

Preparing the Adult Mental Health Workforce to Succeed in a Transformed System of Care

Co-Occurring Disorders: Treatment and Supports for Persons with Mental Health and Substance Use Disorders



NASMHPD/OTA

Module Created by Huckshorn & Jorgenson

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Treatment and Supports for Persons with MH and Substance Use Disorders -- Objectives:

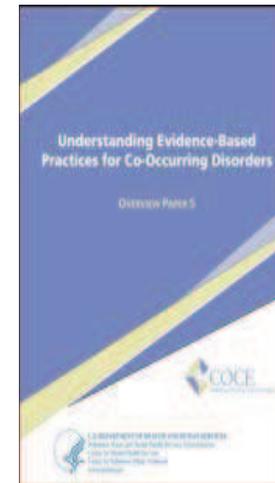
1. Understand the prevalence of MH & SU disorders
2. Understand important treatment concepts for people with MH & SU disorders
3. Learn differences between traditional approaches to care vs. current evidence-based approaches
4. Understand staff roles in providing services and supports to clients with MH and SU disorders



Overview & Introduction

- In the 1970's MH and SA providers recognized that substance abuse in people with MH conditions had “profound and troubling implications” in terms of effective outcomes...
- Today, the *integration* of Co-occurring disorders (COD) treatment interventions is recognized as a priority service for providers of all behavioral health treatment services

(CSAT, 2005)



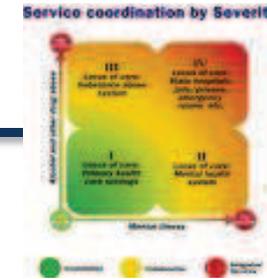
Overview & Introduction

- Present day substance abuse treatment providers report that between 50-75% of their clients have mental health issues
- Mental health providers report that 20-50% of their clients have substance use disorders
- In the face of this information, research, knowledge, and practice is expanding & developing
- Specific strategies have been developed to better work with individuals with these disorders

(CSAT, 2005)



Quadrants of Care Model

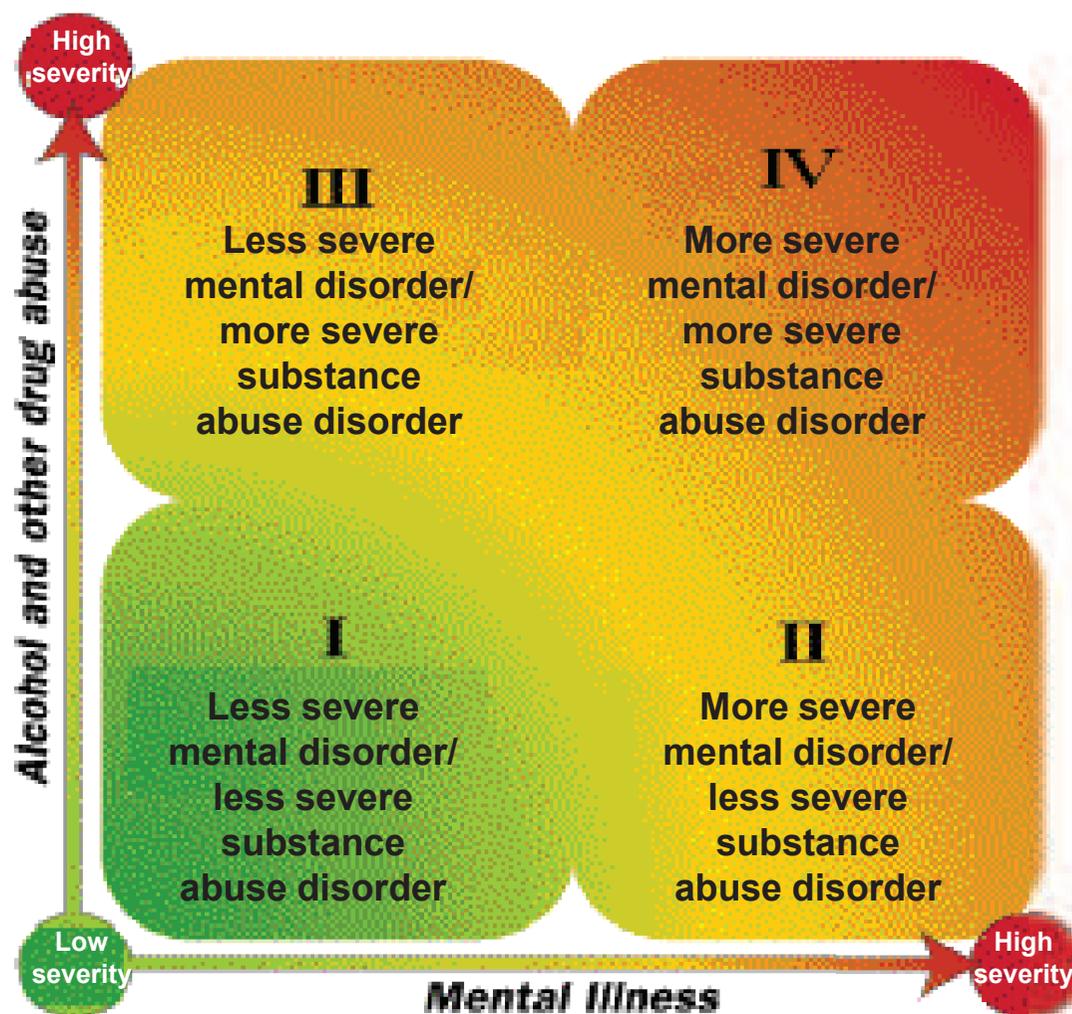


- This model, developed by NASADAD and NASMHPD, is helpful when trying to coordinate services
- It uses 4 separate windows that provide a structure for consultation, collaboration, and integration
- This allows MH and SA providers to target primary client issues and needs

(CSAT, 2005)



The Four Quadrant Framework for Co-Occurring Disorders (COD)



A 4-quadrant framework to guide systems integration and resource allocation

(NASMHPD, NASADAD, 1998; Ries, 1993; SAMHSA Report to Congress, 2002)

Not intended to be used to classify individuals *(SAMHSA, 2002)*, but...



Peer-Based Recovery Support

- Recovery has been a key construct in the addictions field for some time. Recovery, as you know, is a key construct of 12-step and other self-help programs
- “It became clear to me as a clinician that it is not simply acute intervention that helps a person. It’s the ability to receive ongoing contact and support from others, either through professional support or through a community of recovering peers”

Dr. H. Westley Clark, Director of CSAT



The *Recovery* Perspective

AA Quote

The disease is progressive...
So is recovery



“Peer Support is not like clinical support, nor is it just about being friends. Peer support helps people to understand each other because they’ve been there, shared similar experiences, and can model for each other a willingness to learn and grow”
(Mead, 2003)

The *Recovery* Perspective

- SA providers have long used a “recovery model” for their clients.
- In this model they work very hard on addressing *denial*, new coping behaviors, and ways of looking at substance use and misuse
- MH providers have been late to understanding this, and have much to do to catch up
- A primary goal for mental health staff is to gain an understanding of the AA fellowship-based, 12-Step Program

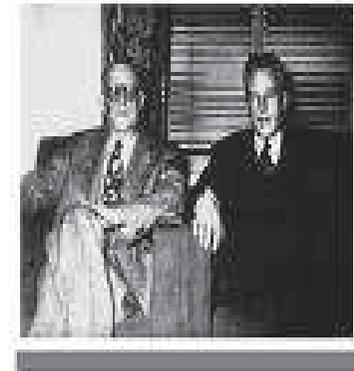


(CSAT, 2005)



AA Twelve Step Program for SA

- The 12-step model was developed by an MD (Dr. Bob) and another alcoholic (Bill W.) in 1935 to help alcoholics recover
- Alcoholics Anonymous (AA) has helped millions recover from addictive disorders
- The complete AA 12-step program can be found in *The Big Book*, and *The Twelve and Twelve*



(Mueser et al., 2003)



AA Twelve Step Program

- The program provides principles and directions to stay sober
- These steps are easy to state but hard to do. Participation requires motivation to not use substances, is VOLUNTARY, & abstinence-based
- Anonymity is a requirement, and no one keeps records or rosters of members (3.5 million estimated)
- While successful for many AA members, the program has been less successful for people who require medications for other illnesses—largely because AA is abstinence-based



(Mueser et al, 2003)



The 12 Steps of AA (paraphrased)

1. We admit we have a problem and our lives have become unmanageable
2. Come to believe that a power greater than ourselves can help us
3. Make a decision to turn our lives over to a higher power
4. Make a searching and fearless moral inventory of ourselves
5. Admit to God, ourselves, and to another human being the exact nature of our wrongs
6. Be ready to have God remove these character defects



(Mueser et al., 2003)



The 12 Steps of AA (paraphrased)

7. Humbly ask God to remove our shortcomings

8. Make a list of persons we harmed and become willing to make amends
9. Make direct amends to such persons unless to do so would harm them
10. Continue to take a personal inventory, and when wrong, promptly admit it
11. Seek through prayer and meditation to improve our conscious contact with God and God's will
12. Pledge to carry this message to other addicts and to practice these principles in daily life *(Mueser et al., 2003)*



What do the 12 steps mean?

- First off, these are brilliant principles to live by regardless of the presence of substance use
- What they basically say is this:
 1. I have become unable to control my behavior
 2. I need help to change my behavior
 3. I need to let go and let others help me
 4. I have lost control over my life as evidenced by...
(detailed list)



What do the 12 steps mean? (Mueser et al, 2003)

5. I am going to clearly identify what I have done wrong to myself, to my HP, and to another human being
6. I am ready to have my HP remove these shortcomings
7. I will make amends to people I have troubled or harmed unless that would make the situation worse
8. I will continue to monitor my behavior in front of peers, and correct it when necessary
9. I will pray to my HP for guidance and how I should be in the world
10. I will strive to help others who share my problems and to practice recovery in all of my affairs



What MH Staff need to know about self-help and COD

- Basic understanding of AA and common 12-step programs. These include groups for narcotics addicts, family members & children of addicts, and others
- Understand the power of self-help and the availability of these programs to anyone
- Understand that not all people with MH conditions will feel comfortable in pure AA groups
 - AA members often don't understand the need for meds
 - The large size of the groups
 - MH symptoms can make a person stand out from others



What MH Staff need to know about self-help and COD

- Many people with mental illnesses have found great support and help in AA groups
- *However--sometimes people diagnosed with psychotic disorders can be stigmatized or treated differently in AA groups*
Staff need to know this before making recommendations
- It is this group that providers should be prepared to support with treatment and aftercare in safe and respectful ways (Mueser et al, 2003)



What MH staff need to know about self help and COD



- *Dual-Recovery* self-help organizations have emerged in recent years
- These groups reflect the fellowship of AA, the values of the MH consumer movement, the importance of peer support, and the need for personal responsibility in recovery
- Clients that have access to these groups can avoid the potential bias and prejudice still common in general AA, and avoid getting inaccurate advice on taking medications

(CSAT, 2005)



What MH staff need to know about self-help and COD

- Common dual-recovery group models generally use a “step-wise” recovery framework that is similar but different from the AA model
- These are four organizations you may come across:
 - *Double Trouble in Recovery (DTR)*
 - *Dual Disorders Anonymous*
 - *Dual Recovery Anonymous*
 - *Dual Diagnosis Anonymous*
- They are all fellowship style, self support organizations led by members

(CSAT, 2005)



Families, Friends and Community



- The value of a supportive family, educated friends, and a loving community is important in an individuals' journey toward recovery
- While ensuring confidentiality, staff can provide general knowledge/education about the recovery process to family, friends, and communities



Moving on to treatment for **people with COD conditions**

- The most common model available for people with MH and SA conditions is “sequential treatment”
- This means that clients are treated for one disorder first before the other. This model is problematic as the client may become a “hot potato” between the MH and SA providers
- This approach is often ineffective because it ignores that MH and SA problems are inter-related and cannot be treated separately

(Mueser et al., 2003)



Integrated Treatment

- Mental health and SA disorders are treated at the same time, whether in a primary SA facility or a MH facility
- This is the best practice model by research, evidence, and available outcomes
- Going back to the Four Quadrant Model, mental health providers need to be able to treat people with low level MH and SA problems, high level MH/low level SA problems, and high level MH and SA problems

(CSAT, 2005; Mueser et. Al., 2003)



Integrated Treatment

- Usually people with serious MH conditions are better treated in MH settings rather than SA settings:
 1. SA providers often use confrontational methods that can be ineffective or harmful for people with serious MH conditions
 2. SA providers often believe that helping clients get housing, a job, or a stable social network is “enabling,” and can shield the person from the usual consequences of their substance use
 3. Typical funding problems often prevent treating 2 disorders simultaneously by 2 different providers (another “hot potato” problem) *(Mueser et al., 2003)*





Integrated Treatment (IT)

- This eliminates funding problems and the question of “who” should serve the client
- Both MH and SA treatment is done at the same time with a focus on the consumer and his/her needs
- *IT* is based on: shared decision making; a comprehensive assessment; teaching assertiveness; a reduction of negative consequences; unlimited services; motivation based treatment; and multiple therapeutic interventions



Assessment Issues

- People admitted to integrated MH settings require a comprehensive assessment that includes:
 - The detection of problems related to SA
 - Classification of how serious these problems are (drinks 3 beers or needs detox?)
 - Gathering information about the person's daily life and how SA impacts that
 - Gathering information about use--when used, why, where?
 - Treatment planning recommendations that address both SA and MH issues simultaneously



(Mueser et al., 2003)



Assessment Issues



- MH staff need to know that SA problems in people with serious mental conditions often *present* very differently than in people without MH disorders
- MH clients often are unable to use as much alcohol or drugs as a person without such problems.
- For instance it is fairly common for addicts to drink a case of beer, a fifth of whisky, or use two grams of coke in one binge. Yet people with serious mental conditions may use substances at a much lesser level ***and then go unnoticed in a typical screening***

(Mueser et al., 2003)



Assessment Issues

- Staff need to focus on the “**effect**” the substances have on: The person’s ability to work & engage in social relationships; The physical health effects; and Their use in dangerous situations
- Care needs to be taken to explore the interaction between their SU and the course of their MI
- If possible staff need to get consent to talk to significant others



(Mueser et al., 2003)



Assessment Issues

- Staff also need to understand it will be difficult to accurately diagnose a newly admitted and unknown person who is abusing substances--and particularly if over a period of time



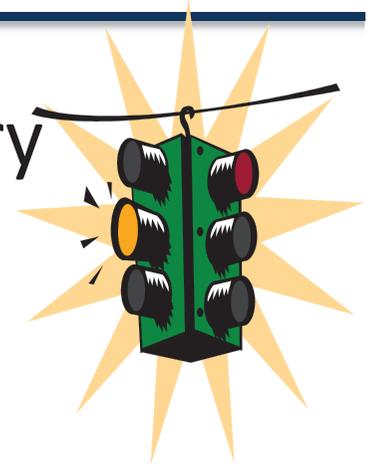
- Many substance-use related symptoms closely mimic mental health symptoms. As such, most people need to be “sober” or drug free for at least 4-6 months before a good differential diagnosis can be made



Integrated Treatment

- Staff often want to identify the “Primary Disorder.” This is generally difficult.
- Ideally, both conditions need to be treated at the same time
- Often, trying to identify the primary disorder generally results in one condition not being treated....

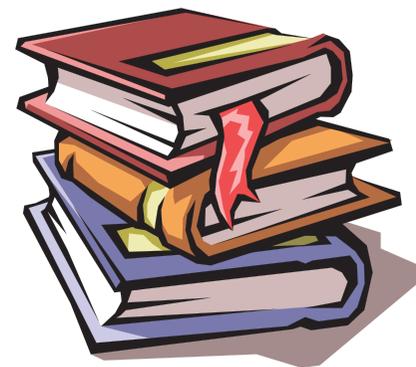
(Mueser et al., 2003)



Almost Finally ...

Direct Care Staff Roles

1. Understand as much as you can about co-occurring disorders and effective treatment options



2. **DO NOT JUDGE** people that you are serving. Most MH clients are living in poverty, with severe symptoms and medication side effects, and they have little to enjoy. It is no wonder then that many turn to using alcohol or drugs to find some “enjoyment/relief” or to help them to cope



Finally.... HOPE

3. Listen, ask questions, provide hope for a better life, link life consequences with substance use if appropriate, encourage abstinence



4. Some programs have an integrated model..some do not. If not, you may advocate to the administration on behalf of the individuals you serve. Perhaps most importantly, get clients linked with community self-help

