Tips for Sustaining Change in Co-Occurring and Person-Centered Services

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A. Person-Centered Services in COD

1. Needs Assessment

- Continuing dilemmas and issues related to engaging people with COD
- "How to apply the stages of change model to things that are not substance misuse. We have to include stage of change on our treatment plans and in our notes for identified challenges such as depression or anger. To say that someone is pre-contemplative about changing their depression seems wrong-headed to me because it may not be that they don't want to change but more that they don't yet know how. It feels judgmental to say someone is pre-contemplative about their psychiatric diagnosis. How to utilize stages of change for a less obvious challenge such as depression?"
- What's working and what's not?
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2. Engaging Clients – Treatment Contract and Documentation

	Client	Clinical Assessment	Treatment Plan
What?	What does client want?	What does client need?	What is the Tx contract?
Why?	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
How?	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
Where?	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
When?	When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

3. Why Individualize Treatment/Service Plans?

1) What is a treatment/service plan, and why use one?
   a) NOT just a written plan on paper
   b) Most important with the most complex clients
   c) Should represent a shared vision

2) Teamwork
   1. The client is the most important team member
   2. The client is the person who should know the treatment/service plan the best
   3. Includes productive work with each other, especially across agencies

3) Engagement
   - Do we view the world through the client's eyes?
   - What does the client want most that drives the treatment/service plan?
   - How can we help the client to be utilizing his/her strengths?
   - How do WE feel if the focus is only on the negative—desires, hopes and goals are critical

(i) Common Treatment Planning Issues for Improvement

1. Problem Statements – Too general and non-specific

Examples: "Psychiatric"; "Substance Abuse"; "Legal"

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2. Goals – Not understood by clients

Examples: By six months, "develop awareness of cognitive deficits" and utilization of cognitive rehabilitation resources"; "Client will reduce the frequency of distorted, negative thoughts, use reframing skills"

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3. Interventions – Generic and not individualized

Examples: Substance abuse education weekly – work on healthy living behaviors; Pros and cons of complying with prescribed treatment activities and medications; Contemplator Discovery Group; Dual Recovery Anonymous; MISA Consultation

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4. Progress Notes – General; often focused on attendance and compliance rather than documenting client's clinical progress

Examples: "More willing to follow rules and compliant with treatment activities"; "Compliant participation in group"; "Attended and participated in all scheduled groups"; "Plan: Continue to monitor"

* Long progress notes
* No notes related to problems e.g., Substance Abuse
* Difficult to see what the progress note relates to in the Treatment/Service Plan

B **Paradigm Shift from Programs to People**

1. ASAM Multidimensional Assessment

- Because mental and substance-related disorders are biopsychosocial disorders in etiology, expression and treatment, assessment must be comprehensive and multidimensional to plan effective care. The common language of the six assessment dimensions of the ASAM Criteria (Second Edition, Revised, ASAM PPC-2R, 2001) are used to focus assessment and treatment.

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	
2. Biomedical Conditions and Complications	
3. Emotional, Behavioral or Cognitive Conditions and Complications	
4. Readiness to Change	
1. Relapse, Continued Use or Continued Problem Potential	
6. Recovery Environment	

- Regardless of the particular setting and client population, there are "generic" treatment strategies:

5 M's:

Motivate - dual diagnosis clients can have denial, resistance and passivity about their addiction and mental health problems; deal with resistance at a pace that keeps the patient engaged in treatment; family and healthcare workers may also need "motivating" to deal with both addiction and psychiatric issues equally. (Dimension 4)

Manage - because dual diagnosis clients easily present to both addiction and mental health programs, treatment is more case management across the addiction and mental health treatment systems, social welfare, legal, and family systems and significant others, than individual therapy; case management especially important for high risk, multiproblem and chronic relapsing clients; take a total systems approach; to improve outcomes, alternative services may be necessary e.g. educational or vocational services, child care and parenting training, financial counseling, coping with feelings and dual relapse groups, daily living skills, tutoring or mentoring services, transportation. (Dimensions 1 - 6)

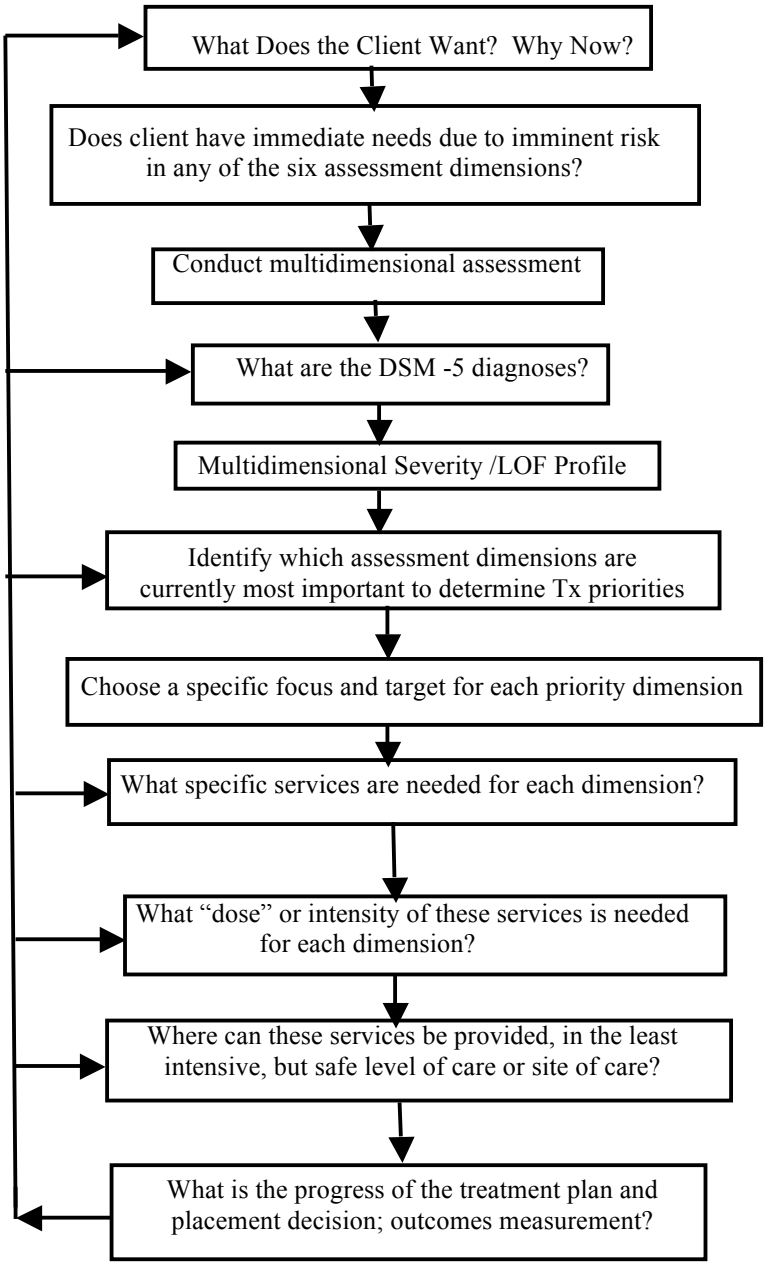
Medication - for a diagnosed co-morbid psychiatric disorder, but only after sufficient assessment strategies exclude addiction mimicking; also for detoxification if necessary; educate clients about their medication and interaction with alcohol/drugs; prepare them on how to deal with conflicts about medication at AA/NA meetings; anti-addiction medication: naltrexone (Vivitrol), acamprosate (Campral)); disulfiram (Antabuse); methadone; buprenorphine; opioid antagonists. (Dimensions 1, 2, 3, 5)

Meetings - mainstream into AA and NA as much as possible, but prepare clients on how to not alienate themselves eg. too readily discussing medication and mental health issues unless with an understanding member or group; help clients deal with their "dual identity"; help identify appropriate meetings in the area and locate or develop special support groups for those unable to be "mainstreamed". (Dimensions 3, 4, 5, 6)

Monitor - to ensure continuity of care, be alert to missed appointments; hospitalizations and professionals unfamiliar with dual diagnosis and the treatment goals eg. drug-free diagnostic trial; promote accountability for an ongoing treatment plan, rather than fragmented response to crises; recognize treatment as a process, not an event. (Dimensions 1 - 6)

2. How to Target and Focus Treatment Priorities

Decision Tree to Match Assessment and Treatment/Placement Assignment



Reference: Mee-Lee D, Shulman GD (2009): "The ASAM Placement Criteria and Matching Patients to Treatment", Chapter 27 in Section 4, Overview of Addiction Treatment in "Principles of Addiction Medicine" Eds Richard K. Ries, Shannon Miller, David A Fiellin, Richard Saitz. Fourth Edition. Lippincott Williams & Wilkins, Philadelphia, PA.,USA. pp 387-399.

3. Rename the Graduation or Treatment Completion Ceremony

Perhaps you could call it the RCA - the *Reflection, Celebration and Anticipation* ceremony or event.

- *Reflection* on what the client and family have learned, seen, gotten in touch with, changed since entering treatment. It can also be a reflection not just of positive things, but in all honesty (this is an honest program), reflection about things still not resolved or still not accepted. This is to model that this is about Progress not Perfection; about beginnings in recovery, not an end or completion of treatment; about reflecting on what might not yet be working, not just putting on a brave front to say everything is rosy

- *Celebration* of any accomplishments in this piece of recovery work done at this time in this program. Celebrating what has worked and what the program community has given the person; a time to be thankful for the challenging work the person has done so far in their recovery that is just beginning, not ending. Celebrating the hope that can be there for the client and family when there was only despair and hopelessness.

- *Anticipation* of what lies ahead in their recovery – plans on how to continue gains that have been made; but also how to keep working on doubts or ambivalences or challenges that still may be there or are even likely to be there. Anticipation of what needs to be done to keep progressing and if not "perfect" and there is a slip or relapse, what is plan B to get back on track – not with shame or a sense of failure, but with determination and commitment to keep moving forward – a day at a time with serenity.

C. **Changing the Treatment Culture for Person-Centered Services**

1. Changing the program mission and vision – organizational culture

- The Culture Iceberg Exercise – Unwritten Rules/Norms and Beliefs/Assumptions

- Gather team members to re-visit the Mission, Vision and Values of the health care system involved in the upcoming or active change process

Addiction counselors may not be interested in working with those "crazy" psychiatric patients; and mental health clinicians may not be interested to in working with "those people - those out of control alcoholics and addicts". In fact that is part of the reason they chose the agency and field of work in the first place. Now they are suddenly expected to work with people with both problems (not that they weren't actually working with them anyway). The juices for working with co-occurring disorders don't automatically flow with administration's declaration of a new direction.

A good place to start in any system's change that requires team members to challenge their attitudes, perspectives and comfort zone of work competence is to meet together to understand the context for and collaborate in fashioning the new Mission. This provides the opportunity for all to take responsibility for re-committing to their job; or for deciding that they are not interested in, or committed to the new Mission.

A discussion of Values allows the team to develop principles before policies, procedures and personalities provoke the inevitable disagreements over what to do if a client shows up to treatment having used alcohol or some other drug on the way. Or what to do when a client refuses to take medication; or when a client wants to stop methamphetamine or heroin, but keep drinking alcohol or smoking marijuana? Discussing and naming the Values before the actual situation arises provides the anchor to guide the practice when things get tossed around.

- For example, suppose one Value was: Relapse in addiction and mental health are both addressed as crises in a person's treatment requiring evaluation of the crisis and revision of the service plan.

Suspension or discharge from treatment and zero tolerance of relapse will not apply to either a person's substance use or mental health crisis.

- Discussion of all the issues in developing such a Value statement engages all team members in fruitful attitudinal and clinical practice implications

2. Develop specific implications for each Value that arises out of the discussion of the new Mission and Vision

Just about every agency and company has a Mission Statement that very few team members can even recall, let alone articulate and speak to the real implications of the Mission.

a) See if you can repeat right now your agency's Mission Statement without looking it up.
b) Or you have always thought of it as being so generically lofty, "motherhood and apple pie" and so broad as to be of little practical use in the dilemmas and pressures of daily life on the job.

One task that can help counteract this common phenomenon is to move beyond the Mission, Vision and Values to a comprehensive exploration and listing of all the implications for each Value. To continue with the example Value above that "Relapse in addiction and mental health are both addressed as crises in a person's treatment requiring evaluation of the crisis and revision of the service plan. Suspension or discharge from treatment and zero tolerance of relapse will not apply to either a person's substance use or mental health crisis."

What would be the implications of such a Value? The list could include:

1. If a crisis of substance use, suicidal, violent or self-mutilation behavior, psychosis, mood instability etc. should occur, all clients will receive timely assessment to address any immediate needs; and to revise the treatment plan to improve the client's progress and outcome
2. If a client's relapse triggers reactions in other clients, this provides the opportunity to assist both the relapsing client, as well as helping other clients learn from their reactions to the relapse and crisis.
3. No client will be excluded from treatment due to the recurrence of symptoms of their addiction or mental illness. However, if a client deliberately undermines treatment by enticing others to use substances or by violating boundaries with violence or impulsive behavior, discharge is appropriate for the client who cannot be engaged in accountable treatment.

3. Different Theoretical Perspectives; Different Treatment Methodologies

(i) Integrated Treatment versus Parallel or Sequential Treatment

- hybrid programs - staffing difficulties; numbers of patients and variability, but one-stop treatment
- parallel programs - use of existing programs and staff, but more difficult to case manage

(ii) Care versus Confrontation

- mental health - care, support, understanding, passivity
- addiction - accountability, behavior change

(iii) Abstinence-oriented versus Abstinence-mandated

- treatment as a process, not an event
- respective roles in both approaches

(iv) Deinstitutionalization versus Recovery and Rehabilitation

4. Example Policy and Procedure to Deal with Relapse or Continued Use Crises

Recovery and psychosocial crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

1. Slip/ using alcohol or other drugs while in treatment.
2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs.
3. Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior.
4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.

2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.

3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

    1. Acute intoxication and/or withdrawal potential
    2. Biomedical conditions and complications
    3. Emotional, behavioral, or cognitive conditions and complications
    4. Readiness to change
    5. Relapse, continued use, or continued problem potential
    6. Recovery environment

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the six ASAM dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-compliance with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and “doing time” rather than “doing treatment and change,” explore what Dimension 4, readiness to change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as co-occurring disorder enhanced services. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in

gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute reoccurrence of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about "triggering" others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with posttraumatic stress disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills. In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

10. Document the crisis and modified treatment plan or discharge in the medical record.

Application to Clinical Vignettes

A recurrence of signs and symptoms of any illness, and in particular addiction, warrants an immediate reassessment of what went wrong, with a goal to improve the outcomes by changing the treatment plan in a positive direction. Once the assessment and new service plan are agreed upon with the patient, the next decision is: where can that plan be safely and efficiently delivered? The new plan may be provided in the current level, or may need a less intensive or more intensive level or different services. But the level of care decision is driven by the individualized treatment plan, not a predetermined policy to always move the person to a more intensive level of care.

Here are some examples:

Transfer to a less intensive level of care:
The patient used while in residential or intensive outpatient treatment because he now believes that after a period of abstinence, he is not really addicted. He is sure that recent substance use problems were caused by a lot of stress with family and work difficulties. It is his view that since he was able to be abstinent with little difficulty, he can safely return to social drinking, which is why he had a couple of beers when having dinner with friends on a recent transitional therapeutic pass or birthday party. While the clinical team is sure he has addiction illness, they agree to transfer him from residential to outpatient services, or from intensive outpatient to once-per-week outpatient sessions to do "discovery, dropout prevention" motivational strategies.

Transfer to a more intensive level of care:
The patient has had increasing cravings to use, but was reluctant to process these cravings with her counselor and peers for fear of lengthening her treatment stay. As her urges to use became almost unbearable, she hoped she could secretly get her old drug dealer to drop off some heroin, which she could use to get some relief. She succeeded in smuggling some heroin into the residential setting and was found slumped over in the bathroom, having overdosed with the needle still in her arm. She was transferred to intensive care. The same transfer would occur if the patient was in outpatient treatment and was discovered overdosed by her roommate.

Transfer to the same level or a different level of care where different services are available:
The patient has been diagnosed with a major depression disorder and has been stable on her antidepressant medication. She has a significant reemergence of her depressive symptoms and has suicidal ideation with moderate to high lethality. She has become intoxicated between her IOP sessions and believes that only drinking will relieve her depressive symptoms. This patient needs co-occurring enhanced services provided in the same level of care, if possible, or in a different level of care where theses services are available.

Continue in the same level of care:
The patient again has had increasing cravings to use, and was reluctant to process these cravings with his counselor and peers. He arranges for some friends to bring him some oxycodone pain pills and some marijuana, which he uses while in residential treatment. Some of his peers notice the flare-up of his addiction and when confronted, the patient owns up to his return to substance use. He realizes as he processes this flare-up in group that he needs to sever all contact with his old drug friends and is willing to do it. His peers promise to support him as he role-plays with them what to say to end his relationship with old drug-using friends. This treatment plan is best continued in the current level of residential care where he has the support of peers who can also learn from his flare-up of addiction while being in a more protected environment.

In an outpatient setting, a patient with two weeks of abstinence off methamphetamine and narcotic analgesic pills is genuinely excited about his recovery process. He visits friends still using methamphetamine on the weekend to try to attract them into recovery. Overwhelmed, he ends up using. Thankfully, he talks about this use in group the next day. He realizes his mistake of visiting with using friends too early in his recovery and determines to stay away and instead go to more Narcotics Anonymous meetings. This treatment plan is best continued in the current level of care where his updated treatment plan can safely be provided. To transfer him to a more intensive level of care would be wasteful of resources and break continuity of care.

If a patient is not invested in treatment and just wants a place to stay as a respite from homelessness, or to get out of jail sooner, and in that context brings alcohol or other drugs into the facility and even influences others to use with him or her, then discharge is reasonable. The treatment program is a treatment place, not a hotel, resort, or marketplace. But if a patient is trying to do treatment to the best of his or her ability, gets a craving to use, and resumes substance use, the procedure is to reassess and change the treatment plan accordingly rather than automatically discharge or transfer to a more intensive level of care.

D. **What Delaware Has Done with COSIG**

1. Kent Sussex Counseling

- Use Stages of Change: realizing clients are at different stages for different things --> to less frustration
- Use Motivational Interviewing (MI)
- Meeting clients where they are at --> builds rapport with clients
- Languages changes in policies and procedures to be more holistic and recovery planning for recovery oriented systems of care and wellness – ASAM Criteria and MI

2. Delaware Council on Gambling Problems

- Gambling therapists improved documentation with revised assessment and treatment planning forms
- More individualized progress notes and better chart flow
- Better bridge between Prevention and Treatment to “capture” people into treatment and recovery
- Can give CEUs on gambling disorder

3. Wilmington Community Mental Health Center and other CMHCs

- Matching the person with the right clinician and treatment agency – what is the most effective care for this client and who can best do the service

- Medication Assisted Treatment (MAT) still a challenge with some physicians uncomfortable with Suboxone (buprenorphine and naloxone)
- Clinicians more empowered to do COD treatment. Some staff had past experience as an addiction-competent clinician but in past times felt reluctant to apply those skills in a mental health setting. Now the application of their knowledge and skills is encouraged and supported
- Risk tolerance of clinicians increased with more knowledge about addiction and the training provided – less fear of the unknown
- Clients encouraged and empowered to address COD and this also teaches staff
- Peer counselors part of the team, Power Statements* and CommonGround (Pat Deegan) web application empowers clients to advocate for their needs
- Smoking cessation supported
- Policy manuals changing to support sustainability

(* A Power Statement is a self-advocacy statement that does three things:
  - It introduces me to the doctor as a person not a patient
  - It says how I want psychiatric medicine to help me
  - It invites my doctor to work with me to find the medicine that will help me achieve my goals

Here is an example of a Power Statement:

I love my girlfriend. I can't be with her if I am paranoid. I want to work with you to find a medicine that will help me be less paranoid so I can be with my girlfriend. But it can't have sexual side effects.)

4. Thresholds
- Institutionalized COD in the assessments and treatment by reviewing committee reports and statistics on screening and staff attitudes e.g., less than 35% of newly hired staff just wanted to do addiction treatment, so attitudes, comfort and skills is increasing towards doing COD work
- COD groups added
- Internal auditing of treatment plans – developed targeted questions that address more specifically clients with COD e.g., worksheets to check for "Are COD noted?" If yes, further questions such as Does the treatment plan include individualized strategies for COD?
- DDCAT audits done
- Enhance attitudes of staff in working in a person-centered manner by having an empty chair in staff discussions over client progress and treatment – "Is that what you would have said if the client was here sitting in that chair?"
- Supervision – onsite and by Skype

5. Gaudenzia
- Improved skills with COD --> fewer dropout of clients and wanting to leave; better retention in care
- Screening for COD increased awareness of COD
- Intake packet incorporates screening as it is in the assessment forms, so institutionalized in all assessments now
- Treatment planning meetings discuss COD now not just addiction
- Much better idea of what COD clients can be well managed and treated and what ones need to be referred to more mental health skilled services

6. SODAT
- Comfort and competence of staff in treating people with COD changed from fear of mental illness to now capable of assessing and treating COD as routine
- Mental health staff added to increase the whole team's comfort and competence
- Services changed from addiction only to COD capable with better collaboration with physicians now
- Person-centered services with each client asked about what they want from treatment

7. Horizon House ACT
- Clients more involved in recovery planning with their input received a month in advance of recovery planning documentation
- Job descriptions redone to include COD and CCDP certification

8. ECHO
- Job descriptions to include COD competence
- Groups – not just Illness Management and Recovery (IMR) but co-IMR; harm reduction not just abstinence; use of Power Statement and CommonGround; client-centered; Motivational Interviewing

What are you doing or have done to advance sustainability for co-occurring and person-centered services?

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E. Improving Treatment Systems to Sustain Changes

1. Staff Issues

- collaborative, concurrent interdisciplinary team
- vulnerabilities inhibiting team cohesiveness e.g., recov. vs non-recov.; M.D. vs counselor; psych. vs addiction-trained; biomedical vs psych. orientation; education vs. life experience; ambiguity tolerance
- team communication - documentation skills; use of jargon and technical terms e.g., "confused", "disoriented", "delusional"
- staff-program match
- stress of working with multiproblem patients - need to be in control; countertransference; overwhelmed with the needs and lack of resources; group supervision and conflict resolution

Incorporate the following into your personal approach to care:

Tolerance:	To listen to another professional's opinion
Open-mindedness:	To give up old views of addiction or psychiatric problems
Patience:	To explore the history and treatment progress carefully before jumping to diagnostic conclusions
Education:	To learn more about addiction & mental illness; meds.; motivating strategies
Serenity:	To realize that professionals cannot always know the answers immediately.

2. Program Issues

- mission of the program, department, institution or agency
- equal emphasizes both mental health and addictions issues
- admission criteria and patient mix - what can staff/program mange
- terminology and treatment tools e.g., "alcoholism vs "addiction
- non-cognitive, activity groups e.g., time use charts; collages
- groups - education about dual identity; feelings group to learn about relapse cues, signs and symptoms
- family involvement; systems work and continuing care
- self/mutual help groups - preparation for AA/NA mainstreaming; Dual Recovery Anonymous
- staff composition reflects training proportionate to program's clientele

F. **Improving Treatment Systems**

There are many systems boundaries that work against effective continuity of care:

- Excessive boundaries, exclusion, and territoriality - policy, funding and practice ignore and sacrifice the complexity of individual needs to achieve and maintain bureaucratic simplicity; continuity of care is nearly impossible under these circumstances.
- Inadequate assessment and diagnosis - on an individual basis, addiction and mental illness are often not diagnosed; inadequate assessment of community needs affects system planning and development of services.
- Lack of trained staff - the polarization of the mental health and addictions fields, historically, has resulted in knowledge gaps only now beginning to improve; lack of experience in both addiction and mental health fields results in fear and resistance to learn and broaden counseling knowledge
- Inadequate array of services - dual diagnosis services either do not exist, or represent a few model programs; even in states where it is more of a priority, there are too many gaps.
- Rigid funding streams - there still are inadequate resources, turf battles and a reluctance to pool resources for training, research or service delivery.
- Lack of a strong shared constituency - because there is little common ground between the addictions and mental health constituencies, the ability to influence policy and service delivery is greatly limited.
- Limited dissemination of effective program models - too little is done to publicize what works in model programs; programs are too infrequently evaluated, or if evaluated, the findings are often not applied in future funding or program planning
- Fragility - when barriers have been overcome, it is usually due to individual efforts that are too fragile and dependent on that person's leadership; positive changes are therefore not sustained by basic structural changes in the mental health and addiction service systems.

(Wayne Thacker, MSW., Leslie Tremaine, Ed.D: "Systems Issues in Serving the Mentally Ill Substance Abuser: Virginia's Experience" Hospital and Community Psychiatry, Vol. 40, No. 10 pp. 1046-1049, Oct. 1989.)

G. **Case Consultation and Systems Issues**

1. Making Treatment Plans a "Living" Document

(a) Principles

1. Problems identified should arise from a biopsychosocial assessment and level-of-functioning (LOF) or severity-of-illness (SI) profile.

2. Problems should be short-term in an acute-care treatment plan; may be longer-term in a program with a longer length of stay (LOS).

3. Treatment planning is a continuous, ongoing process of assessment, problem identification and matched treatment strategies. Thus problems, whether in acute care or longer LOS program, should be specific and treatable within the current level of care (LOC); not fixed for the whole LOS; and should be updated and/or resolved and replaced with new problems identified from ongoing assessment.

4. A problem identified at any time may be listed on the Master Problems Index and coded to indicate whether treatment is to be addressed in the current LOC or later in the recovery or treatment process.

(b) Steps to Writing Problems

1. Review the multidimensional Level of Functioning/ Severity Profile and identify which dimensions are of most concern.

2. Look especially at each high and medium severity dimension and ask yourself what concerns you most within that assessment dimension.

3. Review the specific information related to the dimension in the biopsychosocial assessment for help in defining a problem for each dimension of concern.

4. In general, write only one problem for each dimension of concern to keep the treatment plan focused, specific, fluid and achievable. If there is an additional acute problem needing treatment, then a second problem for that dimension may be necessary.

5. Define the problem using the "2x4" guidelines.

6. Check the problem you have decided to document for specificity and individualization by asking yourself, "What made me say that?". If you can answer with a more specific behavior or observation, then that should be the problem, not the more abstract problem originally chosen.

(c) Clinical Problem or Need:

1. A situation or issue in need of improvement; and
2. Related to the clinical assessment of the client.

(d) Short Term Goal:

1. An expected result or condition which takes a short time to achieve.
2. Related to the identified clinical problem
3. Stated in measurable terms

4. Use action verb to illustrate direction of change - from the perspective of "what the client will be able to do after attending treatment sessions" and not from the perspective of what you as the counselor will do during treatment e.g. "Client will receive education about the effects of drinking on the family"

Begin each Goal with a verb that denotes an observable action, such as: "Define, Describe, List, Explain, Discuss, and Apply" e.g., "Bill will be able to describe how each family member has been affected by his drinking" Avoid words that indicate emotions, feelings or other things that occur in the head, such as "know, learn, appreciate, understand, recognize", etc.

Example: "Bill will appreciate the negative effects and consequences of his drinking on the family"

5. One goal per problem statement
6. Provides a guideline for the direction of care.

(e) Plan of Treatment:

1. Describes the service(s) or action to meet the stated goal
2. Specifies frequency of treatment procedures
3. Has a time for achievement
4. Identifies if client and/or staff member(s) responsible for action or strategy in the treatment plan e.g., Sally is to try the "I have strong willpower, no AA meetings" treatment strategy; and counselor to arrange family meetings or contact to get reports back on how Sally's drinking and family relationships are progressing or not.

2. Medication-assisted treatment issues – policies and procedures

- Review use of medications in the treatment of substance use disorders especially those designed to treat opiate addiction. How and when is the decision made to use medication?

3. Working with Criminal Justice and Mandated Referral Agencies

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered. Clinicians are not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical. Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts following:

* Common purpose and mission – public safety; safety for children; similar outcome goals

* Common language of assessment of stage of change – models of stages of change

* Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement

* Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create incentives for change and provide supports to allow change

* Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

4. Increasing Co-Occurring Disorders Capacity through Collaboration

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client's needs can be a data point that sets the foundation for strategic planning and change

- Finding efficient ways to gather data as it happens in daily care of clients can help provide hope and direction for change:

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter	
Level of Care/Service Received - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service	
Reason for Difference - Circle only one number -- **1**. Service not available; **2**. Provider judgment; **3**. Client preference; **4**. Client is on waiting list for appropriate level; **5**. Service available, but no payment source; **6**. Geographic accessibility; **7**. Family responsibility; **8**. Language; **9**. Not applicable; **10**. Not listed (Specify):	
Anticipated Outcome If Service Cannot Be Provided – Circle only one number - **1**. Admitted to acute care setting; **2**. Discharged to street; **3**. Continued stay in acute care facility; **4**. Incarcerated; **5**. Client will dropout until next crisis; **6**. Not listed (Specify):	

Case Presentation Format

Before presenting the case, state why you chose the case and what you want from the discussion

I. Identifying Client Background Data

Name
Age
Ethnicity and Gender
Marital Status
Employment Status
Referral Source
Date Entered Treatment
Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
Current Level of Service (if this case presentation is a treatment plan review)
DSM Diagnoses
Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. Current Placement Dimension Rating (See Dimensions below 1 - 6)

1.

2.

3.

4.

5.

6.

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

This last section we will talk about together:

III. What problem(s) with High and Medium severity rating are of greatest concern at this time?

Specificity of the problem

Specificity of the strategies/interventions

Efficiency of the intervention (Least intensive, but safe, level of service)

LITERATURE REFERENCES AND RESOURCES

The *ASAM Patient Placement Criteria: PPC Supplement on Pharmacotherapies for Alcohol Use Disorders.*
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International Center for Clinical Excellence – www.centerforclinicalexcellence.com;
www.scottdmiller.com
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Tel: (773) 404-5130; Fax: (847) 841-4874; Mobile (773) 454-8511

Mee-Lee, David (2001): "Treatment Planning for Dual Disorders". Psychiatric Rehabilitation Skills Vol.5. No.1, 52-79.

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American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; (800) 844-8948.

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White, W (2005): "Recovery Management: What If We Really Believed that Addiction was a Chronic Disorder?" Great Lakes ATTC. www.glattc.org

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3. Motivational Interviewing and Ambivalence – Principles of Motivational Interviewing; Spirit of Motivational Interviewing; Working with Ambivalence - Disc 3 of a Five Part Series Workshop

4. Establishing the Treatment Contract; Role Play – What, Why, How, Where and When to establish the Treatment Contract; and a role play with a "17 year old young man" to illustrate this technique - Disc 4 of a Five Part Series Workshop

5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist's Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

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