). For mental health concerns the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) (Dennis, Chan, & Funk, 2006), or Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1983) may be used.

identify specific treatment recommendations (Mueser et al., 2013). The context of the comprehensive assessment should occur within a recovery-oriented perspective. Progress toward recovery is individualized as described in the following definition:

> ***Definition of Recovery***
>
> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, CMHS, 2011).*

Case Study: *Penny and her primary practitioner completed a comprehensive biopsychosocial assessment that included questions about distressing mental health symptoms as well as substance use patterns and periods of abstinence/remission. During her early 20s Penny entered college to become a nurse. Soon after beginning school, her anxiety increased. She experienced racing thoughts, extreme irritability, interruptions in sleep and a pronounced overconfidence followed by periods of despair and an inability to get out of bed. Penny returned to using alcohol and marijuana and eventually discontinued her education.*

In her early 30s, Penny completed substance abuse treatment and was abstinent from alcohol and marijuana. She also participated in individual therapy and was prescribed lithium. She experienced a period of relative stability and returned to school. However, Penny disliked the side effects of her medication and felt she was stable enough to discon-

tinue taking the lithium. She sought care from a physician for her anxiety and was placed on the benzodiazepine Xanax.

Penny currently lives with Don, her boyfriend of 8 years. Due to chronic conflict in their relationship, she is in danger of becoming homeless. Don has a construction business and manages to make a solid living. They both smoke marijuana most evenings as a way to wind down from the day. Don occasionally uses cocaine and in very rare situations Penny has joined him. She has been abstinent from alcohol since receiving a DWI 9 months ago. Penny has been estranged from her two adult children, Linda, 24, and Jeff, 22, for 6 months and 3 years, respectively. Her parents are deceased.

Penny's practitioner was able to collect information from Penny's boyfriend, her children, previous therapists, agencies and hospitals with whom she has had contact. During the assessment the practitioner discovered information about periods of increased mental illness symptoms while Penny was abstinent from substances, and a return to substance use in correlation with mental illness symptoms. The comprehensive assessment provided initial information about Penny's current mental illness symptoms and substance use and was used to determine treatment priorities and programs that align with Penny's needs.

Principle 3: Comprehensive Variety of Services Offered to Clients

Clients are provided with comprehensive integrated services that are cohesive, relevant and responsive to their identified needs and goals (Bipolar Disorder, n.d.). Practitioners coordinate with one another and collaborate with the client to prioritize

COMPREHENSIVE SERVICES THAT ARE RELEVANT TO PERSONS WITH CODS OFTEN INCLUDE BUT ARE NOT LIMITED TO: MEDICATION ASSISTED THERAPY, COGNITIVE BEHAVIORAL THERAPY (CBT), FAMILY THERAPY, LIFE SKILLS/ PSYCHOSOCIAL REHABILITATION, PSYCHOEDUCATION, AND SUPPORTED EMPLOYMENT.

treatment needs in a manner that does not overwhelm the client. A multidisciplinary team provides support for a broad range of issues relevant to the client population served by the agency. This includes culturally relevant information about community support systems and an array of mental health or substance related resources available to clients and their support persons.

Comprehensive services that are relevant to persons with CODs often include but are not limited to: medication assisted therapy, cognitive behavioral therapy (CBT), family therapy, life skills/ psychosocial rehabilitation, psychoeducation, and supported employment. **Medication assisted therapy** helps control distressing symptoms of many health and mental health disorders and is helpful for mood stabilization. Medication is also

used in the treatment of substance use disorders to inhibit substance use, reduce cravings, reduce withdrawal symptoms, and as replacement therapy. **CBT** helps people with CODs learn to change harmful or negative thought patterns and behaviors. **Family therapy** enhances coping strategies and focuses on improving communication and problem solving amongst family members and significant others. **Life skills/rehabilitation** provides clients with new information and opportunities to practice skills such as sleep hygiene practices, self-care, stress reduction and management, and medication maintenance. **Psychoeducation** provides information about the interacting dynamics of CODs and treatment (e.g., recognition of early signs of relapse so they can seek support before a full-blown episode occurs.) **Supported employment** provides opportunities for the client to contribute meaningfully in a work environment. A vocational specialist is part of the treatment team and works as a liaison with employers, client and the rest of the treatment team to support the client in the work environment. A case manager/navigator assists the client and their support persons in accessing resources necessary to their recovery. These relationships are longitudinal in nature and supportive rather than therapeutic.

> A VOCATIONAL SPECIALIST IS PART OF THE TREATMENT TEAM AND WORKS AS A LIAISON WITH EMPLOYERS, CLIENT AND THE REST OF THE TREATMENT TEAM TO SUPPORT THE CLIENT IN THE WORK ENVIRONMENT.

Case Study: *Penny and her treatment team agreed that she would benefit from mood stabilizing medication for her mental health disorder as well as cognitive behavioral therapy to help her develop coping strategies to help regulate and stabilize symptoms such as feelings of despair, racing thoughts, and behavioral dysregulation. Penny and Don recently began family counseling to explore the role and impact of substance use on their relationship, to develop communication skills and to identify strategies to help Don support Penny in her recovery from COD. Penny expressed interest in mending the relationship with her children in the future. If they are reunited, Penny identified a goal of attending family therapy with her children to improve communication and explore the impact of her COD on her relationship with them. Penny also identified a desire to return to work and will be making an appointment to discuss her work goals with the supported employment specialist.*

Penny participates in a skills group to assist her in managing the symptoms of her CODs such as emotional and behavioral regulation, self care, sleep hygiene, and to manage triggers related to her substance use.

Principle 4: An Assertive Approach to Care/Service Delivery

Assertive outreach involves reaching out to individuals who are at risk or in crisis and their concerned persons, by providing support and engaging them in the change process. Sometimes this occurs by engaging the individual who seeks care for a substance use issue and providing services that stabilize a COD. An assertive approach is time unlimited and occurs in a variety of situations, including a client's own community setting (Bond, 1991; Bond, McGrew, & Fekete, 1995). Asser-

tive outreach includes meeting the client in community locations and providing practical assistance in daily living needs. These strategies increase or decrease in intensity depending on the client's day-to-day living needs such as housing, transportation, money management, or seeking employment. This approach also provides opportunities to explore and address how substance use interferes with goal attainment.

Case Study: *Assertive outreach by Penny's multidisciplinary team included meeting with a vocational specialist to assist Penny in looking for a job. Penny's primary practitioner met with Penny weekly in Penny's home and discussed progress towards her goals. Although Penny had not declared she wanted to stop using or cut down this provided Penny's practitioner with an opportunity to introduce discrepancy by exploring how substance use interfered with taking steps toward Penny's goals and practicing or using coping skills. Penny and her primary practitioner examined how Penny's use impeded her ability to follow through with completing job applications and job interviews as steps toward finding steady, meaningful work.*

This brief examined four of the eight principles of COD treatment. The first four principles underscore the importance of the integration of COD services and access to comprehensive assessment and care using assertive outreach and a client centered approach. The next brief will explore the latter four COD principles and implementation strategies. The final COD principles emphasize a long-term care model using a harm-reduction approach, motivation-based stage-wise treatment interventions and multiple treatment modalities (Mueser et al., 2003). The principles in both briefs place the client and their support persons, front and center as active participants, guides, resources and experts in their own recovery. Unpacking the principles of integrated treatment for CODs provides opportunities for practitioners to utilize multiple strategies to engage clients in treatment as discussed in this practice brief.

AS YOU CONSIDER THE PRACTICE OF INTEGRATED CARE, EXAMINE YOUR AGENCY AND YOUR OWN CLINICAL PRACTICE.

As you consider the practice of integrated care, examine your agency and your own clinical practice. Consider how you might try new strategies in an effort to implement the principles of COD treatment. We invite practitioners to engage in a dialogue surrounding the strategies implemented in sessions to engage COD clients. Please consider the following and email us at mcmh@umn.edu to describe successful COD strategies and challenges utilizing the principles of COD treatment.

- What strategies have you tried using one of the above principles that worked particularly well?
- What challenges have you encountered?
- Please provide suggestions for additional strategies you found helpful.

Suggested Citation:

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Ken Winters, PhD

Friday, January 10, 2014 12-1PM

Youth, Drug Abuse and Co-Existing Disorders: Intersections on the Developmental Highway

Adolescence is an exciting period of development, which inherently involves the exploration of identity, Independence, and peer relationships. This period may also include risk-taking behaviors such drug use, as well as the onset of mental and behavioral disorders. This webinar will discuss evidenced-based assessment, intervention and treatment programs, and practices that address youth with a drug problem and co-existing disorders.

Ron Rooney, PhD

Friday, February 14, 2014 12-1PM

Hard to Engage Clients

The author of Working with Involuntary Clients will present strategies for engaging reluctant or involuntary clients.

Betty Poitra, MSW, LICSW, & Denise Lindquist, MSE

Friday, March 14, 2014 12-1PM

Cultural Adaptations: Motivational Interviewing with Native Americans

Both presenters have extensive experience working with Minnesota's Native American communities. This webinar will highlight strategies to adapt motivational interviewing methods to better engage Native American clients.