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MARCH 2014 • PRACTICE BRIEF No.4: Co-occurring Mental Health and Substance Use Disorders: GUIDING PRINCIPLES AND RECOVERY STRATEGIES IN INTEGRATED CARE (Part 2)

OUR MARCH BRIEF

This practice brief is the second of a two part series in which we continue our exploration of eight core principles. There is strong evidence supporting the efficacy and effectiveness of integrated treatment for co-occurring mental health and substance use disorders. Research validates these core principles as crucial to comprehensive integrated treatment. In this brief we will explore principles five through eight and associated practice components underlying integrated treatment. Each evidence based practice component is reviewed with suggestions for implementation strategies and tools followed by a case example demonstrating how the principle can be used in treatment.

The principles of integrated treatment

for co-occurring substance use and mental health disorders (CODs) place the client and their support persons front and center as active participants, guides, resources and experts in their own recovery. These principles provide an opportunity for programs to create structures that support integrated care and encourage practitioners to utilize multiple strategies to engage clients in defining personal recovery and reaching individualized treatment goals.

Osher (2006) identifies two distinct levels of integrated services that support evidence based practice – integrated treatment and integrated programs. Integrated programs provide the broader structural and treatment components of care such as multidisciplinary teams and specific interventions. In contrast, treatment occurs at an interpersonal level between the practitioner and the client and their concerned persons. Treatment involves the application of knowledge, skills and techniques that comprehensively address both substance use and mental health disorders. According to Osher (2006), it is not the use of specific treatment techniques that constitutes integrated treatment, but the selection and blending of techniques, and the manner in which these techniques are presented to the client that define integration.

Principles of Integrated Care for CODs

(Mueser, Noordsy, Drake, & Fox. 2003)

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

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The initial practice brief outlined principles one through four. These principles focused on the integration of COD services and the importance of collaborative care, access to a collaborative, ongoing and evolving comprehensive integrated assessment, the

tion approach, motivation based stage-wise treatment interventions and multiple treatment modalities (Mueser et al., 2003). Each principle will be reviewed with examples of implementation strategies and an illustrative case study to provide suggestions for

sources, and strategies that meet the client's various needs, dependent upon a number of factors, including safety, client identified goals, as well as internal and external vulnerabilities and assets. The harm reduction/stabilization model is inherent in motivational, stage-wise care. It honors the autonomy of the client and supports strides the individual might make toward symptom reduction and life improvement. Harm reduction/stabilization recognizes the bidirectional interactions of CODs and the complexity of these interactions.

The goal of a harm reduction/stabilization approach is for the practitioner and the client to work together to achieve a reduction in use and risk behaviors related to substance use. For some clients, abstinence is the ultimate goal. Harm reduction is an interim measure while managing and attending to other more pressing mental health symptoms. For others, harm reduction offers a means to find stability and relief from mental health symptoms or substance related problems. Some clients may understand the interface of their mental health and substance related disorders and the delicate balance between them, while other clients may be uncertain or ambivalent about a particular outcome or goal regarding their substance use. In this instance, harm reduction is a tool for possible engagement in the change process. It honors the ambiguity that many clients

THIS BRIEF WILL EXAMINE PRINCIPLES FIVE THROUGH EIGHT AND THE IMPLEMENTATION STRATEGIES OF COD TREATMENT. THE COD PRINCIPLES IN THIS BRIEF STRESS A LONG-TERM CARE MODEL USING A HARM REDUCTION APPROACH, MOTIVATION BASED STAGE-WISE TREATMENT INTERVENTIONS AND MULTIPLE TREATMENT MODALITIES

importance of a client-centered approach in offering a comprehensive variety of services, and the use of assertive outreach to skillfully keeping both overt and obscure issues on the table.

This brief will examine principles five through eight and the implementation strategies of COD treatment. The COD principles in this brief stress a long-term care model using a harm reduc-

tioning each of the principles in a client session (SAMHSA, 2009a; 2009b).

Principle 5: Using a Harm Reduction/Stabilization Approach to Care

Individuals experiencing CODs are faced with the daunting task of balancing compounded, multiple issues, often resulting in deficits in life skills. The practitioner's role is to provide support, re-

experience during the process of change and provides the practitioner with an opportunity to use motivational interviewing (MI) strategies to explore the client's definition of recovery and possible ambivalence about abstinence as an outcome (Miller, Rollnick, 2009.) Rather than challenging clients about their ambivalence, practitioners roll with the client's resistance and partner with the client in exploring possible goals related to reduction in substance use or abstinence. Practitioners have an opportunity to explore the role substances have played in creating barriers to attaining client goals while using harm reduction strategies such as psychoeducation and a payoff matrix.

Case Study: Over 9 months of treatment, Penny became abstinent from alcohol. She initially quit after receiving a DWI. Penny realized that she did not like the role alcohol has played in her life and felt that alcohol increased her feelings of hopelessness. It interfered in her relationship with her children and with Don, caused her to miss work because of depression, intoxication, and hangovers and ultimately impeded her ability to practice as a nurse.

Penny viewed her occasional use of cocaine as incidental and unimportant and stated she would be okay with giving it up altogether. She did not feel she had experienced any significant problems related to her use of marijuana. On the other hand, she was fearful that she would not pass an employment drug

PAYOFF MATRIX	
Behavior I'm considering changing: <u>smoking pot</u>	
Alternative Behavior: <u>quitting or cutting down on smoking pot</u>	
Smoking Pot	Quitting Pot
Pros	Pros
<ul style="list-style-type: none"> -like my time together with Don when we smoke -helps me relax 	<ul style="list-style-type: none"> -kids will be happy -don't have to worry about UR's when looking for work -Don and I might fight less
Cons	Cons
<ul style="list-style-type: none"> -makes me paranoid -feel tired all the time -don't feel like doing anything else -munchies eating too much 	<ul style="list-style-type: none"> -I won't have anything to do -I will miss the feeling -I will have trouble falling asleep at night -I don't want to quit

screen and this caused stress and reluctance to search for employment. Penny and her primary practitioner worked together on a payoff matrix to identify the positive and negative implications of continuing, discontinuing, or cutting down on her marijuana use.

In her discussions with her primary practitioner and her recovery group about the payoff matrix, Penny was surprised and unsettled that her use of marijuana had impacted her more than she previously thought.

The matrix offered new insights into the significant role marijuana played in her life. Penny allowed herself to believe that her pot use was recreational and without consequence. She began to rethink this. While Penny gained insight from the payoff matrix and discussion with her primary practitioner and group, she was still not willing to giving up pot altogether, although she expressed interest in cutting down. Rolling with Penny's reluctance to abstain from marijuana use, her practitioner worked within



the spirit of motivational interviewing and engaged Penny using MI strategies such as importance and confidence rulers, reflective statements, and open ended questions to invite change talk. (Miller, Rollnick, 2009.) Her practitioner recognized ambivalence as a normal and sometimes necessary part of the change process and provided opportunities to work with Penny in the future to address Penny's goals and the specific ways her marijuana use has prevented her from attaining them. In later counseling sessions Penny and her practitioner explored marijuana's role in her life as a barrier to achieving her goals of reunification with her children and obtaining meaningful work. Penny was open to these discussions.

Principle 6: Motivation-Based and Stage-Wise Interventions

Motivation-based care recognizes the internal process of change and the centrality of therapeutic

alliance between practitioner and client. It honors the collaborative relationship as integral to the goal setting and ongoing therapeutic relationship. Motivation-based strategies are implemented

recognizing the fluidity and ambiguity of change. Prochaska and DiClemente (1984) describe the change process as including precontemplation, contemplation, determination/preparation, action, and maintenance. It is important to note the change experience is not necessarily linear or sequential, as individuals may experience different levels of awareness or motivation in different aspects of their lives. Using motivation-based interventions requires a non-judgmental

approach and it is important for practitioners to continue to look for opportunities to discuss substance use related to the client's stage of change. To be effective, practitioners need to be willing to tolerate some discomfort when using motivational strategies to address minimization and avoidance from the client.

Stage-wise interventions match treatment strategies to the client's internal experience and encourage motivational congruence between the client and practitioner. Stage-wise strategies are client centered, complement the client's motivation for change, and can be particularly relevant in providing motivational incentives for individuals who, in the early stages of change, are not yet ready to

IN THE INITIAL ENGAGEMENT STAGE OF TREATMENT, EMPHASIS IS PLACED ON DEVELOPING AN ALLIANCE BETWEEN THE PRACTITIONER AND CLIENT AND DEVELOPMENT OF CLIENT COMMITMENT TO THE THERAPEUTIC PROCESS.

implement an aggressive course of treatment (Drake, 1993).

In the initial engagement stage of treatment, emphasis is placed on developing an alliance between the practitioner and client and development of client commitment to the therapeutic process. Strategies are geared toward relationship development, using assertive outreach or motivational strategies. For example, clients who are struggling with medication adherence or the idea of total abstinence from mood-altering

substances may be interested in engaging with the practitioner in identifying what meaningful recovery would look like for them and defining a goal that would bring them closer to that vision of recovery.

Persuasion helps a client develop awareness that substance use is a problem and creates motivation to change. This stage supports the individual's early process of learning to live effectively with CODs. Clients in early persuasion often demonstrate ambivalence about change and may minimize and avoid discussion of substance use. The practitioner incorporates motivational based strategies such as empathic responses or rolling with resistance and facilitates client awareness of discrepancies between their stated goals and barriers to those goals, such as substance abuse, limitations in living skills, or mental health concerns. Intervention tools might include readiness and confidence rulers or a payoff matrix.

In active treatment, individuals work to facilitate further reduction or continued abstinence and are engaged in the process of achieving their goals. Treatment strategies support clients to move in the direction of their stated goals and may include symptom management strategies, participation in recovery support groups, family therapy, cognitive behavioral therapy, and living skills groups, and medication assisted care. Strategies used during active treatment may include teaching

skills for dealing with cravings and developing coping strategies for symptoms as alternatives to self-medicating.

Relapse prevention assists clients in proactively identifying early warning signs of relapse,

including internal and external triggers, as well as emotional and behavioral cues. Once vulnerabilities are identified, strategies are implemented to address the individual's specific needs and fortify recovery, and in the case of relapse, to modify and curtail relapse behaviors. When recovery is stable, relapse prevention focuses on helping clients maintain stability and extend recovery to other areas of functioning. It helps those individuals who are stable in their recovery to develop strategies for avoiding or managing relapse (Marlatt, 1985). Clients improve their functioning by working on health areas such as diet and fitness or recapturing a lost interest or hobby.

Case Study: *After 11 months of treatment, Penny is in the maintenance stage of change in terms of her alcohol use. She has a peer recovery support coach and meets regularly with her. She attends Women for Recovery and dual recovery support groups. Over the course of treatment during the assessment of stages of change, she moved from*

the pre-contemplation through the contemplation and into early preparation/determination stage with regard to her marijuana use. Penny agreed to track the amount and frequency of her marijuana use and her mental health symptoms to see if there was any correlation between

TAKING A LONG-TERM PERSPECTIVE FOR PERSONS WITH CODs MEANS PRACTITIONERS RECOGNIZE THAT INDIVIDUALS RECOVER AT THEIR OWN PACE.

them, and began exploring the impact her marijuana use had on her relationship with Don and her children. After talking with her children during a family session, Penny and her primary practitioner agreed that she would try limiting her use of marijuana to weekends over a 2-month period while incorporating another payoff matrix to examine the positive aspects of this strategy. They have begun discussing barriers in her recovery, including Penny's confidence in her ability to achieve abstinence if she decided to pursue this as a goal for herself.

Penny is in the action stage of change with regard to her mental health issues. She has been adhering to her medications and has some insight into previous patterns that lead to relapse. In the past, when Penny's mental health symptoms were stable, she discontinued her medication regimen, leading to relapse of symptoms in both mental health and substance use disorders. Penny and her primary practitioner role played a discussion Penny was reluctant to have with her psychia-

trist about her Xanax prescription and also practiced assertive communication with recovery support group peers about her continued medication assisted care for anxiety.

As part of her treatment, relapse prevention strategies have been implemented to assist Penny in gaining insight into this pattern. Penny and her practitioner examined previous relapse experiences and identified early warning signs. Penny is working with her practitioner and her peer recovery support coach

THE LONG-TERM PERSPECTIVE TAKES INTO ACCOUNT EACH PERSON'S HISTORICAL EXPERIENCES WITH THEIR MENTAL HEALTH AND SUBSTANCE USE.

to devise a plan that will facilitate feedback from Don and other people in Penny's life when they see possible symptoms of relapse.

Principle 7: Long-Term Perspective or Time Unlimited Model of Care

Taking a long-term perspective for persons with CODs means practitioners recognize that individuals recover at their own pace. CODs both require responsive management, but each requires different strategic interventions. Typically, acute episodic interventions are time limited and target a specific need or problem (e.g., the need for a medication adjustment following symptom flare up or side effects of the medication.)

The long-term perspective takes into account each person's historical experiences with their men-

tal health and substance use. It honors the individual's autonomy and the relationship that individual has with their co-occurring conditions and encourages client self-efficacy in symptom management and recovery. At the same time, this model recognizes that individuals with CODs may need prolonged, responsive, external supports that address their long-term needs. Practitioners partner with the client to develop a plan and identify both immedi-

ate needs and strategies for long range goal attainment. A plan to address these needs might include regularly scheduled or periodic appointments with the practitioner, recovery support groups, regular medication check-ups, regular physicals, and vocational support.

Case Study: Penny initially sought care in a time of crisis. She was experiencing distress in her primary relationship due to her COD and abuse of substances. She had legal consequences from driving under the influence of alcohol and had difficulty maintaining a job due to symptoms of her substance use and mental health disorders.

Initially, Penny's care consisted of engaging her in the process of assessing and stabilizing the circumstances of her life. Once goals were identified and a plan of action was in

place to address immediate needs, Penny and her team were able to begin the process of exploring her CODs and substance use history and identifying potential emerging long-term needs. Penny's vocational support specialist provided support to Penny and her team at a point when Penny began experiencing an increase in her depressive symptoms leading to discontinuation of treatment and missed work over a 2-week period. Her vocational specialist acted as liaison between Penny and her employer. Although Penny did not attend treatment, her multidimensional treatment team assertively reached out to her to provide assistance. Penny met with her prescriber and an adjustment was made in her medication. In addition, her family therapist offered insight to Penny's team into family dynamics that were creating distress for Penny.

Principle 8: Providing Multiple Psychotherapeutic Modalities

Responsive care is delivered in a number of different modalities. Offering choice to clients and their support persons in the mode of care delivery is fundamental to client-centered care. Choice not only reflects the diversity of client needs and experiences, but also the changing needs of the client and their concerned persons over time. One person might fare well in a group setting and benefit from the experiences of others, where another might need individual care. Still others might



benefit from a combination of the two or might be at a point in their recovery that recovery support groups or a peer recovery support specialist might meet their needs. Many clients need help in repairing relationships with loved ones and benefit from family counseling. Individuals experiencing complex mental health and substance use disorders sometimes benefit from in-home or community based services.

Case Study: Like many, Penny's needs change over time. Much of her therapeutic work happens in individual sessions. More recently, Penny and Don have engaged in family sessions and Penny and her children have begun to discuss reconciliation through family therapy as well. Her children are cautious, but have agreed to some initial contact and have been peripherally involved in providing relevant information to Penny and her team about the impact of her use on their relationships.

Penny's primary practitioner and family therapist continue to provide support to Penny in goal setting and attainment. To create balance, Penny's individual sessions were tapered a bit, to accommodate the family work. She also attended psychoeducation and skill building groups in the agency and continues her involvement in recovery support groups in her community.

As Penny's experience demonstrates, these eight principles create a comprehensive model for addressing a client's treatment needs at the same time, in the same place while matching the client's treatment needs with strategies that are meaningful and relevant to the client's definition of recovery, identified goals and stage of change.

Recovery is a dynamic, fluid endeavor. For some it is a process, for others, a goal. These principles offer a framework to guide clients, their concerned persons and the multidisciplinary team in facilitating the recovery experience.

As you think about integrated care, examine your agency and your own clinical practice. Consider the structures in place in your agency that support integrated care and contemplate how you might try new strategies in an effort to implement the principles of COD treatment in your practice. The first brief offered an invitation to expand your clinical repertoire. We again extend that invitation to practitioners, to engage in a dialog about strategies implemented in sessions to engage clients experiencing CODs and how these strategies and principles might be impacted when considered from a culturally pluralistic lens. Please consider the following questions 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?
- If you have suggestions for additional strategies we welcome those as well. ●

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March 27: Innovative Interventions for Co-Occurring Disorders

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6.5 Continuing Education Units can be earned by attending the full program for this day.

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Kirsten Berg, Certified Peer Support Specialist
Friday, April 11, 2014

Forging through Mental Health Challenges: Cultivating Shoulder to Shoulder relationships between Empowered Peers and Informed Providers

This presentation is intended to show how Peers can, and deserve to have access to person-centered treatment while working in partnership with community providers. We are the "experts" on ourselves and by building an informed treatment team the journey and outcomes of recovery and wellness are limitless. The most valuable component to wellness is honoring the peers who have gone before us and to pave the way for future peers to embrace personal responsibility to cultivate and grow a healthy productive life.

Andy Thompson, LICSW, CPRP
Friday, May 9, 2014

Engagement Strategies

Andy Thompson began his professional work in the field of human services in 1997. He has experience working with individuals and families, who have a mental health diagnosis, in a variety of roles and settings including the following: residential facilities, mental health centers, shelters, homeless outreach, and intensive community settings. Andy earned his BA in psychology/philosophy from the University of St Thomas and his MSW degree with an adult clinical emphasis from University of Denver. He is a Licensed Independent Clinical Social Worker, a Certified Psychiatric Rehabilitation Practitioner, and a Certified Co-Occurring Disorders Professional Diplomat. Andy is currently the Program Director for two Assertive Community Treatment teams in Hennepin County.