Applying Skills in Assessing and Treating Co-Occurring Disorders: Challenging Cases; Tips and Topics

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Pretest Questions

Select and Circle the Best Answer:

1. Addiction and mental health systems often clash over:

   a) Viewing substance use problems as being caused by underlying mental health causes.
   b) Viewing mental health problems as being caused by underlying substance use problems.
   c) Whether medication should be used in a person who is also using alcohol or other drugs.
   d) Whether a person should be discharged or not for using substances while in treatment.
   e) All of the above.

2. Reasons for diagnostic confusion in addiction problems and psychiatric disorders are:

   a) Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity).
   b) Prolonged alcohol/drug use can cause short or long-term psychiatric illness.
   c) Alcohol/drug use can escalate in episodes of psychiatric illness.
   d) Addiction illness sometimes co-occurs with mental illness as an independent disorder.
   e) All of the above.

3. Assessment guidelines to distinguish between addiction illness and psychiatric disorders:

   a) Are not important as it is best to just treat symptoms and medicate whatever is present.
   b) Are always useless to pursue as all alcoholics and addicts lie and are unreliable.
   c) Should involve taking a good timeline history.
   d) Should not include questions about periods of time drug-free as addicts use all the time.
   e) None of the above.

4. The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM):

   a) Does not have criteria for co-occurring substance and mental disorders.
   b) Discourage individualized treatment as clients should accept placement in a residential program.
   c) Do not allow for multidimensional, holistic treatment
   d) Has six assessment dimensions that provide a common language for person-centered services.
   e) Do not allow for multidimensional, holistic treatment

5. To ask a client what s/he really wants:

   a) Is as important as assessing what the client needs.
   b) Is unnecessary as their judgment is so poor.
   c) Gives a false impression that they should have choice about treatments
   d) Leads to disrespect of the clinician's authority and non-compliance.
   e) Usually reveals unrealistic goals that should be ignored.

6. Recovery in Co-Occurring Disorders Treatment:

   (a) Applies to both addiction and mental illness.
   (b) Is more than just stabilization of withdrawal and psychiatric symptoms.
   (c) Involves pursuing personal goals and an identity beyond the person's illness.
   (d) All of the above.

7. If treatment providers really embraced a recovery model:

   (a) They would discharge any clients who used alcohol or other drugs in treatment.
   (b) They would plan for continuing care rather than thinking of it as aftercare.
   (c) They would emphasize the importance of graduating from the program.
   (d) They would view prior treatment as an indication of poor prognosis.

8. To implement a recovery model:

   (a) All programs should be rigidly separated to maintain group trust.
   (b) There should be a fixed length of stay to ensure compliance to the program.
   (c) Establish seamless movement through a flexible, broad continuum of care.
   (d) Always initiate treatment in a residential program for at least 28 days.

9. Walking the Talk about Recovery means:

   (a) Considering relapse in addiction no differently from relapse in mental illness.
   (b) Having fixed program completion times for both addiction and mental illnesses.
   (c) Placing people in long term residential if they have had three relapses.
   (d) Holding clients accountable and discharging them if they miss five sessions.
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Indicate True or False:	T	F
10. Ambivalence is a normal part of addiction and mental illness	( )	( )
11. Because of denial, confrontation is more important than collaboration.	( )	( )
12. Persistent medication adherence problems should result in discharge.	( )	( )
13. Intensive case management is needed for both severe psychiatric and addiction illness	( )	( )
14. A full continuum of care is needed to promote recovery, not just residential care.	( )	( )
15. Poor outcomes should result in early discharge to another program immediately.	( )	( )
16. A mental health evaluation should not be done until the client is 30 days sober.	( )	( )
17. If a client is depressed assume Major Depressive Disorder until proved otherwise.	( )	( )
18. Appearance and behavior are important in assessing a person's mental status.	( )	( )
19. Medication should not be used for people who have an addiction and mental illness.	( )	( )
20 If a person is paranoid or psychotic, don't argue rationally about delusions.	( )	( )

A. **Terminology**

- Co-Occurring Mental and Substance-Related Disorders

In "A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders", SAMHSA defines people with co-occurring disorders as "individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person…at least one disorder of each type can be diagnosed independently of the other". The report also states, "Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). There are no specific combinations of….disorders that are defined uniquely as co-occurring disorders."

(www.samhsa.gov/reports/congress2002/foreword.htm)

- "Co-Occurring Disorders refers to substance use disorders and mental disorders"
- "Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques."

(Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005, page 27, 29)

- "The key to effective treatment for clients with dual disorders is the seamless integration of psychiatric and substance abuse interventions in order to form a cohesive, unitary system of care."
- "The integration of services represents the organizational dimension of treatment: Services for both mental illness and substance abuse need to be provided simultaneously by the same clinicians within the same organization, in order to avoid gaps in service deliver and to ensure that both types of disorders are treated effectively."

(Mueser KT, Noordsy DL, Drake RE, Fox L (2003): "Integrated Treatment for Dual Disorders – A Guide to Effective Practice" The Guilford Press, NY. page xvi, 19)

- "Integrated treatment is the interaction between the mental health and/or substance abuse clinician(s) and the individual, which addresses the substance and mental health needs of the individual."

(From page vi in "A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders" 2002, from the Substance Abuse and Mental Health Services Administration (SAMHSA). Resource: www.samhsa.gov/reports/congress2002/foreword.htm)

- One Team, One Plan for One Person

B. **Needs Assessment**

- Intern, clinician, supervisor, administrator
- Level of comfort with co-occurring disorders (COD) assessment and treatment
- Degree if integrated services where you work
- Assessment questions and dilemmas
- Treatment questions and dilemmas
- What have you tried already to better integrate COD services?
- Next steps?

C. **Different Theoretical Perspectives; Different Treatment Methodologies**

1. 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

2. Care versus Confrontation

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

3. Abstinence-oriented versus Abstinence-mandated

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

4. Deinstitutionalization versus Recovery and Rehabilitation

   - role of "least restrictive" setting
   - role for individualized treatment with continuum of care

D. **Why Diagnostic Confusion? -** Diagnostic Confusion due to:

- Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity)
- Prolonged alcohol/drug use can cause short or long-term psychiatric illness
- Alcohol/drug use can escalate in episodes of psychiatric illness
- Psychiatric symptoms and alcohol/drug use can occur in other psychiatric disorders
- Independent addiction and psychiatric illnesses ("Dual Diagnosis")

(Marc A. Schuckit: Am. J. Psychiatry, 143:2 p. 141 - modified)

E. **Assessment Dilemmas**

- Pharmacological and psychosocial aspects of addiction can mimic psychiatric disorders
- Decision tree for "Addiction versus Psychiatric Diagnoses: Either or Both?"
- Take a good history - A definitive psychiatric diagnosis by history requires the psychiatric symptoms to have occurred during drug-free periods of time
- Observe the client for a sufficient time drug-free - shorter time for objective, psychotic symptoms; longer for subjective, affective symptoms; non-drug ways of coping; addiction is a biopsychosocial disorder, so encourage active involvement in a recovery program; incorporate meetings, tools, techniques, and a wide variety of non-drug coping responses to help client deal with the stresses of everyday living; diagnosis as a process, not an event

Mental Status Examination

A – Appearance and Attitude: physical characteristics; apparent age; peculiarity of dress, cleanliness; aggressive, passive, hostile, paranoid, suspicious

B – Behavior: posture (stooped, erect, slouched); gait (shuffling, staggering, stiff, awkward); gestures, tics, grimacing, mannerisms; verbal, non-verbal

C – Cognition: orientation; memory (short and long-term); abstract or concrete thinking; reasoning and judgment; rate of cognitions (flight of ideas, circumstantiality, perseveration)

D – Disturbances of thought: delusions; psychosis; thought blocking; hallucinations

E – Emotions: appropriateness of affect; lability of mood; depression, anxiety, mood swings

F. Evidence-Based Principles and Practices for an Integrated Treatment Model

("Dual Diagnosis – An Integrated Model for the Treatment of People with Co-Occurring Psychiatric and Substance Disorders" by Kenneth Minkoff, M.D. The Dual Network, Volume 2, Edition 1. Summer 2001)

First Principle - Comorbidity is an expectation, not an exception

Key Implications

- Initial assessment includes sufficient data to diagnose and assess both mental and substance use disorders
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Second Principle – Successful treatment requires most importantly the creation of welcoming, empathic, hopeful, continuous treatment relationships, in which integrated treatment and coordination of care are sustained through multiple treatment episodes

Key Implications

- The client's goals for treatment are the central focus that drives the treatment plan.
- Access to treatment is convenient, open and readily available.
- Opportunity to return to treatment is readily accessible.
- Staff and systems are skilled to identify client needs and access necessary services wherever the client presents.
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Third Principle – Within the context of the continuous integrated treatment relationship, case management and care taking must be balanced with empathic detachment and confrontation in accordance withy the individual's level of functioning, disability and capacity for treatment adherence

Key Implications

- Interfacing with consumers should be in the spirit of hope and expectancy for change.
- Appropriate and continuous supports go beyond acute medical needs and extend to community and family supports. (flexible funding programs) (case management)

- Staff has healthy detachment to understand and accept relapses and expect accountability for change while at the same time providing support and compassion for the client.
- Mental health and substance abuse providers need to learn from each other the balance between nurturing support and accountability, and expectation for change.
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Fourth Principle – When mental illness and substance disorder coexist, both disorders should be considered primary, and integrated dual primary treatment is required

Key Implications

- Staffing and services should reflect equal emphasis on both disorders in accord with the prevalence of co-occurring disorders in the populations served.
- Treatments are balanced to effectively address both mental health issues and substance abuse or addiction issues in a client-centered manner.
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Fifth Principle – Both psychiatric illness and substance dependence are examples of chronic, biological mental illnesses, which can be understood using a disease and recovery model. Each disorder is characterized by parallel phases of recovery: acute stabilization, engagement and motivational enhancement, active treatment and prolonged stabilization, rehabilitation and recovery.

Key Implications

- Holistic multi-dimensional assessment is available to guide matching of services to need.
- Identify gaps in the system in order to determine where resources are needed.
- Explore ways to break down barriers in funding and resource allocation to better meet consumer needs.
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Sixth Principle – there is no single correct dual diagnosis intervention. Appropriate practice guidelines require that interventions must be individualized according to the subtype of dual disorder, specific diagnosis of each disorder, phase of recovery/stage of change, and level of functional capacity or disability.

Key Implications

- Content and length of stay reflects the needs of the individual and their response to treatment.
- Helping clients identify what skills they have achieved in managing their illness during successful periods of recovery.
- Staff should remain strengths based and solution focused
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Seventh Principle – Within a managed-care system, any of the individualized phase-specific interventions can be applied at any level of care. Consequently, a separate multidimensional level of care assessment is required.

Key Implications

- Services are abstinence-oriented but not abstinence-mandated.
- Staff should be skilled in assessing and working with all levels/stages of change.
- Services exist to facilitate clients through stages of change. A broader range of "discovery" services is required to balance existing "recovery" services.
- A broad continuum of care exists to allow matching of the intensity of services to client's current level of functioning.
- Episodes of care are seen within the context of on-going continuous services.
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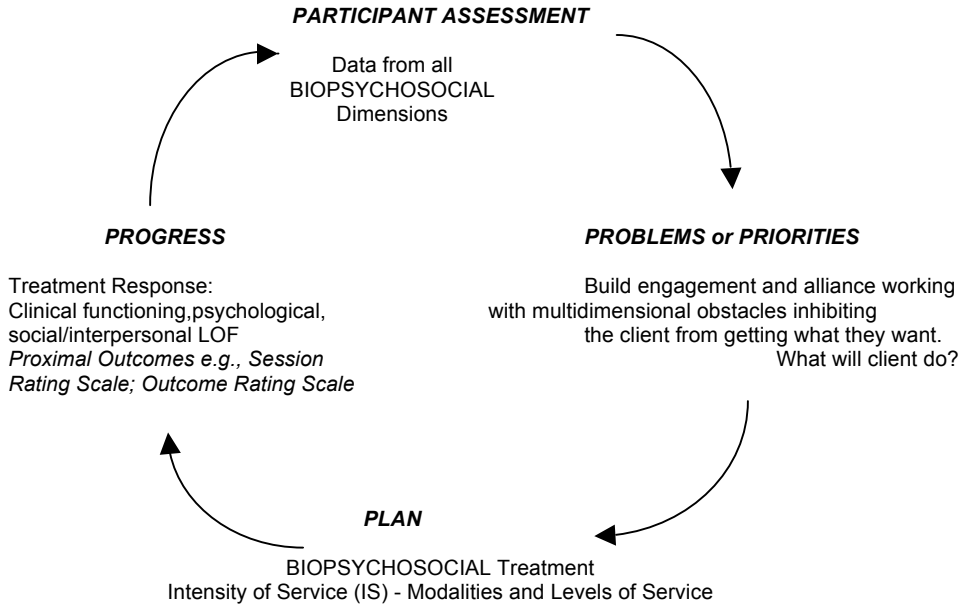
G. **Person-Centered Assessment and Treatment Services**

1. Biopsychosocial Perspective of Addiction and Mental Disorders

A common view allows a common language of assessment and treatment for all involved. Addiction illness and many psychiatric disorders are chronic, potentially relapsing illnesses often needing on-going process of treatment, rehabilitation and recovery, with brief episodes of acute care and stabilization.

2. Client-Directed, Outcome Informed Treatment

A diagnosis is a necessary, but not sufficient determinant of treatment. A client is matched to services based on multidimensional needs and the focus of treatment, not placed in a set program based only on having met diagnostic criteria.



3. Multidimensional Assessment - ASAM Assessment Dimensions

The common language of the six assessment dimensions can be used to determine multidimensional assessment of obstacles and needs to help the client get what they want. Also to identify what the client is willing to do in the context of the alliance and the focus of treatment.

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services.

4. Biopsychosocial Treatment - Overview: 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 e.g. 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 e.g. 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)

5. Treatment Levels of Service - **ASAM Levels of Care/service to match severity of problems**

I Outpatient Services
II Intensive Outpatient/Partial Hospitalization Services
III Residential/Inpatient Services
IV Medically-Managed Intensive Inpatient Services

H. **Applying Skills to Challenging Clinical Issues and Cases**

1. I am interested in finding an approach within the motivational-interviewing framework that will help clinicians address whether or not benzodiazepine use is appropriate for clients who are in treatment for addiction issues. Many agencies follow "no benzo" policies for clients who have such histories but make exceptions for individuals who are able to demonstrate stable recovery or have in some other ways displayed that the class of medications would be helpful to them despite their addictive potential.

How might a clinician work with a client who has an addiction history and is interested in benzodiazepine use within the motivational-interviewing framework?

2. What are your thoughts about people on Suboxone (buprenorphine and naloxone) and getting benzodiazepines? Also, people getting addiction services - should they be allowed benzodiazepines if they have true need for them? We do not allow use due to addiction and risk factors. I am seeing a lot of cases with people wanting benzodiazepines; or being on them and hard to get off; or no wanting to get off.

3. "My question is one of boundaries and perhaps ethics. Is it appropriate, and if so when, for a counselor to step back and let the client live their lives (even if the client as well as the counselor knows it is dysfunctional). Yet the client seems to somehow be functioning doing what they want anyhow.

Do we intervene to the point of destroying a family structure, in the name of therapy? Do we ask our clients to live “perfect lives” even if our own is not so. For example, a male client I am working with did not want to include his wife in a family session believing that she was too angry and mistrusting to be able to talk constructively about her belief that he was having an affair. I pressed him to include her and it did indeed turn out badly and broke his trust in our therapy. Now I have second thoughts about pressing him to include her in a family session.

Isn’t the idea of client-based therapy dealing with what and were the client is in their recovery - not with were we think they should be? Please help clarify this for me."

4. JD is a 47 y/o divorced, African American man who has an Axis I diagnosis of Cocaine/Heroin Dependence and Bipolar Disorder-Manic. His stated reason for being in treatment is so that he can return home and have financial support from his family.

Upon arrival, he was placed on a co-ed unit, but quickly got distracted by getting into relationships with women. He was then transferred to my unit, which is a 42 bed co-occurring male only unit. JD protested, but did adjust and started to make progress in his treatment. After a short time, he realized that he could "sneak away" and meet up with women. At that point, he displayed negative attitude, he became argumentative with staff, was late to group.

He finally admitted that he was indeed sneaking off and having sex whenever he wanted despite "us" trying to keep him away from women. He admitted that he is a sex addict and he can't just "quit" women. JD was put on a contract to limit his contact with women outside of groups. JD broke this contract. He continued to socialize mainly with women.

JD was put on a stricter contract. NO contact with women, with the understanding that he would face discharge if he broke it. JD abided by the contract. But during the time he had no contact, he seemed to go through "withdrawal". He was irritable, anxious, had difficulty sleeping. Slowly he started participating in group again, and processing what he was feeling.

JD completed his contract and asked to go back to a limited ability to socialize with women. Within the first two days, he was observed back to the old behaviors.

Questions:

Do we keep JD on strict contract until discharge to halfway house?
Do we discharge him for breaking his contract?
What do we do?

5. Joe is a 58 yo Caucasian divorced male with two grown sons and three grandchildren. He was referred to the ACT program after being discharged from a pain management clinic for abusing his medications. Joe was in an accident with a forklift 13 years ago and broke his back. He has had two separate surgeries since that time with the last being in 2001. A separate doctor currently prescribes his pain medications ie. oxycodone 20mg every 4 hours, Vicodin 1every 6 hours, gabapentin 600mg 4 times daily.

The ACT team currently delivers his medication daily to ensure that he does not overdose. Joe also has high blood pressure, high triglycerides, diabetes and is directed to take insulin daily. On most occasions, Joe does not take his physical health medications but is consistently attempting to acquire more narcotics.

This has taken a toll on the therapeutic relationship between Joe and ACT members. He is clearly addicted psychologically and physically. Joe refuses to try physical therapy, a new surgery, another pain management, or a methadone clinic. His current medical doctor no longer wants to write the prescriptions but feels responsible until he acquires another means for his pain. His case is one of liability at this juncture.

How would the "discovery" model be worked within this case?

6. Two questions from our Medical Center and Hospital:

(a) We are a long time established Inpatient Drug and Alcohol Rehab. Most of our patients have co-occurring disorders. How would you begin to integrate these concepts into our program?

(b) How do you recommend dealing with a person who has relapsed in treatment, either having brought drugs in with them, buying them or trading medications with peers, or even cheeking meds to build up a supply? There is a responsibility to maintain a "safe milieu" for the rest of the patients. If a person decompensates psychiatrically we usually transfer them to a psychiatric facility. Viewing a relapse as a decompensation while in inpatient treatment, what are the options besides therapeutically discharging.

I. Improving COD Services

1. Integrated Dual Disorders Treatment Fidelity Scale

(http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring)

Integrated Dual Diagnosis Treatment is for people who have co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach helps people recover by offering both mental health and substance abuse services at the same time and in one setting.
This approach includes:
* Individualized treatment, based on a person's current stage of recovery
* Education about the illness
* Case management
* Help with housing
* Money management
* Relationships and social support
* Counseling designed especially for people with co-occurring disorders

In 2002, the Substance Abuse Mental Health Services Administration (SAMHSA) identified the use of co-occurring disorder treatment principles, or Integrated Dual Disorder Treatment (IDDT) for the mental health service setting, for persons with serious and persistent mental illness and significant substance use problems. An IDDT implementation toolkit was developed and made available to treatment providers and states to assist in the implementation of IDDT.

The IDDT toolkit includes an IDDT fidelity scale to measure the degree to which the IDDT principles have been implemented into a particular service or agency. The IDDT scale has been used in Minnesota with Intensive Residential Treatment (mental health short-stay residential) services, Assertive Community Treatment teams, and most recently, outpatient mental health centers and mental health clinics participating in the federal Co-occurring State Incentive Grant (COSIG). An adapted version for inpatient psychiatric units is being utilized in acute care psychiatric units and some DHS State Operated Services inpatient psychiatric units.

2. Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index

The DDCAT is a fidelity instrument for measuring addiction treatment program services for persons with co-occurring (i.e., mental health and substance related) disorders. The DDCAT Index has been in development since 2003, and is based upon the fidelity assessment methodology described below. Fidelity scale methods have been used to ascertain adherence to and competence in the delivery of evidence-based practices, and in particular this methodology has been used to assess mental health programs' implementation of the Integrated Dual Disorder Treatment (IDDT). IDDT is an evidence-based practice for

persons with co-occurring disorders in mental health settings, and who suffer from severe and persistent mental illnesses (Mueser et al, 2003).

The DDCAT utilizes a similar methodology as the IDDT Fidelity Scale, but has been specifically developed for addiction treatment service settings. Further, at this juncture, addiction treatment services for co-occurring disorders are guided by an amalgam of evidence-based practices and consensus clinical guidelines. The IDDT model has been studied in effectiveness trials and has been designated an evidence-based practice.

The DDCAT evaluates 35 program elements that are subdivided into 7 domains.

3. DDCMHT (Dual Diagnosis Capability in Mental Health Treatment)

The DDCMHT is a version of the DDCAT that has been edited to be appropriate for use in mental health service programs. Although the DDCAT had its origins in the addiction field, the domains and elements of the DDCAT Index are also applicable to mental health programs.

4. Crosswalk between IDDT, DDCAT and DDCMHT

The following table compares and contrasts the various domains and elements of the IDDT, DDCAT and DDCMHT tools to stimulate your thinking on where to focus to improve integrated services. Where there are items in the IDDT Fidelity Scale that pertain to specific domains in the DDCAT/DDCMHT, they are crosswalked even if that causes the IDDT numbering to be out of order.

DDCAT and DDCMHT Domains	IDDT Fidelity Scale Items
Program Structure: focuses on general organizational factors which foster or inhibit the development of Co-Occurring Disorder (COD) treatment e.g., mission statement; certification & licensure; coordination and collaboration with substance related services; financial incentives	**4. Time-Unlimited Services** • Substance abuse counseling • Residential services • Supported employment • Family psychoeducation • Illness management • ACT or ICM
Program Milieu: focuses on the culture of program and whether the staff and physical environment of the program are receptive and welcoming to persons with COD. e.g., routine expectation of and welcome to treatment for both disorders; literature and patient educational materials	**6. Motivational Interventions:** Clinicians who treat IDDT clients use strategies such as: (a) Express empathy (b) Develop discrepancy between goals and continued use (c) Avoid argumentation (d) Roll with resistance (e) Instill self-efficacy and hope
Clinical Process: Assessment: examines whether specific clinical activities achieve specific benchmarks for COD assessment. e.g., routine screening for substance related symptoms and assessment for positive screening results; substance use and mental health diagnoses made and documented; substance use and mental health history reflected in medical record; service-matching based on substance related symptom acuity: low, moderate, high; service matching based on severity of the persistence of disability: low, moderate, high; stage-wise treatment	**2. Stage-Wise Interventions:** Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention) **13. Secondary Interventions for Substance Abuse Treatment Non-Responders:** Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as: • Clozapine, naltrexone, disulfiram • Long-term residential care

initial	▲ Trauma treatment ▲ Intensive family intervention ▲ Intensive monitoring
Clinical Process: Treatment: examines whether specific clinical activities achieve specific benchmarks for COD treatment. e.g., treatment plan; assess and monitor interactive courses of both disorders; procedures for substance related emergencies and crisis management; stage-wise treatment ongoing; policies and procedures for medication evaluation, management, monitoring, and compliance; specialized interventions with substance related content; education about substance related disorder and its treatment, and interaction with mental health disorders and its treatment; family education and support; specialized interventions to facilitate use of (COD) self-help group; peer recovery supports for patients	**2. Stage-Wise Interventions:** Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention) **3. Access for IDDT Clients to Comprehensive DD Services** 1. Residential services 2. Supported employment 3. Family psychoeducation 4. Illness management 5. ACT or ICM **6. Motivational Interventions:** Clinicians who treat IDDT clients use strategies such as: ▲ Express empathy ▲ Develop discrepancy between goals and continued use ▲ Avoid argumentation ▲ Roll with resistance ▲ Instill self-efficacy and hope **7. Substance Abuse Counseling:** Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse counseling that include: ▲ Teaching how to manage cues to use and consequences to use ▲ Teaching relapse prevention strategies ▲ Drug and alcohol refusal skills training ▲ Problem-solving skills training to avoid high-risk situations ▲ Challenging clients' beliefs about substance abuse ▲ Coping skills and social skills training **8. Group DD Treatment:** DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems **9. Family Psychoeducation on DD:** Clinicians provide family members (or significant others): ▲ Education about DD ▲ Coping skills training ▲ Collaboration with the treatment team ▲ Support **10. Participation in Alcohol & Drug Self-Help Groups:** Clients in the *action* stage or *relapse prevention* stage attend self-help programs in the community **11. Pharmacological Treatment:** Prescribers for IDDT clients: ▲ Prescribe psychiatric medications despite active

	substance use - Work closely with team/client - Focus on increasing adherence - Avoid benzodiazepines and other addictive substances - Use clozapine, naltrexone, disulfiram
Continuity of Care: examines the long-term treatment issues and external supportive care issues commonly associated with persons who have COD. e.g., co-occurring disorder addressed in discharge planning process; capacity to maintain treatment continuity; focus on ongoing recovery issues for both disorders; facilitation of self-help support groups for COD is documented; sufficient supply and compliance plan for medications is documented	**4. Time-Unlimited Services** - Substance abuse counseling - Residential services - Supported employment - Family psychoeducation - Illness management - ACT or ICM **5. Outreach:** Program demonstrates consistently well-thought-out strategies and uses outreach to community whenever appropriate: - Housing assistance - Medical care - Crisis management - Legal aid **12. Interventions to Promote Health:** Examples include: - Teaching how to avoid infectious diseases - Helping clients avoid high-risk situations and victimization - Securing safe housing - Encouraging clients to pursue work
Staffing: examines staffing patterns and operations that support COD assessment and treatment e.g., psychiatrist or other physician; on site staff with SA licensure; access to supervision or consultation for substance related disorders; supervision, case management or utilization review procedures emphasize and support COD treatment; peer/alumni supports are available with COD	**1a. Multidisciplinary Team:** Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team **1b. Integrated Substance Abuse Specialist:** Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff iun IDDT **10. Participation in Alcohol & Drug Self-Help Groups:** Clients in the *action* stage or *relapse prevention* stage attend self-help programs in the community
Training: appropriateness of training and supports that facilitate the capacity of staff to treat persons with COD. e.g., basic training in prevalence, common signs and symptoms, screening and assessment for substance related symptoms and disorders; staff is cross-trained in mental health and substance use disorders, including pharmacotherapies.	**1a. Multidisciplinary Team:** Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team **1b. Integrated Substance Abuse Specialist:** Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff iun IDDT

- Looking at the DDCAT/DDCMHT domains and IDDT Fidelity Scale areas and any other brainstorming ideas, identify "low hanging fruit" that would broaden services efficiently (Actions and Issues that can be initiated immediately with existing or re-configuring resources; for which there is team consensus; and that have a good chance of success)

- Identify strategies to achieve this most efficiently e.g., changing an existing group into a multiple family group for psychoeducation (IDDT #9); replacing the next staff member to leave with a clinician with co-occurring disorders expertise (IDDT #1a or 1b); starting an institutional Dual Recovery Anonymous group at your agency (IDDT #10); use an existing prescriber's meeting to discuss and train on pharmacological issues (IDDT #11)

J. **Counseling Techniques**

1. Use inpatient and residential treatment for crises in people with Borderline Personality Disorder carefully and judiciously

The benefits of a 24-hour treatment setting in the midst of a crisis can also be its liabilities for certain people with BPD and other personality vulnerabilities. A safe place to sleep and eat away from the stress of the outside world can also re-create a psychological "womb". Such 24-hour care can precipitate regression as longstanding needs for nurturance are aroused.

Equally longstanding however, are fears of abandonment and mistrust whether anyone will really be there for them. Twenty-four hour settings spark off powerful, conflicted dynamics in the client. On the one hand they are starved for nurturance, while at the same time the client has strong urges to control the expected rejection and abandonment. It is as if the client is saying: "This safe and secure setting is so fulfilling and I have wanted this nurturance all my life. But if I can't count on this continuing and I will be emotionally abandoned anyway, I at least want to be in control of the rejection.

The sudden fluctuations in mood, interactions and the alliance with such BPD clients partly arise from these conflicted dynamics. The clinical implications are:

- Keep the inpatient or residential stay as brief as possible to limit the degree of regression
- Focus the inpatient stay on preparing the client for return as soon as possible to the real world, using the safe milieu to practice cognitive and behavioral strategies that increase the confidence of the client and family that he or she is safe enough to continue recovery in the community e.g., what can you think about and do differently next time there is a crisis and you have an impulse to cut yourself?

You might say: "*This brief stay in the inpatient unit or residential program is to practice some ways to cope with this and any other crisis without hurting yourself or others. We won't be working on all the things that are important to talk about when you continue care in an outpatient setting. This will not be a stay to get a total emotional makeover; nor to understand and solve all the issues and concerns of your life to be happy. But we will hang in with you to think and do whatever it takes to help you cope in the community as soon as possible. That is where the real ongoing work will be done, not here. So let's think about what you could do differently to cope with another crisis like this one.*"

2. Be careful about reinforcing suicidal behavior

Imagine if every time a person becomes suicidal the response is to move from a stressful environment to a safe, caring treatment environment. The client quickly learns to see themselves as unable to cope in the community; and that all that will work is to have others take over control of them and their environment. So the next time a similar crisis arises, guess where the person thinks of first to go as a way to cope and get relief?

Most clients know that if they have run out of money and want to get off the streets; or get relief from the stresses at home or the street, the surest way to get to a 24 hour setting is to present depressed and suicidal. That is not to say that everyone who presents suicidal is not really suicidal; nor that we should never hospitalize people who are suicidal. But when hospitalization and intense treatment is always the first option, it reinforces this as the main coping and relief mechanism.

Marsha Linehan suggested that in a Dialectical Behavior Therapy approach, the message is that hospitalization and intense treatment is the last option if at all, but certainly not the first option. Compared with treatment-as-usual, DBT reduces the prevalence and medical severity of parasuicide episodes, therapy dropout, and inpatient psychiatric days.

You might say: "*I really understand that life feels hopeless and depressing right now and that it seems that death is the best and only option. But I am glad you are here talking to me, because that tells me a part of you actually has hope that it might not actually be the only option for you. So let's work on how to explore all the options, not just the death one and I will hang in with you in that process. There is no magic in an inpatient stay. It will not solve all the problems right now; and it may even delay solutions and make things worse. So let's think together on what we can do to focus on active functioning in the community and to get on with the part of you that found life worth living and brought you to reach out for help. You wouldn't have called me if you wanted to die, as you know I don't help people die. But you do know I want to be there for you to help you live. Thank-you for reaching out and asking me to help you live. Now let's get on with focusing on that that."*

Reference:
Linehan MM, Tutek DA, Heard HL, Armstrong HE: "Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients" Am J Psychiatry. 1994; 151:1771-1776.

K. **Different Approaches for Different Dual Diagnosis Clinical Situations**

Past abuse: help patient stay in recovery, but don't dig and uncover traumatic experiences until sufficient non-drug coping skills developed.
Verbally aggressive and challenging: empathize with the fear or the mistrust but don't patronize nor verbally spar with the patient.
Intellectualizing, obsessing: allow discussion of ideas for five minutes at the end of session, but don't discount patient by saying, "don't analyze" or "get out of your head", provide action or doing tasks to communicate.
Withdrawn and reluctant to verbalize: provide action or writing tasks to facilitate discussion eg. reading to group from a homework or action assignment.
Hypomanic or manic: separate from the group if overstimulated or withhold from group or activity if escalating.
Psychotic or paranoid: empathize with the concern, but don't agree with or condone the delusion or misperceptions.
Criminal code and criminal thinking: help client develop the responsible code and reverse criminal thought processes. Feelings are signals to start thinking it through by going inside oneself and choosing responsible, accountable behavior. Criminal thinking goes outside and blames people, places and things using feelings to define the thought process, thus choosing irresponsibility and lack of accountability e.g., client awakes and feels bored and like skipping work; allows the feeling to form the thoughts and says "they're jerks", or "it's a stupid job", or "they don't pay me enough" - and then chooses not going to work or being responsible and accountable.

A responsible code person awakes with the same feeling of boredom and of not wanting to go to work, but then thinks: "they're relying on me", or "I've got a family to support", or "they pay me for this job" - and then chooses to go to work and be responsible and accountable. (David Koerner's training in corrective thinking and criminal thought process).

L. **Moving Towards Integrated Treatment**

1. Co-Occurring Mental and Substance-Related Disorders Criteria – ASAM PPC-2R

(a) **Description of Services**

Dual Diagnosis Program Descriptions – AOS/MHOS, DDC, DDE

The *ASAM PPC-2R* describes three types of services. Programs capabilities are defined as follows:

1. **Programs that offer Addiction-Only Services (AOS)/Mental Health-Only Services (MHOS)**

- Cannot accommodate patients with psychiatric illnesses that require ongoing treatment, however stable the illness and however well functioning the individual. Such programs are said to provide Addiction-Only Services (AOS). Cannot accommodate those with addiction illness are Mental Health-Only Services
- The policies and procedures typically do not accommodate co-occurring disorders: for example, individuals on certain psychotropic medications generally are not accepted in AOS, coordination or collaboration between chemical and mental health services is not routinely present, and mental health issues are not usually addressed in treatment planning or content in AOS and vice versa in MHOS

2. **Dual Diagnosis Capable (DDC) Programs**

- Dual Diagnosis Capable (DDC) programs routinely accept individuals who have co-occurring mental and substance-related disorders.
- DDC programs can meet such patients' needs so long as their psychiatric disorders are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders do not interfere with participation in addiction treatment in AOS; and vice versa in MHOS
- DDC programs address dual diagnoses in their policies and procedures, assessment, treatment planning, program content, and discharge planning.
- They have arrangements in place for coordination and collaboration between chemical and mental health services.
- They also can provide addiction consultation, psychopharmacologic monitoring and psychological assessment and consultation on site; or by well-coordinated consultation off-site.

3. **Dual Diagnosis Enhanced (DDE) Programs**

- DDE programs can accommodate individuals with dual diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment.
- Such patients are not so acute or impaired as to present a severe danger to self or others, nor do they require 24-hour, psychiatric supervision.
- DDE programs staffed by psychiatric and mental health clinicians as well as addiction professionals. Cross-training is provided to all staff. Such programs tend to have relatively high staff to patient ratios and provide close monitoring of patients who demonstrate psychiatric instability and disability.
- DDE programs typically have policies, procedures, assessment, treatment planning and discharge planning that accommodate patients with dual diagnoses.
- Dual diagnosis-specific and mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies are more likely to be available (particularly in outpatient settings)
- Ideally, there is close collaboration or integration with a mental health program that provides crisis back-up services and access to mental health case management and continuing care.

(b) **Risk Domains**. A Risk Domain is an assessment subcategory within Dimension 3:

- ***Dangerousness/Lethality***. This Risk Domain describes how impulsive an individual may be with regard to homicide, suicide, or other forms of harm to self or others and/or to property. The seriousness and immediacy of the individual's ideation, plans and behavior—as well as his or her ability to act on such impulses—determine the patient's risk rating and the type and intensity of services he or she needs.

- ***Interference with Addiction Recovery Efforts***. This Risk Domain describes the degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and, conversely, the degree to which a patient is able to focus on addiction recovery. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)

- ***Social Functioning***. This Risk Domain describes the degree to which an individual's relationships (e.g., coping with friends, significant others or family; vocational or educational demands; and ability to meet personal responsibilities) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)

- ***Ability for Self Care***. This Risk Domain describes the degree to which an individual's ability to perform activities of daily living (such as grooming, food and shelter) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)

- ***Course of Illness***. This Risk Domain employs the history of the patient's illness and response to treatment to interpret the patient's current signs, symptoms and presentation and predict the patient's likely response to treatment. Thus, the domain assesses the interaction between the chronicity and acuity of the patient's current deficits. A high risk rating is warranted when the individual is assessed as at significant risk and vulnerability for dangerous consequences either because of severe, acute life-threatening symptoms, or because a history of such instability suggests that high intensity services are needed to prevent dangerous consequences.

  For example, a patient may present with medication compliance problems, having discontinued antipsychotic medication two days ago. If a patient is known to rapidly decompensate into acute psychosis when medication is stopped, his or her rating is high. However, if it is known that he or she slowly isolates without any rapid deterioration when medication is stopped, the risk rating would be less. Another example could be the patient who has been depressed, socially withdrawn, staying in bed and not bathing. If this has been a problem for six weeks, the risk rating is much higher than for a patient who has been chronically withdrawn and isolated for six years with schizophrenic disorder.

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

Relapse or Continued Use Crises result from a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, as follows:

1. Slip/ using alcohol or other drugs from overconfidence; 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 inadequate skills to deal with the feelings.

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/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

4. 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 6 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. Use the "What, Why, How, Where and When" to reassess the treatment contract, if there appears to be resistance to developing a modified treatment plan in step 5 above.

7. Determine if the modified strategies can be accomplished in the current level of care; or need a more or less intensive level of care in the continuum of services.

8. If, on completion of step 6, the patient recognizes the problem/s; 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.

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

5. Gathering Data on Policy and Payment Barriers

- Policy, payment and systems issues cannot change quickly. Find efficient ways to gather data as it happens in daily care of clients:

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert 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 - 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):	

Fire Starters

1. Addictive and psychiatric disorders are both significant chronic conditions characterized by episodes of exacerbation, remission and relapse.

2. All clients should be retained in treatment and treated with great respect in spite of non-follow through with treatment plan recommendations, including failure to take prescribed medication or return to use of their drug of choice.

3. Addiction and mental illness are both no-fault disease categories.

4. No behavioral health problem is so grave that the client cannot be engaged in the recovery process.

5. It is more important to convey caring and concern than to avoid being manipulated or conned – even at the cost of "enabling".

6. Medication can be an effective strategy in the treatment of both disorders.

7. Can someone on methadone be in recovery?

8. Evaluating and monitoring how a client is functioning in their living environment with significant others is equally as important as to whether they go to AA or other recovery groups.

(Some modified or added from original Fire Starters developed by Mike Boyle, M.A., Executive Vice President, Fayette Companies www.BHRM.ORG E-mail: mboyle@fayettcompanies.org)

Stephen

Stephen is 51 years old and is accompanied by his wife. He wants help, but is depressed. During his intake interview for this, his second DUI arrest, he looks disconsolate and he speaks in a monotone as he wonders if his wife will leave him. His alcohol use has resulted in alienation from his children, guilt feelings and his job may now be threatened, as he has been warned by his supervisor about his poor attendance and performance. Most of his friends drink, but none of them think he is an alcoholic.

He has not had any previous addiction treatment other than DUI classes after his first DUI four years ago. He attended AA for six months on and off and did have a sponsor, but felt more and more that he wasn't as bad as others at AA and gradually stopped going.

Stephen has been alcohol-free for three weeks. He has used cocaine (snorting) about three times per month over the past four years, but stopped two months ago. He has had no legal or financial problems related to cocaine. Stephen has continued on diazepam (Valium) 5 mg. qid which he has taken for five years to relax him because of mild hypertension. He has no other chronic physical problems but has lost 10 pounds weight over the past month and has been sleeping poorly. He wishes he could sleep and get away from all his problems but denies any organized suicidal plans and says he wants help.

1. Where would you place him for treatment – level of care and MHOS, DDC or DDE?

Case Presentation Format

Before presenting the case, please state why you chose the case and what you want to get 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)

C.W.

February 18

The following is a report on C.W. The consultation issue involved the question of whether primary alcohol dependence or primary psychiatric interventions were needed; and also recommendation for level of care and treatment plan given this patient's three hospitalizations since age 15 with the current admission involving high risk suicidal behavior. CW is a 19 year-old, white, single, unemployed tire worker who was admitted 2/13 intoxicated on alcohol and also positive for marijuana in his drug screen. He was depressed and suicidal and had cut his chest; written "Die" on his chest; and taken an overdose of Prozac.

Wanda on Welfare

Wanda is a 46-year old divorced, female who was married at 18 to a male who was emotionally and physically abusive and lived at home less than half of the time of their eight-year marriage. The marriage was also characterized by infidelities by both her and her husband and regular and sometimes heavy marijuana and alcohol use. Two children resulted from this marriage, a son, Juan, now 26 and a daughter, Rosa, now 24. She has had no contact with either of these children for the last 12 years after she became pregnant and delivered a baby girl, Gloria, from an African-American father, whom she claims she met in a bar one night and doesn't even know his name. She was referred for assessment by her caseworker.

In the last 20 years, since the divorce, her drinking and marijuana use have increased markedly and she would often spend her days at home alone with Gloria, drinking and smoking heavily and neglecting her daughter. On one occasion the authorities became involved and threatened to remove Gloria from the home. As a result, she began seeing a counselor and at her suggestion, she began attending AA and NA briefly. Her counselor retired from practice and Wanda discontinued recovery group meeting attendance. The issue of custody apparently ceased being an issue but Wanda does not know why.

She is the child of an alcoholic father whom she alternately idolized and feared and who was seductive but not openly sexual with her as she was growing up. He father was killed in barroom brawl when she was 30 years old. Her mother 67 years old, lives alone and is still in denial about Wanda's father's alcoholism. She is the younger of two female children and her older sister is a teetotaler and a pillar of her church. They have not had contact in about three years.

A year ago she again began attending AA and claims she enjoys it. She attends weekly. She now drinks about once a week without apparent problem. She no longer smokes pot. She does feel hypocritical attending AA and still drinking but she neither wants to stop drinking nor discontinue her AA attendance because she has a few women friends there. They do not know about her current drinking. She had considered finding another counselor because of her dissatisfaction with her life but never translates this into action. She does not believe that she has a drinking problem. She is not sure what she wants, other than what she has.

She lives with Gloria in a rented apartment and spends most of her day watching television and considers herself a "soap opera addict." She is in a relationship with a drug dealer although she claims not to use any of the cocaine or heroin that her boyfriend sells. She likes him because "he buys her things." He also helps with the rent although he does not live there. Gloria is doing poorly in school and has been picked up for a shoplifting offense. On two occasions she told Wanda that she was spending the night with a girlfriend and this was later determined to be untrue. Wanda has no idea where she was each of those nights. They are in a constant struggle with Gloria calling her mother a "slob" and Wanda calls Gloria a "tramp."

She has been on welfare for most of her adult life and sees nothing unusual or undesirable about it. She has never worked outside of a few brief stints earlier as a dishwasher (2 times, once for 2 weeks and once for 3 weeks) and as attendant in a car wash (1 month). Both jobs came to an end because of her failure to show up for work because of using, oversleeping or being hung over. She has no job skills and is not particularly interested in acquiring such skills or working. She is aware that her welfare benefits will be terminated if she doesn't do something about work and feels that the State is being unfair.

Wanda said she has no medical problems although she states that she can't wait for menopause because her periods are so painful and her bleeding so heavy. She later added that she has migraine headaches although has never seen a doctor about them. Her affect is slightly flattened but beyond that, she neither appears depressed nor does she claim to be depressed. She has never sought substance abuse or mental health treatment except for the earlier six-month period with the counselor.

LITERATURE REFERENCES AND RESOURCES

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To Order: www.mckillipbascis.com; (509) 258-7314

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., & Griffith J.H. (Eds.) (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; (800) 844-8948. Web page: www.asam.org

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

Mee-Lee, David with Jennifer E. Harrison (2010): "Tips and Topics: Opening the Toolbox for Transforming Services and Systems". The Change Companies, Carson City, NV
To order: The Change Companies at 888-889-8866. www.changecompanies.net.

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To order: The Change Companies at 888-889-8866. www.changecompanies.net.

Mueser KT, Noordsy DL, Drake RE, Fox L (2003): "Integrated Treatment for Dual Disorders – A Guide to Effective Practice" The Guilford Press, NY.

RESOURCES FROM SAMHSA

1. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) presented **"A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders**". It provides a summary of practices for preventing substance use disorders among individuals who have mental illness and also a summary of evidence-based practices for treating co-occurring disorders. Resource: www.samhsa.gov/reports/congress2002/foreword.htm

2. A 2003 publication, **"Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders"** is also available on the SAMHSA website or though the SAMHSA National Mental Health Information Center at (800) 789-2647. SAMHSA Publication No. 3782, SAMHSA

3. Center for Substance Abuse Treatment. "**Substance Abuse Treatment for Persons With Co-Occurring Disorders"** Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005

(TIP 42 is available online at the Health Services/Technology Assessment Text (HSTAT) section of the National Library of Medicine Web site at the following:
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073

REFERENCE FOR ASAM PPC-2R AND RESOURCES FOR ASAM PPC

"Addiction Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria" Ed. David R. Gastfriend. The Haworth Medical Press. 2004.

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
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; To order ASAM PPC-2R: (800) 844-8948.

RESOURCE FOR ASSESSMENT INSTRUMENTS

A variety of proprietary assessment instruments for identifying substance use disorders, psychiatric diagnoses for adults and adolescents.

Level of Care Index (LOCI-2R): Checklist tool listing ASAM PPC-2R Criteria to aid in decision-making and documentation of placement.
Dimensional Assessment for Patient Placement Engagement and Recovery (DAPPER): Severity ratings within each of the six ASAM PPC-2R dimensions.
To order: The Change Companies at 888-889-8866
For clinical questions or statistical information about the instruments, contact Norman Hoffmann, Ph.D. at 828-454-9960 in Waynesville, North Carolina; or by e-mail at evinceassessment@aol.com

RESOURCE FOR E-LEARNING AND INTERACTIVE JOURNALS

E-learning module on "ASAM Multidimensional Assessment" and "Assessment to Service Planning and Level of Care"– 5 CE credits for each module
"Understanding the Dimensions of Change" – Creating an effective service plan" – Interactive Journaling
"Moving Forward" – Guiding individualized service planning" – Interactive Journaling
To order: The Change Companies at 888-889-8866. www.changecompanies.net.

CLIENT WORKBOOKS AND INTERACTIVE JOURNALS

The Change Companies' MEE (Motivational, Educational and Experiential) Journal System provides Interactive journaling for clients. It provides the structure of multiple, pertinent topics from which to choose; but allows for flexible personalized choices to help this particular client at this particular stage of his or her stage of readiness and interest in change.
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