Clinical Guide

IDDT

INTEGRATED DUAL DISORDER TREATMENT

the evidence-based practice

A training booklet from

CENTER FOR EVIDENCE-BASED PRACTICES

& its Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence

Featuring Stage-Wise Treatment

www.centerforebp.case.edu

CASE WESTERN RESERVE UNIVERSITY EST. 1826

CONSULTING & TRAINING

This booklet is part of an evolving consulting and training process from the Center for Evidence-Based Practices (CEBP) at Case Western Reserve University. For more information about the Center, see the back cover of this booklet. For more information about Integrated Dual Disorder Treatment (IDDT), the evidence-based practice, consult these resources from our website.

INTEGRATED DUAL DISORDER TREATMENT (IDDT): AN OVERVIEW OF THE EVIDENCE-BASED PRACTICE

- 6-page booklet, tri-fold format
- At-a-glance descriptions of IDDT's core components
- Use for education, training & consensus building

IMPLEMENTING IDDT: A STEP-BY-STEP GUIDE TO STAGES OF ORGANIZATIONAL CHANGE

- 40-page booklet
- 5 stages of change, 8 to 10 practical action steps in each stage
- Use in planning and implementation committees

MEDICAL PROFESSIONALS & INTEGRATED DUAL DISORDER TREATMENT (IDDT)

- 8-page booklet
- At-a-glance descriptions of how IDDT can enhance medical practice
- Use for education, training & consensus building

THE SPIRIT OF MI | MOTIVATIONAL INTERVIEWING

- Audio CD
- 19 original tracks, interviews, tips
- Learn how MI enhances direct practice with people who have co-occurring disorders

IDDT POSTER: STAGES OF CHANGE & TREATMENT

- 18"(w) x 24"(h) poster
- Tips for each stage of IDDT treatment
- Display in your office as a reminder of IDDT's core components

READINESS RULER

- 7"(w) x 1.75"(h) laminated ruler
- 2 sides: Importance & Confidence Scales (zero-to-10)
- Use this tool to help people evaluate the importance of the personal changes they desire and their confidence about making those changes

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IDDT AT-A-GLANCE

PROBLEM

TWO DISORDERS

Research shows the over 50 percent of people in the United States who have been diagnosed with a severe mental illness will also have a diagnosable co-occurring substance use disorder (alcohol or other drugs) during their lifetimes (see Regier in Sources on page 46).

SEPARATE SERVICES

Historically, people with co-occurring disorders have been excluded from mental health treatment because of their substance use disorder. Likewise, they have been excluded from substance abuse treatment because of their severe mental health symptoms. As a result, they frequently have not gotten the help they need.

NEGATIVE LIFE OUTCOMES

Individuals with co-occurring disorders are more likely to experience the following:

- Recurring psychiatric episodes
- Continued abuse of and dependence upon alcohol and other drugs
- Hospitalization and emergency room visits
- Relationship difficulties
- Violence
- Suicide
- Arrest and incarceration
- Unemployment
- Homelessness
- Poverty
- Infectious diseases, such as HIV, hepatitis, and sexually transmitted diseases
- Complications resulting from chronic illnesses such as diabetes and cancer

SOLUTION

INTEGRATED TREATMENT

The Integrated Dual Disorder Treatment (IDDT) model combines substance abuse services with mental health services and helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. IDDT is multidisciplinary and combines pharmacological, psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. Treatment is individualized to address the unique circumstances of each person's life.

Treatment components

IDDT is built upon the following core treatment characteristics (components):

- Multidisciplinary Team
- Co-occurring Treatment Specialists
- Stage-Wise Interventions
- Access to Comprehensive Services (e.g., residential, employment, etc.)
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interventions
- Substance-Abuse Counseling
- Group Treatment
- Family Psychoeducation
- Participation in Alcohol & Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Treatment of Non-Responders

Evidence-Based Practice | EBP

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) endorses the Integrated Dual Disorder Treatment (IDDT) model as an evidence-based practice.

The Integrated Dual Disorder Treatment (IDDT) model was developed by Robert E. Drake, M.D., and his colleagues at the Dartmouth Psychiatric Research Center of Dartmouth Medical School (see Sources on page 46).

A BETTER LIFE

IMPROVED OUTCOMES

Decrease
- Duration, frequency, and intensity of symptoms of mental illness and substance use disorders
- Hospitalization
- Arrest and incarceration
- Duplication of services
- Treatment drop-out
- Utilization of high-cost services

Increase
- Abstinence from use of alcohol and other drugs
- Continuity of care
- Improved relationships
- Consumer quality-of-life
- Stable housing
- Independent living

LIVING IN THE COMMUNITY

Most people with severe mental illness receive treatment in the least restrictive environment as possible—not in a hospital but in the community, where many social and economic situations and circumstances influence and affect their symptoms, health, and well-being. These situations and circumstances may include the following:

- Access to safe, affordable, and stable housing
- Access to safe and nutritious food
- Access to competitive employment and stable income
- Medical care and insurance
- Relationships with peers/friends
- Relationships with family members

A WORD ABOUT WORDS

Medical professionals often refer to people who have a severe mental illness and/or substance use disorder as *patients*. Behavioral healthcare professionals often refer to them as *clients* or *consumers*. Many individuals and advocacy organizations are not comfortable with any of these terms and would rather use the phrase *people with* or *people who* have a health condition or disorder.

In this booklet, we will use the word patient from time to time, because this is still the language that many medical professionals use everyday. Yet, we are also using this booklet to introduce readers to the purpose of the multidisciplinary IDDT team. These teams are comprised of professionals who tend to use the words client and consumer, so we will use this language as well.

Finally, we agree with the consumer advocacy movement which asks that people who receive services be talked about and treated as individuals, not as diagnoses. All *people* have hopes, fears, dreams, life-experiences, and a personal narrative to tell. We all need someone to listen, to acknowledge, to respect, to accept, to encourage.

BELIEVE

IDDT WILL HELP YOU HANG IN THERE WITH PEOPLE WHO HAVE CO-OCCURRING DISORDERS AND NOT GIVE UP.

IT WILL HELP YOU BECOME A SOURCE OF HOPE.

YOU DO MAKE A DIFFERENCE

There are a growing number of medical and behavioral healthcare professionals around the country who are bearing witness to personal transformations of people with co-occurring mental and substance use disorders, a population that historically has been among the most difficult to engage and serve. These professionals are utilizing the Integrated Dual Disorder Treatment (IDDT) model and seeing some very positive indicators of recovery as consumers begin to

- Engage with providers and identify personal goals
- Talk honestly about their use and abuse of alcohol, tobacco, and and other drugs
- Reduce and eventually eliminate their substance use
- Understand and manage the symptoms of their mental disorders
- Attain competitive jobs in their local communities
- Remain out of the hospital
- Remain out of jail
- Attain and maintain safe and stable housing
- Attend support groups and psychoeducational groups
- Establish supportive social networks
- Improve their physical health and attention to personal hygiene and appearance
- Increase their economic independence

CATALYST FOR CHANGE

Treatment providers who use the IDDT model do not force changes to occur. Consumers must do the difficult work of change. In fact, recovery would not occur without each person's readiness, willingness, and ability to change. Yet, it is likely that many of these success stories would not be occurring if these service providers were not giving consumers the level of attentiveness that IDDT promotes and supports.

You see, the strength of IDDT is that it assembles some very useful concepts and interventions into

one package and arranges the timing of their delivery in four stages of treatment, which facilitate recovery through realistic expectations and incremental changes over time. IDDT provides a framework to use these interventions systematically.

Many people with severe mental illness and substance use disorders do not have access to the quality care they need. They also experience broken relationships and, thus, have fewer opportunities to connect with people who support their hopes, dreams, and efforts for a better life. Nor do they have many opportunities to participate in social roles that are meaningful to them. They are often unemployed, isolated, and alone. As a result, they frequently find company among people who do not support recovery but rather support addictions and destructive behaviors.

IDDT offers hope for change, because it integrates service systems so that consumers receive care—no matter how severe their symptoms, no matter how much they use or conceal their use of alcohol or other drugs, no matter how often they might start and stop treatment, and no matter how often they might relapse. IDDT also encourages positive peer supports through psychoeducational groups and self-help groups. Here, they get connected with people like themselves who are on a recovery journey.

THE HEART OF IT

To claim that IDDT in and of itself produces transformation among consumers would be an erroneous overstatement. The truth is that IDDT provides *opportunities* for more meaningful and less judgmental relationships, but it does not provide the relationship itself. It is people like you who do this—with your compassion, patience, persistence, optimism, and commitment to healing. This is the heart of the treatment. With these attributes, medical and behavioral healthcare providers such as yourself are more likely to establish a **therapeutic alliance** with consumers—feelings of safety and trust that will sustain the relationship over time and through difficult emotional experiences.

CHALLENGES YOU FACE

It is likely that as people with co-occurring disorders begin treatment they will expect history to repeat itself—that they will be ignored, abandoned, reprimanded, or shamed in other ways. As a result, they will test your commitment to them. When this occurs, IDDT's principles and practices will help you keep your passion, compassion, and commitment to healing aligned with the core of "the other," the "healthy self," "the person" who wants to get better. In other words, IDDT will help you hang in there with people who have co-occurring disorders and inspire you not to give up. It will help you become a source of hope.

WELCOME

For those of you who are familiar with IDDT and are returning to rekindle your interest, welcome back. For those of you who are new to IDDT, we are glad to have you aboard. We look forward to accompanying you on your journey of discovery and practice innovation. ■

IDDT provides **opportunities** *for more meaningful and less judgmental relationships, but it does not provide the relationship itself. It is people like you who do this—with your compassion, patience, persistence, optimism, and commitment to healing.*

ACCESS TO QUALITY CARE

ONE OUT OF EVERY TWO PEOPLE WITH A SEVERE MENTAL ILLNESS IN YOUR PRACTICE WILL HAVE A SUBSTANCE USE DISORDER AT SOME POINT IN THEIR LIVES.

People in your community deserve access to the best healthcare practices available. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). IDDT is designed for people who have been diagnosed with a severe mental illness and a co-occurring substance use disorder. We created this booklet as a way to inform, to educate, and to advocate for integrated treatment.

Although IDDT services appear to begin once a patient has been screened, assessed, and diagnosed with both disorders, this is not where the work of integrated treatment truly starts. It commences—or, more precisely, could and should commence—in every office of every primary healthcare specialty that can and should be an access point to (or referral source for) behavioral healthcare (i.e., mental health and substance abuse services).

As you know, effective treatment of all diseases begins with effective screening, those few questions that can be easily slipped into normal day-to-day conversations with your patients. It is the screening that leads to a more thorough assessment which leads to referral and effective, timely treatment. In other words, treatment success depends upon all of you—even if your role is that momentary yet all-so-important contribution of screening and referral.

PURPOSE OF THIS BOOKLET

We hope you use the information in this booklet to do one or more of the following in the support of integrated co-occurring services:

- Begin training in the principles and practices of integrated treatment
- Advocate for integrated treatment in your service organization, hospital, and community
- Create partnerships and collaborations with service teams
- Become a referral source for integrated treatment
- Become an active member of an implementation steering committee or stakeholder group

This booklet gives you a basic introduction to the challenges of treating co-occurring mental and substance use disorders and the role of multidisciplinary IDDT service teams. It also gives you some tips for your practice that you can use today. However, it does not try to give you all of the background about co-occurring disorders or answers to all treatment questions. It is designed to get you started—to prepare you for training, consultation, and discussions with colleagues.

WHO SHOULD USE THIS BOOKLET

- **Mental health professionals**
- **Substance abuse professionals**
- **Criminal justice specialists/liaisons**
- **Supported Employment specialists**
- **Housing specialists**
- **Residential treatment providers**
- **Family and marriage counselors**
- **Peer specialists**
- **Psychiatrists, other physicians, and nurses**
  - *50% of your patients need integrated treatment*
    Research shows that one out of every two people with a severe mental illness who you see in your practice has or will have a co-occurring substance use disorder at some point in his or her lifetime.
  - *A fatal condition*
    Addiction is progressive and destructive. When it is untreated, it frequently has a fatal consequence.
  - *Medication should be combined with psychosocial treatment*
    Research shows that people who only receive medication as treatment relapse more frequently. However, people who receive medication along with psychosocial treatments may relapse less often.
- **Internists and family practice physicians**
  - *The frontline of early detection*
    Primary care physicians are among the first healthcare professionals to see consumers who present symptoms of mental illness and substance use. They are key to early detection, referral, treatment, and the prevention of negative outcomes.
  - *Prescribing psychotropic medication*
    Many of you see patients with symptoms of mental illness in your practice and may be treating the symptoms with psychotropic medications. Some of these patients may be experiencing more severe symptoms than they report. In addition, their symptoms may become more severe over time. IDDT may be a better treatment option for some patients because it includes biopsychosocial treatments.
  - *Poverty (urban and rural communities)*
    In many urban and rural communities, there is a shortage of psychiatrists to serve people with severe mental illness, especially in economically depressed areas. In these communities, primary care physicians often provide clinical leadership and prescriptive authority for people with these severe conditions.
  - *Primary health conditions*
    People with severe mental illness are more likely to experience negative outcomes, including acute and chronic physical illnesses. They need you to understand their impairments as well as their strengths to help them achieve and maintain their health and wellness (see page 14).
- **Other Physicians**
  The physicians listed below are also important collaborators and team members. They play an important role in screening patients for mental disorders and/or substance use disorders.
  - *Obstetrics and gynecology*
    For many women without health insurance, pregnancy may connect them with systems of care for the first time since the onset of their symptoms of mental illness and addiction. Screening, assessment, and referral are crucial not only for the mother but for her children.
  - *ED physicians*
    People with severe mental illness and substance use disorders may seek primary medical care at emergency departments for many different reasons, including a lack of insurance and a lack of involvement with primary healthcare providers, among others. In addition, people with addictions are likely to experience traumas because of intoxication, impaired judgment, and risky behaviors. These traumas often result in emergency room visits.
  - *Neurologists*
    Consumers with co-occurring severe mental illness and substance use disorders frequently experience periods of intoxication, withdrawal, increased impulsiveness, and impaired judgment. As a result they are likely to experience strokes, seizures, and traumatic brain injuries, resulting from events such as car accidents, falls, and fights. For these reasons, neurologists will be involved in screening, evaluation, treatment, and referral for ongoing services.
- **Nurses**
  Many organizations (community-based agencies, health clinics, and hospitals) utilize nurses to screen, assess, diagnose, counsel, and prescribe and manage medication. Nurses have the opportunity to interact with patients and their families in ways that other medical professionals do not. Nurses are often a source of important collateral information about the patient's daily life, as well as patient history and family history, all of which inform treatment plans. ■

INTERACTING WITH CONSUMERS

WHY DO YOU GET FRUSTRATED WITH SOME PEOPLE WHO HAVE CO-OCCURRING DISORDERS MORE THAN OTHERS?

It is often difficult to determine if the feelings, thoughts, and behaviors of consumers with co-occurring disorders are due to the symptoms of addiction, to the symptoms of mental illness, or to both. Realizing that people with dual disorders have two chronic, progressive, relapsing, and potentially fatal brain diseases may allow you to have more patience in dealing with them.

Providing care to people with mental disorders can be challenging at times, because symptoms may impair their cognition and social cognition, which often makes communication difficult. In addition, the impairments may inhibit and limit a person's ability to manage medications, symptoms, and overall health and well being. Substance intoxication and substance withdrawal may also impair judgment, self awareness, and ability to communicate.

COGNITIVE IMPAIRMENTS

Individuals with severe symptoms of mental disorders often experience the cognitive impairments listed below:

- Slow mental processing speed
- Impaired cognition/thinking, which includes a decrease in:
  - Attention/concentration
  - Memory
  - Problem solving
  - Mental stamina
  - Motivation, initiative, and energy
- Impaired social cognition—the ability to interact socially and emotionally with others, for example:
  - Ability to recognize and respond to social cues, such as eye contact, posture, tone of voice, etc.

(See Hogarty and Flesher, see McGurk in Sources on page 46.)

RESISTANCE & THE STRENGTH OF ADDICTION

Addiction produces complex psychological defense mechanisms that make it difficult for people to see their problems. Therefore, individuals may not believe they need to quit using. For people addicted to alcohol and other drugs, the drink or the drug assumes *survival salience*, which means the substance becomes as important—or even more important—than necessities for survival, including water, food, trusting relationships, sleep, and sex. Some people with addiction equate the need "to use" substances with the need to breathe!

Addictions frequently influence people to behave in ways that are contrary to their values and society's values. For instance, your patients may value honesty and trust in relationships, but they may frequently lie, cheat, steal, manipulate, or take advantage of others in order to obtain alcohol and other drugs and to keep the addiction going. For example, they might conceal how much and how often they use substances. They might try to convince physicians and nurses to prescribe medications that have addictive potential, such as benzodiazepines, stimulants, and opiates. They may try to steal some prescription pads and forge a signature.

YOUR EXPECTATIONS & EMOTIONAL REACTIONS

The disease of addiction leads to maladaptive behaviors that perpetuate the addiction. That's easy to understand intellectually. However, when people present maladaptive behavior, it may make you feel cheated, manipulated, frustrated, ashamed, angry, and defensive. These are all normal reactions, but they are not reasons to refuse or quit trying to help.

The more you understand the disease process and the less you take the behavior of consumers personally, the easier it becomes to work with them. In addition, you may need to adjust your expectations a bit. In the early stages of treatment, people with addictive disorders may not be as honest and straight forward as you wish them to be.

ADMIT POWERLESSNESS

It may be difficult for consumers to admit they are powerless over their cravings and compulsions to use alcohol, tobacco, and other drugs. Likewise, it may be difficult for *you* to admit that you are powerless over your patients' behavior or circumstances. When you understand that the addiction is more powerful than both of you, it is easier to align yourself with the healthy part of the consumer who may want to recover.

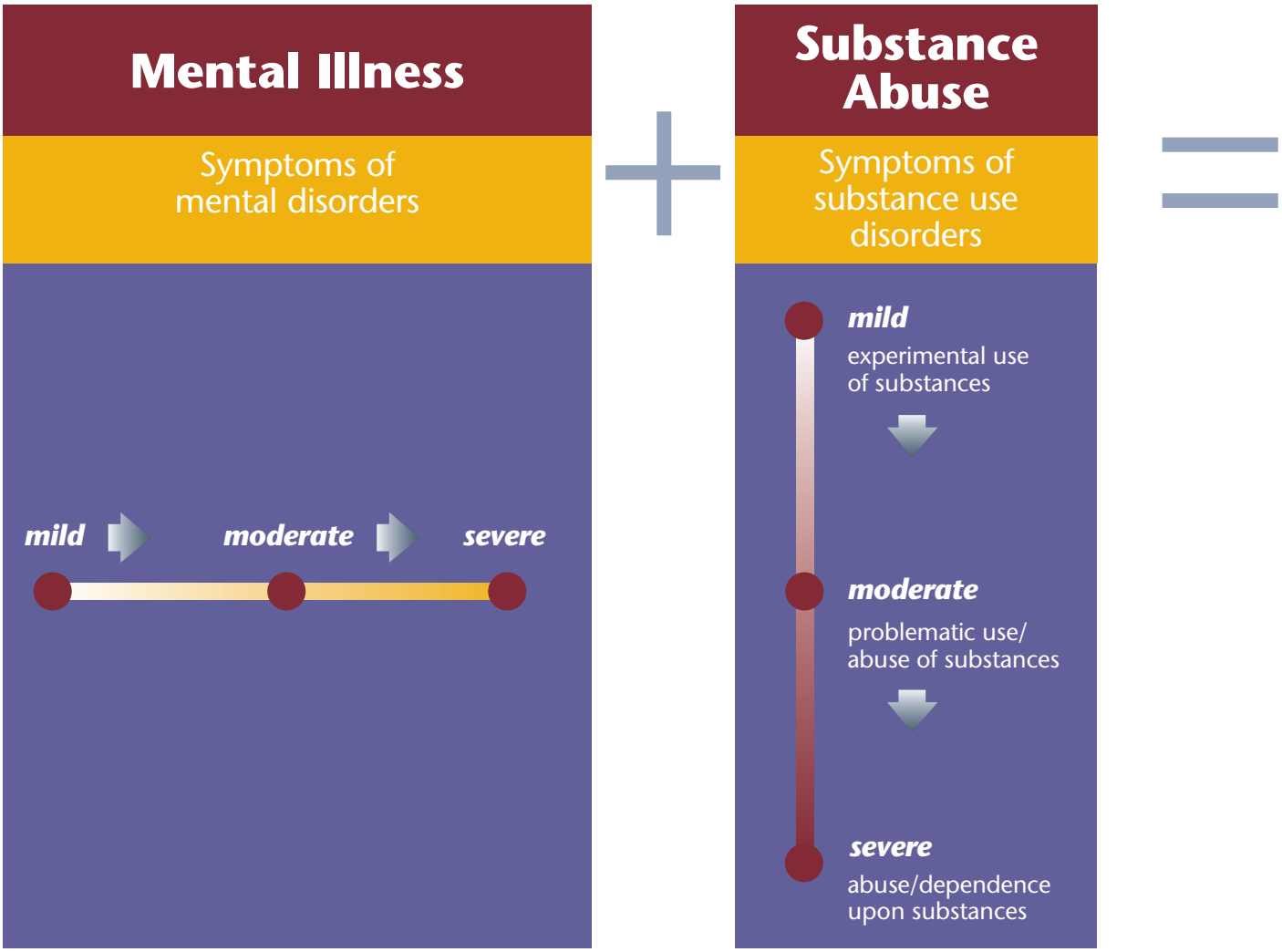
STRATEGIES FOR SUCCESS

A slight shift in your perspective may go a long way in building trust—the foundation of the therapeutic alliance—with each consumer. Once this change in perspective occurs, your thoughts, language, and behavior will change as well. Some strategies for success include the following:

1. **Tolerate imperfections**
   Try to see each consumer/patient as a "person with an illness who has a right and deserves to get well" rather than a "bad person trying to get good." Consumers with co-occurring disorders are coming to you because their feelings, thoughts, and behaviors are out of control, so don't make perfect behavior a prerequisite for treating them.
2. **Focus on the individual**
   Do not judge consumers for problematic behaviors and circumstances. Delineate between the behavior and the person. Collaborate with the consumer to address the addiction and mental illness. Identify their personal strengths and dreams. Develop person-centered plans of care.
3. **Show compassion**
   People experience an enormous amount of suffering and pain as a result of their severe mental illnesses and addictions. It will be helpful to convey the following: "You deserve better than this. Let's find a way to help you. Let's work together on this."
4. **Set limits**
   Say "No" and mean it when you have to (e.g., medical professionals limiting or not prescribing addictive medications, such as benzodiazepines and opiates). Explain your rationale. For example, you might say this: "Because of your addiction, I cannot fulfill your request because it would worsen your chances for recovery."

   It is likely that consumers will not like to hear "No" for an answer. You may need to agree to disagree. You might say something like this: "From time to time, you might find that you and I have a difference of opinion. You might even get mad at me because of it. Your anger is not surprising. It is understandable. I encourage you to share it with me. I am not going to deny you treatment if you get angry. I'm here to help you in your recovery."

   It will be helpful for consumers to hear you disagree with them and to know that, even if you disagree, you do not reject them as a person or shame them in any way. They can rely on you to tolerate their strong feelings and beliefs. They can come back, because you will be there.
5. **Rely on teamwork**
   Remember that it is difficult to respond to a person's addiction and mental illness by yourself. It takes a multidisciplinary team to provide the best care possible. It is best that each consumer has the appropriate level of care for the severity of his or her illness. This may include group treatment, individual counseling, case management, family support, peer support, and self-help groups.
6. **Take good care of yourself**
   It is easier to give your full attention to people with co-occurring disorders when you are taking care of yourself outside of work. Talk to other colleagues about your frustrations and successes. Together, you may find creative solutions to the challenges you face. You will also find others who share the joy that comes from witnessing the small steps of recovery that occur daily. After all, it is the small successes that add up over time to become the triumphs. ■



MENTAL DISORDERS

There are many categories of mental disorders and, thus, many identifiable symptoms. Yet, symptoms may be understood in general terms as feelings, thoughts, perceptions, and behaviors. It is helpful to think of **symptoms of mental disorders** as occurring on a continuum of mild, moderate, and severe.

The term *severe mental illness* is often applied to disorders such as schizophrenia, schizoaffective, bipolar, severe depression, and severe anxiety because people with these conditions often experience negative life outcomes (see page 4) when their symptoms remain untreated. Symptom severity is typically defined by the following:

- Intensity
  - Mild
  - Moderate
  - Severe
- Duration & Frequency
  - Acute/ temporary
  - Periodic/ episodic
  - Chronic/ persistent

SUBSTANCE USE DISORDERS

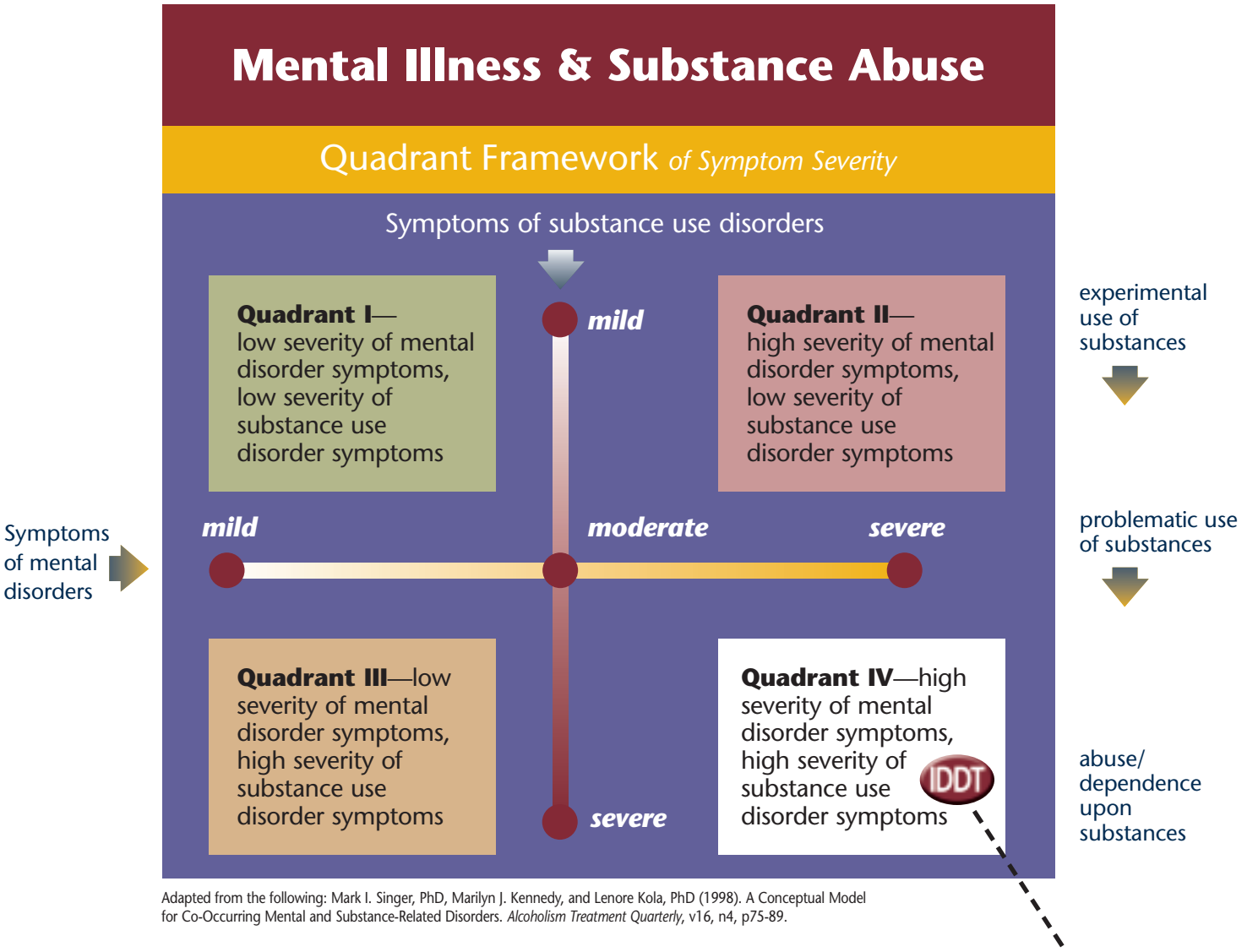
It is helpful to think of **symptoms of substance use disorders** as occurring on a continuum of mild, moderate, and severe (see illustration above). Addiction is a maladaptive pattern of substance use that leads to clinically significant impairment or distress (see APA in Sources on page 46). Without treatment, addiction is a progressive and often fatal illness. It has the potential to destroy a person's body, mind, hope, and interpersonal relationships.

Substance use disorders typically develop on a continuum that includes the following:

- Experimental use
- Regular use
- Problematic use
- Substance abuse
- Substance dependence (addiction)

Addiction is a common term that is used interchangeably with the clinical term *substance dependence*. According to the National Institute on Drug Abuse (NIDA), addiction is a chronic relapsing brain disease characterized by compulsive drug seeking and use, despite negative or harmful consequences. Addiction disrupts the normal functions of the brain, just as heart disease disrupts the normal functions of the heart.

(For more information, see Diagnosis & Eligibility section on page 24.)



Adapted from the following: Mark I. Singer, PhD, Marilyn J. Kennedy, and Lenore Kola, PhD (1998). A Conceptual Model for Co-Occurring Mental and Substance-Related Disorders. *Alcoholism Treatment Quarterly*, v16, n4, p75-89.

CO-OCCURRING DISORDERS

When symptoms of mental disorders and substance use disorders are present within an individual at the same time, they both contribute equally to distress. This is often called **co-occurring disorders**. Other words to describe it include the following:

- Dual disorders
- Co-morbidity
- Mentally ill and chemically abusing (MICA)
- Mentally ill and substance abusing (MISA)
- Substance abuse and mental illness (SAMI)

Consumers, family members, and service providers often use these words to refer to co-occurring disorders, no matter how severe the symptoms. However, it is important to clarify the severity of symptoms. This information will help service providers and consumers choose the most effective interventions for their needs. For instance, IDDT was designed for people who experience severe symptoms of both disorders (i.e., Quadrant IV). However, many of the terms, concepts, and strategies of the IDDT model are applicable to people whose symptoms are less severe.

There is a popular belief that a high percentage of people with severe mental illness use alcohol and other drugs because they want to self-medicate (or numb) the pain of their symptoms. The research in this area is inconclusive. Some researchers speculate that people with mental disorders choose to use alcohol and other drugs for the same reasons as people who do not have mental disorders. Examples include the following:

- To change their mood and enjoy a good feeling
- To be social
- To fit in with others and feel a sense of belonging

CLINICAL DEFINITION

The Axis classification and assessment system in the *Diagnostic Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR)* does not yet specifically address the phenomenon of co-occurring disorders. However, current practice guidelines suggest that both disorders may be considered as primary. Service providers should list both diagnoses as primary in their clinical documentation. This will indicate that the person needs help managing symptoms of and problems related to both disorders at the same time. ■

THE INTEGRATED DUAL DISORDER TREATMENT (IDDT) MODEL WAS DEVELOPED FOR PEOPLE WHOSE SYMPTOMS ARE MOST SEVERE. HOWEVER, MANY OF THE TERMS, CONCEPTS, AND STRATEGIES OF THE IDDT MODEL ARE APPLICABLE TO PEOPLE WHOSE SYMPTOMS ARE LESS SEVERE.

INTEGRATED PRIMARY HEALTH

WHAT CAN YOUR ORGANIZATION DO TO HELP CONSUMERS IMPROVE THEIR PHYSICAL HEALTH AND MENTAL HEALTH AT THE SAME TIME?

There is a growing national concern about the need for integrated primary and behavioral healthcare services that are effective for helping people with mental illness and substance use disorders participate more actively in the process of maintaining their physical health. This section is intended as a general introduction to emerging ideas and approaches.

According to a 2008 report from the National Association of State Mental Health Program Directors (NASMHPD), people with serious mental illness die, on average, 25 years earlier than people without these conditions, mainly from medical conditions that can be treated, managed, and prevented. NASMHPD supports emerging policies and practices for the integration of primary and behavioral healthcare, emphasizing the importance of two guiding principles:

- Overall health is essential to mental health
- Recovery includes wellness

SYMPTOMS IMPACT THE MANAGEMENT OF PERSONAL HEALTH

There are many factors that contribute to poor health, but it is important, first of all, to consider the impact of symptoms of mental illness and substance use disorders. Symptoms often inhibit cognition and, thus, a person's ability to understand health information and how it might apply to his or her personal situation. Also, symptoms often inhibit social cognition (see page 10) and, thus, a person's ability to engage in meaningful relationships with healthcare professionals, especially during the difficult (often intrusive and sometimes traumatic) processes of examination, diagnosis, treatment planning, treatment, and rehabilitation. In other words, symptoms often challenge the formation of trusting relationships between patients and healthcare providers—relationships that are necessary for communicating and understanding essential information about illness and health and for discussing, choosing, and participating fully as partners in effective treatment options.

SYSTEM FRAGMENTATION IMPACTS OUTCOMES

People with mental illness and substance use disorders often receive care from multiple locations and systems that are not effectively coordinated (e.g., primary care clinics, hospitals, community mental health centers, substance abuse treatment centers). As a result, people may not access the treatment they need in a timely and organized manner and, thus, may experience the following:

- Multiple diagnoses
- Low motivation to change their behaviors
- Frequent relapse
- Rapid readmission to hospital settings
- Premature death

RISK FACTORS

The NASMHPD report highlights several common contributors to chronic health conditions and poor health outcomes which can be addressed in an integrated primary and behavioral healthcare setting:

- Tobacco use
- Poor nutrition
- Lack of exercise
- Obesity
- Substance abuse
- Side effects of psychotropic medication (e.g., weight gain, metabolic problems such as high cholesterol and diabetes)
- Poverty
- Social isolation
- Inadequate access to quality medical care (primary and preventative)

MEDICAL CONDITIONS

The report also emphasizes that chronic health conditions, such as those listed below, contribute more to premature death among people with severe mental illness than suicide:

- Infectious diseases
- Sexually transmitted diseases
- Liver disease
- Pulmonary (lung) disease
- Cardiovascular (heart) disease
- Hypertension
- Diabetes
- Dental disorders (a common source for infections, including those that affect the heart)

HEALTH INDICATORS: SCREENING & ASSESSMENT

While behavioral health providers typically conduct diagnostic screening and assessment for suicide risk among people with severe mental illness, they often do not screen and assess for other health risk-factors. Therefore, NASMHPD recommends that the following indicators be included in ongoing screening and assessment processes *within* behavioral healthcare settings:

- Personal & family history of diabetes, hypertension, cardiovascular disease
- Weight/height/body mass index (BMI)
- Blood pressure
- Blood glucose or HbA1C
- Lipid profile
- Tobacco use/history
- Substance use/history
- Medication history/current medication list with dosages
- Social supports

EMERGING MODELS OF INTEGRATION

Serious mental illness and substance use disorders are often chronic, debilitating illnesses. Systems of integrated primary health and behavioral health should be built upon the *Chronic Care Model*, which emphasizes what is called *care management*. This approach includes educating and supporting consumers in a manner that helps them with the following:

- Accessing community resources
- Becoming an informed partner in decision-making
- Adopting strategies for the self-management of their health and chronic diseases

According to NASMHPD, people who benefit from the care-management approach are less likely to experience hospitalizations for preventable conditions and complications from illnesses. They are also more likely to have a better quality of life and experience higher satisfaction with services.

Person-Centered Healthcare Home

Implementation of the Chronic Care Model for individuals living with mental illness and/or substance use disorders is best accomplished with what is called the *person-centered healthcare home*. Ideally, this is a single physical location that co-locates outpatient primary care services and behavioral healthcare services within a single structure, such as a community mental-health center, substance-abuse center, or methadone clinic.

Team-Based Care

A healthcare home brings together the following service providers:

- Medical nurse practitioner and/or primary care physician
- Primary care supervising physician
- Nurse care manager
- Mental-health case manager
- Other behavioral healthcare providers (e.g., substance abuse counselor, benefits specialist, employment specialist, peer specialist)

Integrated Services

The healthcare home also brings together the following services with a biopsychosocial-spiritual philosophy:

- Regular screening, assessment, and tracking
- Evidence-based practices
- Behavioral health services
- Disease-management strategies
- Wellness programs
- Outcome measurements

GETTING STARTED

The Center for Evidence-Based Practices (CEBP) has teamed up with Shawnee Mental Health Center in Portsmouth, Ohio to develop one of the first planning and evaluation instruments in the United States that helps organizations integrate primary and behavioral healthcare for people with severe mental illness. This initiative was funded by the U.S. Substance Abuse and Mental Health Services Administration. The CEBP is using the new Integrated Treatment Tool with organizations to plan, develop, and evaluate integrated primary and behavioral healthcare services. Organizations that wish to begin this process are encouraged to contact the CEBP for consultation services. ■

The following documents were reviewed for the development of this section of this booklet. Parks (2008), NCCBH (2009), and Jarvis 2010) (see Sources on pages 46).

SCREENING & ASSESSMENT

WHY SHOULD YOU CONTINUOUSLY ASSESS PEOPLE FOR MENTAL ILLNESS, SUBSTANCE USE DISORDERS, AND PRIMARY HEALTH CONDITIONS?

All clinical interviews begin with a few *screening* questions. Affirmative answers from consumers prompt you to ask additional, more detailed questions, transforming your conversation into an *assessment*. Your interviews with people should include a screening for mental disorders and substance use disorders. We have created separate sections below for mental-health screening and assessment as well as for substance-abuse screening and assessment to emphasize that they are distinct yet related processes to integrate into your day-to-day routines.

GUIDING PRINCIPLES

Here are some basic principles about continuous screening and assessment to incorporate into your daily practice.

- **Seek information from multiple sources**
  Multiple sources of information include family members, integrated-treatment team members, and additional contacts and ancillary providers such as the following: housing and residential program managers, previous treatment providers, parole or probation officers, primary care providers. Many consumers will give permission to multiple service providers and family members to discuss their recovery experiences. Some will not.
- **Clarify and resolve discrepancies in information**
- **Ask about multiple substances**
- **Be straightforward and matter-of-fact when you ask your questions**
  People with addictions to alcohol and other drugs are likely to keep their addictions concealed. If you don't ask, it is likely they will not tell.
- **Assess continuously over time**
  Every meeting with a consumer is an opportunity to gather additional information. Screening and assessment are not events. They are ongoing processes.
- **Monitor the interactive course of mental illness, substance use disorders, and primary health conditions over time**

SCREEN & ASSESS CONTINUOUSLY

A thorough assessment of the life experiences of people with severe mental illness and substance use disorders is important for accurate diagnoses, effective treatment plans, and interventions that

can slow and eventually stop the progression of the diseases. Assessments should include detailed questions about each person's mental health experiences and substance use habits and should occur continuously over time, not just in the first or second appointment. Here are a few facts to remember:

- Not all people with a severe mental illness (SMI) use alcohol and/or other drugs.
- Not all people who abuse substances have mental illness.
- If a consumer with SMI uses alcohol or other drugs, this does not mean he or she has a diagnosable substance use disorder.
- However, research shows that over 50 percent of people with SMI will develop a co-occurring substance use disorder at *some point in their lives.* Therefore, it is likely that one out of every two people with an SMI who you see in your practice has had, currently has, or will have a co-occurring substance use disorder.
- Therefore, all consumers with SMI have a greater *statistical risk* of developing a substance use disorder, even if they do not use right now or use without any apparent negative consequences.
- Some consumers may be keeping their substance use or abuse concealed. They may be ashamed of their addiction or be afraid of rejection from you and other service providers, their family members, and friends. They may also fear legal consequences of their lifestyles.

LISTENING TO STORIES | THE ART OF SCREENING & ASSESSMENT

Over time, as you prove to people that you will not judge them or kick them out of treatment, they will begin to feel safer with you and, thus, begin to share bits and pieces of information about their personal histories. It is helpful to know what to listen for.

It is also important to become familiar with the symptoms of mental and substance use disorders, so you will be able to detect them accurately in the stories that consumers tell you about their daily lives. As you learn to hear details of symptoms in their narratives, you will know when and how to probe a little further, that is, to shift from screening and assessment of symptoms to understanding the negative impacts of symptoms upon their lives.

A MIX OF SYMPTOMS & SIDE EFFECTS

The combination of symptoms and side effects experienced by people with co-occurring disorders can be very confusing and dangerous.

Similar symptoms

Mental disorders and substance use disorders often have similar symptoms. Examples include but are not limited to the following:

- Depression
- Anxiety
- Paranoia
- Hallucinations
- Agitated behavior

Medication side effects

The side effects of psychotropic medications can sometimes appear to be and feel a lot like symptoms of either disorder. Examples include but are not limited to the following:

- Sedation
- Insomnia
- Changes in appetite
- Abnormal body movements

In addition, if people with co-occurring disorders continue to use alcohol and other drugs while taking the psychotropic medications that help them progress toward abstinence, they could experience negative physical and psychological effects. This will also reduce the therapeutic effectiveness of the medication. Therefore, it is necessary to have psychiatrists and other trained professionals monitor the person's use and progress—to help them notice and interpret symptoms and make adjustments to medication if necessary.

WHO

Service organizations have different protocols for who on the service team conducts screening and assessment. It may be one or all of the following:

- Psychiatrist
- Psychologist
- Licensed social worker
- Nurse
- Licensed counselor
- Other

WHEN

A thorough baseline assessment should occur at the onset of services. Although the process of assessment occurs continuously, a formal comprehensive assessment should be updated at least annually.

BARRIERS TO ACCURATE SCREENING & ASSESSMENT

Symptoms

Intoxication, withdrawal, and behavioral manifestations of addiction can mimic most known psychiatric disorders and vice versa. Also, symptoms of primary health conditions can complicate assessment. For instance, diabetes may create symptoms that may appear as alcohol intoxication.

Memory & Reliable History

Many individuals affected by severe mental and substance use disorders often find themselves struggling to provide accurate information about their personal histories and their experiences with symptoms of both disorders. The reliability of the person as a historian of symptomology should be considered when conducting a screening and assessment.

Individuals with co-occurring disorders often hide their symptoms from friends, family members, and service providers in fear of rejection and/or legal consequences. So a collateral history (from others) is important, though may be less accurate than you expect.

continued on next page

WE HAVE CREATED SEPARATE SECTIONS FOR MENTAL-HEALTH SCREENING AND ASSESSMENT AS WELL AS FOR SUBSTANCE-ABUSE SCREENING AND ASSESSMENT TO EMPHASIZE THAT THEY ARE DISTINCT YET RELATED PROCESSES TO INTEGRATE INTO YOUR DAY-TO-DAY ROUTINES.

PRIMARY HEALTH CONDITIONS

It is important to screen continuously for primary health conditions among people with severe mental illness and substance use disorders. Individuals with co-occurring disorders tend to have higher rates of chronic and acute medical illnesses and less access to regular medical care, so there is a greater chance that medical illness may contribute to the cause of presenting symptoms.

There are several contributors to chronic health conditions and poor health outcomes which can be addressed during an integrated screening and assessment. A list of these primary health items is located in the "Health Indicators" section on page 15.

SCREENING & ASSESSMENT TOOLS

There is no substitute for the ability to identify and distinguish among symptoms of mental health, substance abuse, and physical health during conversations with consumers. There are a number of tools that can help service providers develop the skills to acquire this information. These are mental-health-screening tools and substance-abuse-screening tools that provide good questions to make a part of your conversations with consumers. Choose those that are comprehensive and appropriate for people with co-occurring mental and substance use disorders. It is more effective to have properly trained and supervised staff use a consistent approach with all patients, as this will create a standardization of care.

MENTAL HEALTH SCREENING & ASSESSMENT

It is important to conduct a thorough assessment of each person's past and current life-experiences to determine how symptoms of mental disorders have impacted and currently impact health and wellness. A *screening* for both substance use and mental health disorders must be included in the mental health assessment.

The assessment informs diagnosis, which informs treatment planning. It helps service teams determine which biopsychosocial interventions will best support and promote recovery.

Symptoms of psychosis

The word *psychosis* refers to a mental disorder in which a personality is seriously disorganized and contact with reality is usually impaired. In the *DSM-IV-TR*, the word psychotic (psychosis) refers to the presence of specific symptoms for different diagnostic categories, the most common being "prominent hallucinations, disorganized speech, or disorganized or catatonic behavior" (see APA, p297, in Sources on page 46).

Listen carefully to the subtleties of the dialogue between you and your patients, and listen carefully for symptoms. Be prepared to ask consumers to explain further their responses to you.

(For more information about symptoms, see tables on pages 25, 26 & 27.)

MH Screening Tools

Typically, there are screening tools that capture symptoms for each mental disorder. The process of screening typically includes a few specific questions that you include in your conversations with consumers. Affirmative answers from consumers will transform your screening into an assessment, which includes a larger number of questions. A few examples of mental-health screening tools include the following:

- Modified MINI (Mini International Neuropsychiatric Interview)
- Referral Decision Scale (RDS) *(See Hart in Sources on page 46.)*
- Addiction Severity Index (ASI)

MH Assessment Tools

Assessments should be conducted by someone in the organization who is trained, supervised, and experienced with the process.

CUNNING, BAFFLING & POWERFUL

Addiction typically does not start with extreme consequences. In the beginning, the behavior may simply involve the occasional use of a substance and a good feeling. Over time, the desire for the good feeling may progressively transform into an addiction with a self-destructive lifestyle, but the person often remains unaware. There is a saying in Alcoholics Anonymous which states that an addiction to alcohol is "cunning, baffling, and powerful." This is true for all chemical addictions.

Addiction produces complex psychological defense mechanisms that are difficult to understand and address. Therefore, individuals may not believe they need to quit using. However, much is known about the symptoms and the treatments that research has proven to be effective.

SUBSTANCE ABUSE SCREENING & ASSESSMENT

We have created a separate section for substance-abuse screening and assessment to demonstrate that these are somewhat different from mental-health screening and assessment. However, screening and assessment for both disorders should be conducted at the same time to create one integrated and, thus, seamless process.

It is important to conduct a thorough assessment of each person's past and current life-experiences to determine how symptoms of substance use disorders have impacted and currently impact health, mental health, and wellness.

If a consumer reports that he or she does, in fact, use substances like alcohol or cannabis from time to time, this does not mean he or she has a substance use disorder. However, he or she may be understating the frequency or quantity of use as a defense against the realization or shame of a deeper problem.

When you are conducting an integrated screening and assessment, it is important not to barrage people with question after question but to convey during the course of the conversation that you are attempting to learn as much about them as possible so, together, you may plan for the best possible treatment.

Keep in mind that if people are referred to treatment for a substance abuse problem, they may be more inclined to discuss their substance use and not their mental health symptoms. Likewise, if they are referred for mental health problems, they might be less inclined to discuss their use of substances. It is important to convey the importance of exploring both.

Finally, it is also important to conduct an assessment for primary health conditions and risk factors and to include any related diagnoses in the treatment plan. (For more information, consult pages 14 & 15.)

SA Screening Tools

The process of screening typically includes a few specific questions that you include in your conversations with consumers. Affirmative answers from consumers will transform your screening into an assessment, which includes a larger number of questions. A few examples of substance-abuse screening tools include the following:

- UNCOPE
- CAGE-AID

SA Assessment Tools

- Addiction Severity Index (ASI)

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11 CLASSES OF SUBSTANCES

In the *DSM-IV-TR*, the term *substance* refers to a drug of abuse, a medication, or a toxin. Substances are grouped into 11 classes:

- Alcohol
- Amphetamine or similarly acting substances/stimulants (stimulants) (e.g., Ecstasy, methamphetamine, ephedrine)
- Caffeine
- Cannabis
- Cocaine (e.g., powder, crack)
- Hallucinogens (e.g., LSD, Ecstasy, psilocybin, mescaline)
- Inhalants (e.g, glue, paint thinner)
- Nicotine
- Opiods
- Phencyclidine (PCP)
- Sedatives, hypnotics & anxiolytics

(See APA, *DSM-IV-TR*, in Sources on page 46)

TOPICS ADDRESSED IN AN INTEGRATED ASSESSMENT: MENTAL HEALTH	
Presenting risk to self or others	Does the person speak of committing any of the following, either directly or indirectly in the stories he or she tells: ■ Self-injury ■ Suicide ■ Homicide
Presenting symptoms of mental disorders	Is there evidence of the following in the person's actions, speech, or stories: ■ Hallucinations (visual, auditory, olfactory, etc.) ■ Delusions ■ Disorganized thinking and/or speech ■ Disorganized behavior ■ Catatonic behavior (stupor) *(For more information, see table on page 25.)*
Presenting symptoms of substance use disorders	■ Identify symptoms of substance use disorders and differentiate them from mental disorders, for example: • Intoxication vs. psychosis? • Substance-induced psychosis vs. biologically-based psychosis? • Benzodiazepine withdrawal vs. hallucination? • Substance-induced anhedonia (inability to experience pleasure) vs. depression or catatonia *(For more information, see Differential Diagnosis on page 26.)* ■ Determine severity of symptoms of both disorders ■ Identify the internal and external triggers of symptoms
Past psychiatric history	Ask about the following and/or listen for evidence of these in stories the person tells: ■ Use of medications and other treatments ■ History of hospitalizations and other treatments ■ Prior attempts at self-injury, suicide, and/or homicide ■ Family history of mental illness
Spiritual considerations	Carefully distinguish between diagnostic characteristics and beliefs and behaviors that are related to or accepted by the person's spiritual or religious community, for example: ■ Personal beliefs, values, spirituality, and pastoral care ■ Expressive grieving ■ Communicating with the deceased
Cultural considerations	Carefully distinguish between diagnostic characteristics and cultural traits, for example: ■ Beliefs ■ Emotional expressiveness (emotionality) ■ Rituals ■ Emotional restraint (Stoicism)
Physical illness & medical history	Listen for and ask about medical (primary-health) conditions and treatments, which may cause presenting symptoms: ■ Diseases (e.g., thyroid disease, anemia, seizure disorders, diabetes) ■ Allergies ■ Incidents of neglect, physical or sexual abuse, head injury and other trauma
Medication side effects	Identify any medication-induced causes of presenting symptoms (e.g., lethargy, irritability, metabolic syndrome)
History of treatment & recovery	Listen for and ask about each person's experiences with the following: ■ Age of first treatment experience ■ Number of admissions for outpatient treatment • Was treatment successfully completed? If not, why not? ■ Number of admissions for inpatient treatment • Was treatment successfully completed? If not, why not? ■ Use of psychotropic medication(s)? • Names, dosage, and adherence patterns?
Barriers to recovery	Determine if the person is experiencing the following: ■ Inadequate housing ■ Unemployment or underemployment ■ Inadequate nutrtion ■ Inadequate healthcare ■ Lack of social support
Facilitators of recovery	Listen for and ask about the following: ■ Personal strengths (e.g., resilience, determination, self-awareness of symptoms) ■ Family and social support ■ Hobbies and interests ■ Current employment status and/or interests ■ Past successes and future goals ■ Use of self-help and support groups, such as the following: • National Alliance on Mental Illness (NAMI) • Schizophrenia Anonymous (SA), Emotions Anonymous (EA) • Depression and Bi-Polar Support Anonymous (DBSA) ■ Peer support & consumer-operated services ■ Medical power of attorney

TOPICS ADDRESSED IN AN INTEGRATED ASSESSMENT: SUBSTANCE ABUSE	
History of use	Ask about the following *for each substance* that the person uses: ■ Age at first use ■ Most recent use, peak use (when? quantity?), periods of abstinence ■ Has the person ever tried to quit ■ Pattern of use (e.g., quantity, frequency) ■ Context of use (e.g., use alone, with friends, with family)
Multiple substances	The following substances and chemical compounds are frequently abused by people. Ask about these in your conversations with consumers: ■ Club drugs ■ Designer drugs ■ Commercially available synthetic drugs of abuse (e.g., bath salts, K2) ■ See 11 Classes of Substances in box on page 19.
Lack of control over use	■ Using more than intended (quantity or frequency) ■ Unable to stop once aware that a problem exists
Past and current consequences	■ Legal (e.g., arrest, conviction, incarceration, probation or parole status) ■ Medical (e.g., accidents and trauma, liver disease, heart disease, severe weight loss, etc.) ■ Psychosocial (e.g., impaired social functioning, divorce, loss of custody of children) ■ Loss of housing or work
Periods of sobriety	■ Ask about/look for periods of sobriety. What symptoms of mental illness occurred during periods of sobriety? ■ If your patient has never had a period of sobriety, this should cause you to question all other Axis I diagnoses that may have been assigned to the patient. The symptoms of addiction might be mimicking the symptoms of mental illness.
Symptoms of substance use disorders and mental disorders	■ Ask clients if they had problems in their lives before the substance use (e.g., social, family, academic). ■ Ask about family history of substance use. ■ See table on page 27 for more information
Spiritual considerations	Carefully distinguish between diagnostic characteristics and beliefs and behaviors that are related to or accepted by the person's spiritual or religious community, for example: ■ Personal beliefs, values, spirituality, and pastoral care ■ Expressive grieving ■ Communicating with the deceased
Cultural considerations	Carefully distinguish between diagnostic characteristics and cultural traits, for example: ■ Beliefs ■ Emotional expressiveness (emotionality) ■ Rituals ■ Emotional restraint (Stoicism)
Physical illness	■ Symptoms may be caused by primary health conditions (e.g., thyroid disease, anemia). However, symptoms may also be caused by substance abuse. Sorting this out is an important part of the assessment process.
Medication side effects	■ Symptoms may be caused by medication side effects (e.g., drowsiness, fatigue, anxiety, tremors). However, symptoms may also be caused by substance abuse. Sorting this out is an important part of the assessment process. ■ Identify any medication-induced causes of presenting symptoms (e.g., lethargy, irritability, metabolic syndrome)
History of treatment & recovery	■ Age of first treatment experience ■ Number of admissions for detox ■ Number of admissions for outpatient treatment • Was treatment successfully completed? If not, why not? ■ Number of admissions for residential or inpatient treatment • Was treatment successfully completed? If not, why not? ■ Use of medication (e.g., naltrexone, methadone, buprenorphine) • Names, dosage, and adherence patterns?
Use of self-help programs & peer support	■ Which groups? [(e.g., Narcotics Anonymous (NA), Alcoholics Anonymous (AA), Cocaine Anonymous (CA), Dual Recovery Anonymous (DRA)), Double Trouble?] ■ Frequency of attendance? ■ Did the person have a sponsor and a home group? ■ How far did the person get in working the 12-steps?

COMPREHENSIVE ASSESSMENT

HOW DO YOU USE ALL OF THE INFORMATION FROM SCREENING AND ASSESSMENT TO FORM A COHERENT PICTURE OF THE CONSUMER'S PERSONAL HISTORY & NEEDS?

Screening and assessment for two or more disorders produces large amounts of information, the significance of which can be difficult to comprehend efficiently and effectively. Therefore, the IDDT model suggests two approaches to help summarize and analyze the longitudinal and contextual data (see below). Using one or both of these approaches together is a process that is commonly referred to as a comprehensive assessment. The purpose is to examine each consumer's past and current life experiences to determine how symptoms of both disorders have impacted and currently impact health and well-being. Engaging in this process helps inform diagnosis and treatment planning.

COMPREHENSIVE LONGITUDINAL ASSESSMENT

This tool explores the *impact of life events upon symptoms* of both disorders and vice versa. It organizes the assessment information that you collect during your clinical interviews on a timeline. It defines significant periods (or chunks) of time to give you a visual representation of the historical cycles of symptoms and consequences. It helps you detect patterns and see the impact and/or progression of symptoms of both disorders upon the person's functioning/independent living.

STRUCTURE OF COMPREHENSIVE LONGITUDINAL ASSESSMENT

Timeframe	*Consumer's Functional Status*	*Mental illness and treatment*	*Substance use and treatment*	*Interactions of both disorders*
■ Dates (span of months or years) ■ Significant events/ circumstances	Description of the patient's overall daily functioning, for example: ■ Living arrangements ■ Employment status ■ Relationship status	■ Severity of symptoms ■ Treatments ■ Responses to treatments	■ Names of substances ■ Frequency of use ■ Severity of symptoms ■ Treatments ■ Responses to treatment	Reciprocating relationship among mental illness, substance use, and life-events

(Source: For more information, consult Mueser in Sources on page 46.)

CONTEXTUAL ANALYSIS

This form of assessment examines "the context" of a person's use of alcohol and other drugs. It focuses on each consumer's internal and external experiences, including his or her daily circumstances and his or her internal and external responses—feelings, thoughts, and behaviors—as well as the consequences of behaviors. The contextual assessment is an interactive style that often inspires consumers to tell clinicians stories about their daily lives. This helps the clinician understand "the context" in which symptoms of mental illness and substance abuse arise and intensify and the ways in which consumers express and attempt to manage those symptoms.

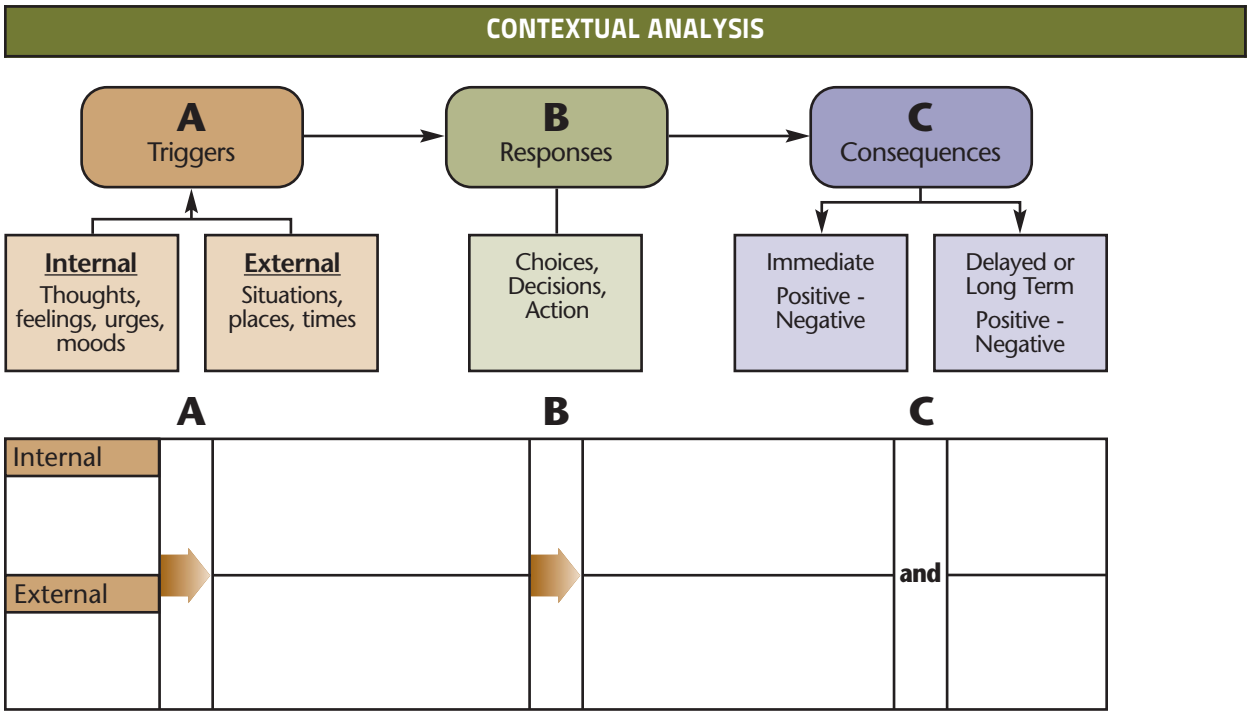
Unlike the comprehensive longitudinal assessment (see page 22), which is intended to identify patterns in a consumer's history, the contextual assessment intends to create an understanding of the consumer's daily life. You might consider saying something like this, "Would you please describe for me a typical day? … What time do you get up? … What do you do next? …"

When done skillfully, the clinician's contextual assessment will feel a lot like the simple act of listening to someone tell a story of his or her daily life. However, keep in mind that this seemingly simple act should elicit a lot of very useful information.

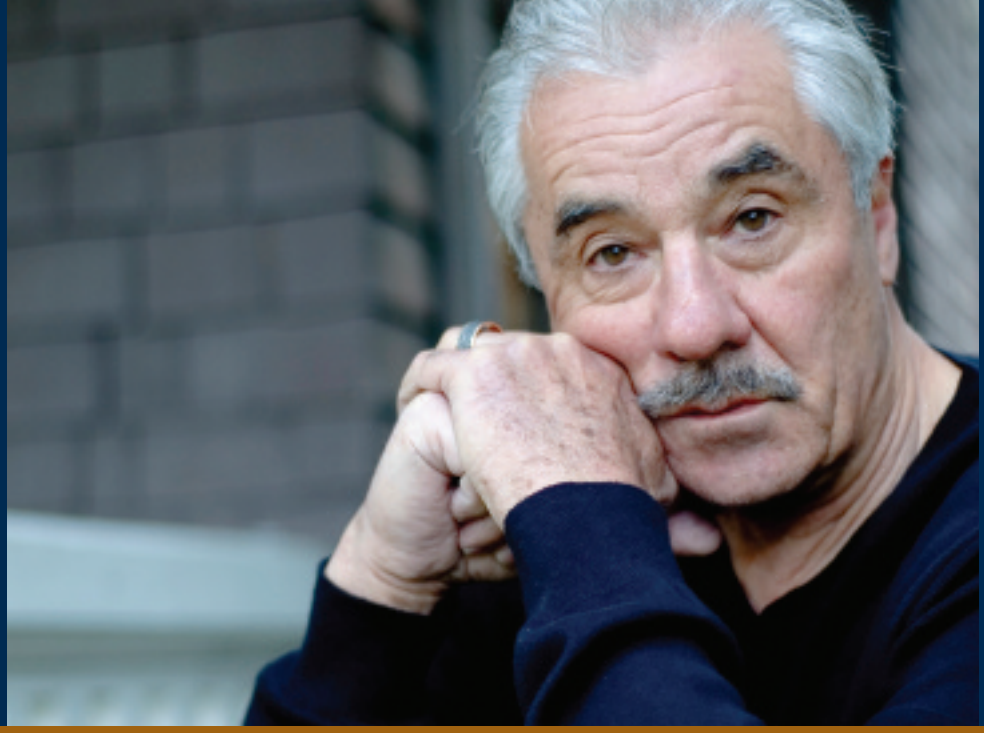
A contextual analysis may be drawn as a diagram to give you a visual depiction of how each consumer's internal and external triggers influence his or her internal and external responses and how those responses elicit consequences. This approach helps the IDDT team plan stage-based interventions that help the consumer manage feelings and thoughts and, thus, change behaviors and minimize negative consequences.

The diagram also informs motivational interviewing strategies—to help you help each person notice the discrepancy between his or her stated goals for recovery and current behaviors. For example, the diagram might inspire you to notice an important relationship among the person's substance use, moods, outbursts, and unstable housing experiences.

(For related information, see Motivational Interviewing section on page 33). ■



Adopted from the following: SAMHSA (Substance Abuse and Mental Health Services Administration) (2009). Integrated Treatment for Co-Occurring Disorders: Building Your Program. DHHS Pub. No. SMA-08-4366. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.



DIAGNOSIS & ELIGIBILITY

HOW DO YOU DISTINGUISH BETWEEN MENTAL DISORDERS AND SUBSTANCE USE DISORDERS?

Integrated services rely upon members of the clinical team to be experts in diagnostic criteria not only for mental disorders but also for substance use disorders, which includes an expert knowledge of symptoms of its two subcategories—substance abuse and substance dependence. These diagnostic categories apply to most of the 11 classes of substances listed in the *DSM-IV-TR* (see sidebar on page 19) and suggest different courses of therapeutic action. The service team needs to be proficient with these diagnostic criteria because one out of every two people with a severe mental illness will be experiencing symptoms of a substance use disorder at some time in their lives.

The screening and assessment processes (see page 16) may be conducted by people from a variety of disciplines. The *diagnosis* or *diagnoses* from the *DSM-IV-TR* are frequently assigned by a psychiatrist or other licensed professional assigned by the organization. Therefore, he or she needs to understand and be proficient with screening, assessing, and diagnosing of co-occurring disorders. This will enable him or her to evaluate effectively the accuracy of diagnoses made by other team members or previous service providers.

MENTAL DISORDERS

Mental disorders are diagnosed based upon symptoms that fit into particular categories described in the *DSM-IV-TR*. The major categories of mental illness in adults include the following:

- Mood disorders
- Psychotic disorders
- Anxiety disorders
- Somatoform disorders
- Cognitive disorders
- Personality disorders
- Substance use disorders

SUBSTANCE ABUSE VS. SUBSTANCE DEPENDENCE

Alan I. Leshner, Ph.D., former director of the National Institute on Drug Abuse, offers a useful distinction between substance abuse (a preventable behavior) and substance dependence (a treatable disease). He suggests that there is a continuum of substance use severity. He writes that at some point an imaginary electrical "switch" in the brain is turned on and substance abuse is transformed into substance dependence (see Leshner in Resources on page 46).

The table on page 27 will help you distinguish between substance abuse and substance dependence. It was created with reference to the *DSM-IV-TR*.

SUBSTANCE-INDUCED MENTAL DISORDERS

Not everyone who presents with symptoms of a mental disorder actually has one. The symptoms might be induced by the use of mood-altering and psychoactive substances. Prominent symptoms of substance-induced mental disorders include depression, hallucinations, and delusions, among others. The symptoms are typically the direct result of the following:

- Use of alcohol
- Use of other drugs
- Use of medication
- Exposure to chemicals/toxins (e.g., glue, paint thinner)

Substance-induced mental disorders include the following:

- Substance-Induced Delirium
- Substance-Induced Dementia
- Substance-Induced Amnestic Disorder
- Substance-Induced Psychotic Disorders
- Substance-Induced Mood Disorders
- Substance-Induced Anxiety Disorders
- Substance-Induced Sexual Dysfunctions
- Substance-Induced Sleep Disorders

Diagnostic challenges

If someone chooses to become abstinent, it may become easier to distinguish between symptoms of mental disorder and symptoms of substance-induced mental disorder. During a long period of abstinence, if symptoms dissipate and disappear, then it is likely he or she has presented symptoms of a substance-induced disorder. If the symptoms persist, it is likely the consumer has presented symptoms of a non-substance-induced mental disorder(s). There are a few challenges to this diagnostic and treatment approach:

- Abstinence takes time to achieve and maintain
- Relapse to substance use is likely; it is a part of recovery.
- Psychotic symptoms may occur as a symptom of withdrawal (see APA, p340, in Sources on page 46).
- Psychotropic medications have side effects that may also mimic symptoms of several mental disorders.

There is limited research data about how much time must pass to consider a symptom as substance-induced. For instance, clinical observations suggest the following:

- Cocaine-induced hallucinations or depression may be present even after abstinence has been achieved.
- Alcohol-induced depression may last six months or longer if someone has been drinking alcohol heavily for many years.
- Amphetamine-induced psychosis may last as long as eight weeks.

(See ASA, DSM-IV, *p209-211, in Sources on page 46.)*

Clinical responses

- Treat substance-induced symptoms and mental-disorder symptoms at the same time. For example, prescribe medication to reduce cravings and medication to reduce hallucinations or depression.
- Explain the diagnostic challenge to your patient and encourage him or her to work with you to reduce and eventually eliminate substance use, to manage cravings and other symptoms, and to manage relapses.
- Refer to your comprehensive longitudinal assessment and contextual assessment and analysis (see page 22).
- The longer someone is abstinent and symptoms persist, the more likely he or she has a non-substance-induced mental disorder.

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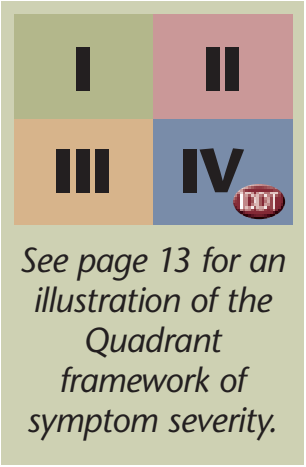
EXAMPLES OF MENTAL ILLNESS INCLUDE THE FOLLOWING:

Name of mental disorder	Examples of symptoms
Schizophrenia and Psychotic Disorders	■ Hallucinations (hearing voices or seeing things that others do not) ■ Disorganized speech and/or behavior ■ Delusions (fixed false beliefs)
Bipolar Mood Disorders	■ Decreased need for sleep ■ Pressured speech (talking so fast that no one can interrupt) ■ Elevated mood (feelings of prolonged and intense elation) ■ Increased activity ■ Depressive episodes (see below)
Depressive Mood Disorders	■ Depressed mood ■ Loss of interest in life ■ Changes in sleep ■ Changes in appetite and weight ■ Feelings of worthlessness: excessive or inappropriate guilt ■ Fatigue or loss of energy ■ Diminished ability to think or concentrate or indecisiveness nearly every day ■ Suicidal thoughts, plans, and/or attempts
Anxiety Disorders	■ Panic attacks ■ Phobia (unreasonable fears) ■ Chronic worrying ■ Obsessions (intrusive thoughts) ■ Compulsions (rituals performed to decrease obsessions) ■ Physical issues (e.g., racing heartbeat & breathing)



See page 13 for an illustration of the Quadrant framework of symptom severity.

- Realize that there are going to be diagnostic uncertainties and be open to changing your diagnoses and treatment plans over time.
- Remember that the processes of screening, assessment, and diagnosis are continuous. The diagnostic uncertainties presented by individuals with co-occurring disorders require that screening, assessment, and diagnosis not be limited to an initial upfront interview but be part of an ongoing process of dialogue between consumers and clinicians.

(For more information, see Carlat, p181, in Sources on page 46.)

POLYSUBSTANCE DEPENDENCE

This diagnosis is assigned when a patient uses more than one substance and does not meet the criteria for dependence upon any one specific substance. Symptoms must meet criteria for several different substance use types. You might use this diagnosis when you first get to know a patient. Yet, as you continue your relationship and continue your assessment over time, your patient's symptoms may become more specific to a particular substance (e.g., cannabis, cocaine, alcohol) and, thus, more recognizable to you. As the symptoms become clearer, a diagnosis of substance abuse or dependence for each specific substance may be more accurate.

(For more information, see APA, p293, in Sources on page 46.)

PRIMARY VS. SECONDARY DIAGNOSES

The Axis classification and assessment system in the *DSM-IV-TR* does not yet specifically address the phenomenon of co-occurring mental and substance disorders. However, current practice guidelines suggest that both disorders may be considered as primary. Service providers should list both diagnoses in their clinical documentation. This will indicate that the consumer needs help managing symptoms for both disorders at the same time.

ELIGIBILITY

The IDDT model has been designed for people whose symptoms are reflected on the severe end of the symptom continuums for both disorders (see Quadrant framework on page 13) especially for the following mental disorders:

- Schizophrenia and related psychotic disorders
- Bipolar mood disorder
- Depressive mood disorders

Service teams have created criteria to identify people who most need IDDT services. The eligibility criteria are typically based upon a person's ability or inability to function in the community. Examples include frequency of the following:

- Incarceration
- Housing loss
- Frequent hospitalization
- Frequent use of crisis services
- Fractured relationships with family members and friends

FOR TREATMENT PLANNING ONLY

It is important to emphasize that the Quadrant framework of symptom severity on page 13 is a *framework* for treatment planning. It is not a diagnostic tool like the Axis system in the *DSM-IV-TR*. The Quadrant framework is designed to group patients according to symptom severity and to match those patient-groups with the most appropriate and effective treatments available.

Here are some additional important points to remember:

- Some IDDT programs/teams use the quadrants after screening, assessment, and diagnoses for co-occurring disorders are completed—along with ASAM criteria—to help determine the level of care needed and eligibility for IDDT services.
- The quadrants divide all dual diagnosis patients into four groups based upon severity of symptoms/illness.
- IDDT was initially designed as a service model for Quadrant IV.
- Some organizations are using IDDT with people in other quadrants.
- Many underlying principles and practices of IDDT (e.g., stages of change, stages of treatment, motivational interviewing) are applicable to patients in several other quadrants. ■

DIFFERENTIAL DIAGNOSIS

Differential diagnosis is a challenging process of differentiating between symptoms of mental illness and substance use disorders. Here are a few examples of questions to ask about symptoms you observe and/or consumers report.

Substance use disorder	Mental illness
Is this intoxication . . .	or is this psychosis?
Is this a substance-induced psychosis . . .	or is this a biologically-induced psychosis (e.g., hallucination or delusion from schizophrenia or schizoaffective disorder, etc.)?
Is this benzodiazepine withdrawal . . .	or is this a symptom related to a mental disorder?
Is this an effect of methamphetamine withdrawal . . .	or is this poverty of thought?
Is the flat affect a symptom of substance-induced anhedonia (inability to experience pleasure) . . .	or is this a symptom of depression or a psychotic disorder?

QUICK GUIDE TO DIAGNOSTIC CRITERIA FOR SUBSTANCE USE DISORDERS (SUD)		
Subcategory of SUD	*Substance Abuse*	*Substance Dependence*
Intensity	Abuse has psychological symptoms	Dependence has psychological & physical symptoms
	A behavior that is preventable.	■ A disease that is treatable. ■ A condition in which the structure of the brain is changed by the use of mood-altering chemicals.
Progressive nature	May progress into dependence	Will not regress diagnostically to the category of abuse or casual use. Once someone receives this diagnosis, he or she can no longer be assigned the diagnosis of substance abuse for a given substance.
Consequences of substance use symptoms	This form of the disorder involves a pattern of repeated use that often results in recurring and significant psychological and interpersonal consequences.	This form of the disorder involves a pattern of repeated use that not only results in recurring and significant psychological and interpersonal consequences but also may show negative physical effects, including the following: ■ Tolerance: needing more and more of the chemical(s) to achieve the desired effect (feeling, mood) ■ Withdrawal: behavior changes from a decrease of the substance(s) in the body ■ Cravings and compulsive use
Criteria for the disorder	Consult *DSM-IV-TR* for exact language of symptoms/criteria (See APA, p191-197, in Sources on page 46).	
Criteria/ pattern of use	Patient experiences . . . ■ 1 or more of the 4 impairments or distresses listed below ■ During the same 12-month period ■ That are clinically significant	Patient experiences . . . ■ 3 or more of the 7 impairments or distresses listed below ■ During the same 12-month period ■ That are clinically significant
Criteria/ impairments or distresses (i.e., symptoms)	1. Recurrent failure to fulfill obligations at home, school, or work (e.g., repeated absences and poor performance) 2. Recurrent intoxication in situations that are physically hazardous, such as driving a car or operating machinery 3. Recurrent arrests or other legal problems that are related to substance use (e.g., disorderly conduct, DUI) 4. Continued use despite the experience of difficulties such as damaged or lost relationships, physical disputes, divorce, or job loss	1. *Tolerance*: • Needing increased amounts to achieve intoxication • Experiencing diminished intended effect of substance as it is taken in larger and larger amounts 2. *Withdrawal:* • Displaying behavior change that occurs when concentrations of the substance(s) in the blood or tissue decline • Taking another substance to relieve withdrawal from the first substance 3. Taking the substance in larger amounts or over a longer period than originally intended 4. Persistent desire to cut down or regulate use, often with unsuccessful efforts and results 5. Spending a lot of time obtaining the substance, using the substance, or recovering from its effects 6. Reducing or giving up important social, occupational, or recreational activities because of substance use 7. Continuing to use even though the individual recognizes that the substance contributes to physical problems or to psychological problems such as anxiety or depression
Criteria/other	Patient's symptoms for this particular (class of) substance have never met the criteria for substance dependence	Even if a patient has never experienced tolerance or withdrawal, his or her symptoms may still meet the criteria for substance dependence.

"STAGING" & TREATMENT PLANNING

HOW DO YOU EFFECTIVELY TREAT THE WHOLE PERSON AND ALL DISORDERS SIMULTANEOUSLY?

Staging is a process to help you plan treatment after you screen for, assess, and diagnose co-occurring disorders. *Staging* is a word that is commonly used to describe an individual's readiness to make a change and the subsequent process of matching a menu of comprehensive services with each consumer's stage of treatment (see Stage-Wise Treatment table on page 51).

STAGES OF CHANGE

There are five stages of change:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

The stages of change can be used to describe a process that each of us experiences as we embark on a personal journey to improve the quality of our lives (see table on page 29). The stages are applicable to most aspects of life, too many to list here (e.g., diet, exercise). However, they also apply directly to those who desire and need to eliminate the use of alcohol, tobacco, and other drugs and would like to embark on a personal journey of behavior change. The stages-of-change approach suggests that change occurs incrementally over time. Thus, *big changes* like sobriety, symptom management, and an increase in independent living are usually built upon a series of *small, overlapping, incremental* changes.

Keep yourself person-centered

During team meetings, you and your fellow team members use the stages of change to evaluate how much each consumer might be ready, willing, and able to acknowledge and discuss his or her mental illness and substance use disorder and to participate actively in different kinds of treatment. In fact, you may also use the stages-of-change approach continuously to help consumers become more aware of their own processes of change.

Talking frequently about the stages of change will help you and other team members ensure that you are not too far ahead (i.e., expect too much) or are not too far behind (i.e., expect too little of) each consumer and his or her readiness, willingness, and ability to change. The stages-of-change approach is an important tool because it not only encourages you and your IDDT team members to keep the consumer in mind, but it also encourages you to keep yourself in mind—your feelings and thoughts about the therapeutic process. It is a tool to enhance your alliance with consumers.

THE READINESS RULER

Using a common language enables the team to evaluate more consistently each consumer's treatment process for positive personal change. The Readiness Ruler has great applicability when assessing a person's readiness to change.

- How ready do you feel to change this behavior?
- How important is it to you to change this behavior?
- How confident do you feel in your ability to change behavior?

(To obtain copies of the Readiness Ruler, see page 2.)

STAGES OF TREATMENT

There are four primary stages of IDDT treatment:

- Engagement
- Persuasion
- Active treatment
- Relapse prevention

The stages of treatment are closely related to the stages of change, yet they are different. The stages of change are based upon the Transtheoretical Model of Change (TTM) and describe a process of personal change. The stages of treatment are based upon the Substance Abuse Treatment Scale (SATS). They focus upon the helping relationship and the consumer's behavior as it relates to the use of alcohol and other drugs. There are two basic behavioral indicators that help you decide each client's stage of treatment:

1.) Relationship to team

- Is there a therapeutic alliance yet with any team members?
- How connected is the person with service team members?

2.) Duration of substance use

- How long has the person been in the process of reducing substance use?
- How long has there been an absence of symptoms of substance use disorders (substance abuse, substance dependence)?
- How long has the person been abstinent from substance use?

STAGES-OF-TREATMENT TOOL

There is an instrument available to help the treatment team continuously evaluate each consumer's stage of treatment. It is the Substance Abuse Treatment Scale (SATS). Using this instrument with all of the people you serve will create a standardization of care that is important for evaluating the quality of services.

STAGE-WISE TREATMENT TABLE

The table on page 51 has been created to help you with the "staging" process. It includes tips for interventions by treatment team members. It also includes a list of comprehensive services.

THE PROCESS OF "STAGING"

IDDT teams utilize the stages of change and treatment to ensure that they are in line with each consumer's personal recovery goals and personal change process. For instance, you do not encourage people to attend an active-treatment group just because they are talking about cutting back on how much they drink. It is best to look at their behavior over a period of time to determine if they are ready for a more significant change. A person who is talking about cutting back is more likely in an early persuasion stage of treatment.

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STAGES OF CHANGE

Stage	Definition
Precontemplation	Individuals in this stage are not likely thinking about or intending to change a problem behavior—or initiating a healthy behavior—in the near future. People in this stage are usually not armed with the facts about the risks associated with their behavior.
Contemplation	An individual enters this stage when he or she becomes aware of a desire to change a particular behavior. In this stage, individuals weigh the pros and cons of changing their behavior.
Preparation	By the time individuals enter this stage, the pros in favor of attempting to change a problem behavior outweigh the cons and action is intended in the near future. Many individuals in this stage have made an attempt to change their behavior in the past but have been unsuccessful in maintaining that change.
Action	This stage marks the beginning of actual change in the behavior. By this point, an individual has shown continued progress in the process of behavior change. Regression to earlier stages is probable.
Maintenance	Individuals are thought to be in this stage when they have successfully attained and maintained behavior change for at least six months. While the risk for relapse is still present in this stage, it is less so. Individuals need to exert less effort in engaging in change processes after 12 months of sustained change.

Source: The Habits Lab, University of Maryland—Baltimore. The Transtheoretical Model of Change (TTM). http://www.umbc.edu/psyc/habits/content/the_model/index.html

IDDT acknowledges that recovery is not linear. It is often cyclical because the change process moves back and forth and relapse can be a part of the process. As a result, IDDT teams systematically evaluate each client's stage of treatment at regular intervals. The process of staging clients has the following components:

1.) Stage clients at least every 6 months

- Begin staging at the time of the initial assessment.
- Six months is enough time to know if a change in behavior (i.e., use of alcohol or other drugs) is significant and warrants a change in treatment strategy. Quarterly treatment-plan reviews provide good timing for staging as well.
- Staging every week or month may be too frequent. Consumers who reduce their use or achieve sobriety for one week or one month are, in fact, demonstrating an incremental success but may not experience a change that is big enough (or lasting enough) to warrant a change in treatment strategy.
- People can make significant progress in motivation to change especially in protective settings (e.g., residential treatment, hospitals, jails).
- Most clients do not change their readiness, willingness, and ability to reduce and eliminate their substance use during the course of a single week or month unless in a protective environment. Yet, any movement warrants exploration and support.

2.) A team activity

- Include all members of the multidisciplinary team in discussions about each client. All team members may have information to contribute that will inform the treatment-planning process.
- Include other team members in the staging meetings, such as part-time team members and collaborators (e.g., employment specialist, housing specialist, peer specialist).
- The team leader guides the team discussions to ensure team members remain focused on the consumer and the staging tool (e.g., SATS).
- Every time you discuss a consumer's progress—formally in team meetings and informally during impromptu conversations—refer to the last "staging" assessment. Do current services/interventions match the client's stage of treatment?

3.) Use a staging tool

- All team members have a copy of the SATS (or other stages-of-treatment tool) and refer to it during discussions about each consumer.
- Discussions about each consumer's use of alcohol and other drugs are based upon the previous 6 months of his or her life (see #1 above).

4.) Hospitals, jails and other institutional settings

- Consumers in these settings are staged differently. Review their experiences during the six months prior to admission to determine their current stage of treatment.

STAGE-WISE TREATMENT		
STAGES OF CHANGE	**STAGES OF IDDT TREATMENT**	**CLINICAL FOCUS**
Transtheoretical Model of Change (TTM)	***Substance Abuse Treatment Scale (SATS)***	
Consumer's internal readiness to change	***Consumer's readiness to address his or her substance use and relationship with helper***	***Service team's response to individual's demonstrated readiness to change***
Pre-Contemplation	**Engagement**	Build a relationship and working alliance with the consumer; provide practical support for daily living; assess continuously
Contemplation and Preparation	**Persuasion**	Understand the engaged client's personal goals; help the client find his or her motivation to consider reduction in substance use and to participate in other recovery-oriented activities.
Action	**Active Treatment**	Help the motivated client reduce substance use by acquiring skills and supports for managing symptoms of both disorders in pursuit of personal goals.
Maintenance	**Relapse Prevention**	Help clients in stable remission develop and use strategies for maintaining abstinence and recovery

The stages of change are adapted from the following: James O. Prochaska, John C. Norcross, Carlo O. DiClemente (1995). *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward.* New York: Harper Collins.

The stages of treatment are adapted from the following: Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice.* New York: Guilford Publications, Inc. Also see Osher in Sources on page 46.

- Reviewing each consumer's readiness to change on a weekly basis will help practitioners provide interventions/services that are most aligned with the person's internal change process.
- Significant changes in motivation can take place in short amounts of time in these settings.
- The knowledge and skills acquired by people in these settings will likely be tested once they return to the community. They will likely face the temptation to start using again. Therefore, continuously observe their adjustment to life in the community and reevaluate their stage of treatment. Adjust your treatment approaches to align with each person's experience.

5.) Documentation

Include the stage of treatment and rationale in each consumer's clinical record.

- Include the completed staging tool in each consumer's clinical record.
- Include the consumer's stage of treatment on the treatment plan.
- Compare the consumer's stage of treatment with his/her progress notes to ensure the following:
  - That current interventions match the stage of treatment.
  - That current interventions match the consumer's stated goal(s) for treatment/recovery.
- Many teams choose to enter each consumer's stage of treatment into a database so they can report and analyze individual and team-caseload changes over time. This can be used as a process or outcome measure.

STAGE-APPROPRIATE INTERVENTIONS

The Stage-Wise Treatment table on page 51 illustrates the relationship between your patient's current behavior and a menu of interventions that are commonly used in response. The goal of treatment is to help consumers develop or recover their self-determination and self-management of illness through incremental successes (stages), at a pace that is manageable for them. Some important milestones that consumers experience during the stages of treatment include the following:

- Trust the providers and develop a mutually respectful relationship
- Identify behaviors that interfere with personal goals
- Acknowledge, accept, and understand the nature of mental and substance use disorders and their interaction
- Manage cravings and other symptoms of both disorders
- Plan for and manage relapses of both disorders
- Reduce and eventually eliminate substance use
- Maintain sobriety and develop a sober lifestyle.

STAGING & MENTAL-HEALTH TREATMENT

Objective criteria have not been established for stages of change or stages of treatment as they relate to mental health symptoms. ■

STAGE-WISE TREATMENT

HOW DO YOU INSPIRE PEOPLE TO ENGAGE IN TREATMENT AND TO STICK WITH IT?

Medication is an important ally in the treatment of co-occurring severe mental and substance use disorders. However, it is not the only component of treatment. Research shows that the most effective treatment outcomes occur when medication is combined with a variety of psychosocial interventions such as treatment groups, self-help groups, and multiple-family group therapy, among others. A brief description of *biopsychosocial* treatments is provided in the table on page 51.

GOALS OF TREATMENT

People are more likely to initiate and sustain a personal change process in treatment if they are able to work toward goals that matter to them. It is important for service providers to align themselves (and their work) with the expressed goals of consumers. This will create an important therapeutic alliance.

Some common goals expressed by consumers and some common outcomes include the following:

- Fulfillment of daily-living needs/quality-of-life needs (e.g., a safe and affordable place to live, a part-time or full-time job, improved health, managing money)
- Increase meaningful activities (e.g., school, work)
- Improve social relationships (e.g., with family members, friends, co-workers who support abstinence and recovery)
- Increase awareness and self-management of cravings and other symptoms of both disorders
- Reduce the negative impact of symptoms of both disorders
- Reduce substance use
- Change harmful psychological defense mechanisms (e.g., denial) into healthy adaptive coping mechanisms
- Stop the progression of addiction and mental illness
- Utilize daily living skills to increase independent living in the community
- Long-term abstinence from substance use

STAYING ALIGNED WITH PEOPLE

It is not unusual to get frustrated at some point in your work with consumers, because co-occurring disorders are so complex. This feeling of frustration is an important tool. It may be an internal signal that you and the people you serve are not aligned with his or her current motivation for change. There may be many reasons for this. Yet, it is highly likely that one or both of the following is occurring:

- The consumer's attention has drifted from his or her stated goals.
- The consumer is in a stage of change or treatment (see page 30 & 51) that is different from the stage in which you perceive him or her to be. For

instance, you may be relating to the consumer as if s/he is in the "active treatment" stage when, in fact, s/he is in the "persuasion" stage.

It is up to you to match your thinking and your interventions to each person's stage of treatment. For instance, your primary role in the persuasion stage is to help individuals address their ambivalence and find their motivation for change. Your primary role in active treatment is to help them develop and utilize skills for managing the disorders. Use the following to guide your clinical relationship with each consumer and to maintain your therapeutic alliance:

- Stages of change (see page 29)
- Stages of treatment (see page 30)
- Motivational interviewing (see below)

Acknowledge the short-term benefits of substance use

In the early stages of your relationship, it is useful to tell consumers that you understand how the use of alcohol and other drugs may, in fact, make them feel better for a while. When you acknowledge the short-term benefits, you acknowledge the person's life experiences.

As you know, substance use often has a short-term benefit: "the high" or the "mellow mood" will go away. So, it is important to help consumers consider that the following will occur with continued use:

- Difficult feelings and thoughts will return
- Substance use tends to worsen the symptoms of both illnesses

USE MOTIVATIONAL INTERVIEWING TECHNIQUES TO HELP CONSUMERS ADDRESS THEIR AMBIVALENCE TO CHANGE—AND TO IMPROVE THE QUALITY OF THEIR LIVES.

PSYCHOSOCIAL TREATMENT

The Staging & Stage-Wise Treatment table on page 51 demonstrates how medications are combined with different psychosocial treatments during the four stages of integrated treatment to help consumers decrease and eventually eliminate their substance use and to help consumers manage symptoms of both disorders. Below is a brief overview of Motivational Interviewing, a psychosocial intervention that all team members utilize with consumers.

MOTIVATIONAL INTERVIEWING | MI

Motivational interviewing (MI) is a therapeutic conversational technique that enables you to help consumers identify, verbalize, and own their desires and needs for a better life as well as their ambivalence to change. Their desires and needs are their goals for recovery—their intrinsic motivation for positive change. For example, a consumer may not want to acknowledge or talk about her addiction to cocaine or the occurrence of hallucinations. However, she might admit that she would like to find a new apartment in a safe neighborhood. Make this the primary focus of your therapeutic work. Help her notice how her symptoms may be preventing her from finding and keeping the apartment of her dreams.

With MI, you listen for evidence of each person's readiness, willingness, ability, and ambivalence to change. MI intentionally avoids confrontation to minimize defensive responses from consumers and to decrease their resistance to working with you.

MI is typically used in earlier stages of treatment, especially the persuasion stage (see table on page 30). It helps you and your team members stay in-step with each consumer—so you are not too far ahead (i.e., expect too much) or too far behind (i.e., expect too little of) his or her readiness, willingness, and ability to change. There are four core principles of MI.

1.) Express empathy

- Accurately reflect to consumers your understanding of what they have said.
- Accept the person as s/he is (e.g., some consumers will appear anxious about change while others may appear numb or indifferent to it).
- Help normalize each consumer's feelings of ambivalence (i.e., most people are uncertain or apprehensive about making big changes in their lives).
- Be sure to emphasize how difficult the personal change process can be.

2.) Develop discrepancy

- Take time to ask about and to listen to each consumer describe his or her goals for daily living and recovery.
- Help the consumer notice the relationship (discrepancy) between his or her expressed desires/goals and those behaviors which block the achievement of those goals: help consumers "connect the dots" among their goals, their behaviors, and their current life experiences/outcomes.

3.) Roll with resistance and avoid argumentation

- Resistance to treatment is not a personality trait of the consumer.
- Resistance is often a signal that the service provider is not aligned with the consumer's present feelings, thoughts, or perceptions.
- Resistance is a signal to re-examine the consumer's stage of treatment (see page 30) and/or to change your treatment strategy.
- Argumentation triggers defensiveness, which will harm the therapeutic alliance.

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- Consumers do not have to accept the label of "alcoholic" or "addict" to change their behavior; "problematic use" is a term that may defuse defensiveness and resistance.

4.) Support self-efficacy

- Elicit and support the consumer's sense of self-confidence and self-efficacy—his or her ability to make the change.
- Your optimism is an important part of the recovery process; do not underestimate its role.
- Expect to "carry hope" for the consumer in the early stages of recovery.
- Be supportive and positive as you help elicit change.
- If you do believe that the consumer can and will recover, he or she will likewise sense this from you.
- In other words, your feelings and thoughts are contagious; they have the power to influence.

O.A.R.S.

Motivational Interviewing (MI) equips you with methods to help consumers explore their ambivalence and clarify their reasons for change. Each letter stands for a skill you can use during conversations with your patients.

O = Open-ended questions

- These questions cannot be answered with a simple "yes" or "no," or a two-word response.
- Often start with "What?" or "How?"

A = Affirmation

- Directly acknowledge and affirm consumers (e.g., target specific behaviors and statements of appreciation and understanding).
- This method builds rapport and reinforces open exploration of goals and motivation for change.

R = Reflective listening

- Listen carefully to the narratives of consumers.
- Make a reasonable guess at the person's statements and the meaning behind what he or she is saying.
- Do this in the form of a statement, not a question.
- Do not assume an intended meaning; rather, "check it out" with the consumer.

S = Summarize periodically

Periodically summarize your conversations to help consumers link together and reinforce information that has been discussed. This achieves the following:

- Demonstrates that you have been listening carefully and helps you stay connected
- Prepares the consumer to elaborate further and transition to next step
- Allows the consumer to "hear herself" again—her hopes, dreams, goals, and motivation for change

Elicit self-motivating statements from consumer

The following help address a consumer's ambivalence to change:

- Explore consumers' goals and values
- Ask evocative questions (e.g., what role do substances play in your life; how would your life change if you cut back or stopped using substances?)
- Use the importance ruler (e.g., "On a scale of 1 to 10, how important is it for you to change this behavior right now?") Also use the confidence ruler (see Readiness Ruler on page 2).
- Explore the decisional balance (e.g., the pros and cons of changing and not changing)

(For more detailed information about Motivational Interviewing, see Miller and Rollnick, p65 to 83, in Sources on page 46.)

MEDICATION TREATMENT

Psychiatrists and other medical professionals may be wary of prescribing psychotropic medication to people with severe mental illness who are actively drinking and using other drugs. They have significant concerns that the chemical mix might have negative consequences. Yet, substance abuse among people with severe mental disorders is very common, so it is important to increase your knowledge and comfort level in treating both disorders simultaneously.

Medications reduce the negative impact of symptoms. They help patients manage feelings and thoughts and engage in therapeutic conversations. As consumers progress through the four stages of treatment, you may need to adjust your prescription practices. Research shows that medications are most effective when combined with psychosocial treatment (see Mueser in Sources on page 46).

FOR MENTAL DISORDERS

Psychiatrists and other medical professionals prescribe medication such as the following to minimize severe symptoms of mental illness:

- Antidepressants
- Antipsychotics
- Mood stabilizers
- Anti-anxiety agents

FOR SUBSTANCE USE DISORDERS

Medical professionals will also prescribe medication such as the following to reduce cravings and help manage symptoms associated with alcohol and other drug(s):

- Naltrexone
- Buprenorphine
- Acamprosate

(For more information, see table on page 35.)

PRESCRIBE MEDICATION FOR BOTH DISORDERS TO ACTIVE USERS

It is not reasonable to require consumers to be abstinent prior to prescribing psychiatric medication, especially when they are in the first two stages of treatment (i.e., engagement and persuasion). In these stages, consumers are typically not ready or sometimes are unable to stop drinking or using other drugs.

Reasons to prescribe

It is likely that you are already prescribing psychiatric medication to patients who are active substance users. You just don't realize it, because many consumers elect not to tell you how much they are actually using alcohol or other drugs.

Prescribing to active substance users who have mental health disorders is better than not prescribing at all. Without psychiatric medication, your patient experiences two untreated chronic brain diseases that have very negative consequences (see Negative Life Outcomes section on page 4).

Medication will likely make a positive impact upon both illnesses.

Potential risks and effective safeguards

You likely already explain to consumers that using alcohol and other drugs while taking psychiatric medication is not recommended. The medication will be much less effective in the presence of these substances. Also, the mixture of chemical properties of medication and chemical properties of alcohol or other drugs may cause physical harm. Prescribers should clearly document in each consumer's medical record the following:

- That you have explained the risks
- That he or she understands the risks
- That the consumer has given consent for treatment
- That you are actively working with him or her and other service team members to monitor the physical and psychological effects of medication and the adjustments that have been made to minimize negative effects

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MEDICATIONS FOR SUBSTANCE USE DISORDERS

Substance use disorder	*Name of medication*	*Mechanism of action*
Alcohol dependence (For related information, see NIAAA p16 in Sources on page 44.)	Naltrexone (ReVia)	■ Opiate receptor antagonist (i.e., blocks a specific drug receptor in the brain and, thus, decreasing the craving and preventing "the high")
	Disulfiram (Antabuse)	■ Inhibits intermediate metabolism of alcohol (i.e., blocks the metabolism of the parent drug and, thus, causes a reaction of nausea, flushing, and sweating to create an adverse reaction to drinking alcohol)
	Acamprosate (Campral)	■ Stabilize inhibitory and excitatory forces in the brain
Opiate dependence (e.g., Heroin and other opiates)	Naltrexone (ReVia)	■ Opiate receptor antagonist (i.e., blocks a specific drug receptor in the brain and, thus, decreasing the craving and preventing "the high")
	*Methadone	■ Opiate receptor full agonist (i.e., activates the opiate receptor, replacing other opiates and decreasing craving)
	*Buprenorphine (Subutex, Suboxone)	■ Opiate receptor partial agonist (i.e., activates the opiate receptor but not to the same degree as a full agonist)
Nicotine (tobacco)	Nicotine replacement (patches, gum, inhaler, lozenge, nasal spray)	■ Nicotine receptor agonist (i.e., activates the nicotine receptor, and decreases craving)
	Buproprion (Wellbutrin, Zyban)	■ Norepinephrine and dopamine reuptake inhibitor (i.e., decrease craving for nicotine)
	Varenicline (Chantix)	■ Nicotine receptor partial agonist (i.e., activates the nictoine receptor but not to the same degree as a full agonist)

**Medical professionals must have a special license or certification to prescribe these medications.*

OFFER MEDICATIONS THAT DECREASE CRAVINGS OR SUBSTANCE USE

In general, patients who are in the late persuasion, active treatment, or relapse prevention stages of treatment (see page 30) are the most appropriate candidates for medications that reduce cravings for substance use. They have expressed an interest in and exhibited behavior that demonstrates a desire to cut down or eliminate use. There are currently several medications available for the treatment of cravings. These medications have different functions, which are briefly described in the table at the bottom of page 35.

DECREASE OR AVOID MEDICATIONS THAT HAVE ADDICTIVE POTENTIAL

Medications for psychiatric symptoms and general health concerns that have addictive potential should be used sparingly and with extreme caution and close monitoring in patients with a history of substance abuse and dependence. These often include the following:

- Benzodiazepines
- Stimulants
- Sleep aids
- Opiates

Utilize the service team

Collaborations with other service providers from the multidisciplinary service team will help closer monitoring of the effects of medications upon consumers. Team members may look for evidence of abuse or adverse effects of medication and regularly inform the prescriber so he or she may make fast, accurate decisions in the interest of consumer well-being.

Know your patient

There are certain situations in which the team psychiatrist (or other presciber) may consider prescribing benzodiazepines, stimulants, or pain killers to consumers with a history of substance use disorders. In these cases, it is helpful to know your patient for an extended period of time (more than 12 months). This will give you a chance to observe how he or she reacts to medications and other forms of treatment.

Prescriptions from other providers

Consumers may come to you already taking benzodiazepines or opiates that are being prescribed by another physician. Communicate with the other doctor(s) to coordinate care—so that everyone is on the same page about the diagnoses and treatment plan.

In addition, many states and communities now have prescription-monitoring systems, which can be accessed by physicians and pharmacists. The purpose of these systems is to coordinate care and prevent prescription drug abuse.

Attention Deficit Hyperactive Disorder (ADHD)

If the consumer claims to have a history of ADHD treatments, it is helpful to see written verification from previous service providers that the person, indeed, was treated with stimulants during childhood for ADHD. Ask the consumer for a release of information that allows you to communicate with the other physicians and direct-service providers.

INCREASING ADHERENCE TO MEDICATION

Reason for non-adherence	*Possible response/solution*
Practitioner does not have therapeutic relationship (alliance) with consumer	■ Develop a working relationship (alliance) with consumer.
Consumer does not understand or agree with the rationale for medication	■ Review and discuss pros and cons about use of medication ■ Explain reason for medication ■ Discuss benefits and risks of medication ■ Explain possible treatment alternatives if consumer is resistant
Concern about side effects from medication	■ Assure consumer that if side effects occur, they will be addressed (e.g., "Let's try it. If you get side effects, let's talk about how to manage them.") ■ If side effects are too overwhelming, inform consumer that medication can be changed. (e.g., "Let's talk about lower doses of this medication or a different medication.")
Consumer is too disorganized to take medication regularly	Utilize behavioral tailoring techniques, for example: ■ Rubber band medication bottle to toothbrush ■ Store med bottle on top of microwave ■ Use pill reminder boxes ■ Have consumer schedule daily visits with an IDDT staff member to assist with taking medications ■ Have consumer schedule weekly visits from/with the IDDT nurse to fill pill reminder boxes or to receive injectable medication
The medication regimen is too complicated	■ If possible, prescribe medication to be taken once a day instead of multiple times per day ■ Identify and try to discontinue extraneous medications ■ Utilize treatment-team members or natural supports like family members to assist consumers in managing their medication routines

(For more information, see Mueser in Sources on page 46.)

Pain Management
There is a difference between acute pain management and chronic pain management for a person who has an addiction (substance use disorder). SAMHSA has recently released treatment protocol addressing the needs of substance abusers with chronic pain (see SAMHSA, Tip 54, in Resources on page 46).

Acute Pain
In a situation of acute pain, a person with a substance use disorder should be treated like any other person in acute pain. For instance, medical professionals should prescribe pain medication for a heart attack or broken leg.

Chronic Pain
In a situation of chronic non-terminal pain (e.g, sciatica), a person with an addictive disorder should avoid the use of opiates. However, the prescription of these medications cannot always be avoided. Medical professionals should consult an addiction specialist or a pain management specialist with explicit knowledge of and sensitivity to managing pain with chronic substance abusers. If a specialist is not available, consider the precautions briefly described below.

Precautions
If you cannot avoid prescribing a potentially addictive medication, here are some helpful tips for managing treatment:

- Document the clinical rationale for the medication.
- Document that you have explained the danger to the consumer and that he or she understands the addictive potential of the medication and the risks involved in taking it.
- Prescribe small amounts with no refills.
- Insist on "one prescriber, one pharmacy" for all controlled substances.
- Ask team members to outreach to consumers frequently to assess and support adherence with the regimen and to identify what other substances they may be using.
- Have a plan (similar to a behavioral contract) in place prior to prescribing controlled substances, in case the patient misuses the medication or relapses to use alcohol or other drugs. This plan could include the following:
  - What to do in case of withdrawal symptoms
  - What alternative medications will be offered
  - Whether/if controlled substances will be offered again to that patient

INCREASING ADHERENCE

People with severe mental illness who do not have a substance use disorder often do not take their medication exactly as prescribed for a variety of reasons, for instance, negative side effects such as fatigue, weight gain, or low sex drive. Consumers with substance use disorders tend to adhere less to prescriptions, especially in the early stages of treatment. There are several common reasons for non-adherence which you and the IDDT team may need to address (see table on page 36).

Managing dosage
Sometimes, it may appear that the prescribed dosage of medication is ineffective. Before increasing the dosage, be certain that the consumer is taking the medication—that it is "getting from the bottle to the bloodstream." These questions may help you troubleshoot problems:

- Did the consumer lose the prescription?
- Has the prescription been filled?
- Did the consumer misplace the bottle?
- Did the consumer start the medication at all?
- How many days in the last week has the consumer taken the medication?
- How many days in the last week has the consumer had alcohol or other drugs?
- Is the consumer using large amounts of tobacco or other substances that may adversely affect their body's ability to metabolize psychotropic medications?

Rely on team members
Some of your colleagues on the IDDT service team will have more frequent contact and can provide information. For example, the IDDT model recommends that case managers have caseloads of no more than 15 to 20 patients. This allows for very close monitoring. Think of them as the "eyes and ears" of your practice. Use them to inform prescription changes. ■

(For more information, see Brunette in Sources on page 46.)

ALTERNATIVE TREATMENTS

There is considerable evidence for the usefulness of pscyhotropic medication in the treatment of serious mental illness. However, there is an emerging awareness of alternatives to pharmaceutical-based treatment. Many people find that non-pharmaceutical treatments are helpful (e.g., deep-brain stimulation, acupuncture, Dialectical Behavioral Therapy (DBT)).

Consult the Stage-Wise Treatment table on page 51.

CLINICAL LEADERSHIP

HOW DOES A TEAM OF PROFESSIONALS FROM MANY DIFFERENT DISCIPLINES WORK TOGETHER TO HELP CONSUMERS ACHIEVE THEIR GOALS?

Service providers from multiple disciplines and systems of care help consumers access and utilize resources. The team may consist of the following:

- Team leader
- Case manager(s)
- Nurse
- Psychiatrist
- Mental health therapist
- Substance abuse counselor
- Criminal justice specialist/liaison
- Supported Employment specialist
- Housing specialist
- Family specialist
- Peer specialist

The treatment team meets regularly to discuss pressing issues and to discuss each consumer's progress. Team members use formal and informal meetings to provide insight and advice to one another and to plan treatment interventions and coordinate care. They meet individually and as a group with each consumer and their caregivers (family, friends, and other supporters). Successful IDDT initiatives coordinate all aspects of recovery to ensure that consumers, caregivers, and service providers are working together toward the same goals in a collaborative manner.

THE IDDT TEAM LEADER

Each community-based service team has a team leader. This person is responsible for building and maintaining the team. He or she hires staff, provides administrative and clinical supervision, fosters communication among team members, and encourages resolution when disagreements arise.

The team leader is a champion of the practice and is skilled in training and coaching with an expertise in the treatment of co-occurring disorders. He or she meets one-on-one with team members, meets with the team as a group, facilitates ongoing clinical training, and represents the team at administrative and steering committee meetings.

Psychiatrists, other physicians, and other medical professionals are among the most highly credentialed members of the team and, thus, provide additional clinical leadership. They are ultimately accountable for all medical decisions.

However, the IDDT team leader provides clinical supervision to IDDT service team members. They also provide informal training during team meetings and one-on-one interactions. They have a vital role in teaching consumers and their family members about mental illness, substance use disorders, and the process of recovery from both.

PERSON-CENTERED TEAM APPROACH

With integrated treatment, the relationship with each consumer is one of partnership and collaboration. Therefore, services are highly individualized and person-centered.

Ultimately, consumers determine what team members need to do to support recovery. Team members listen carefully to what each person wants to achieve—whether it's reducing the amount of alcohol and other drugs he or she uses, staying out of the hospital, reconnecting with family and friends who support recovery, or finding and keeping a safe and affordable place to live and not being evicted for symptom recurrences. For many, their goal is to find a competitive part-time or full-time job. All treatment activities, including medication management, are intended to help consumers achieve their stated goals. Team members verbalize this to each other and the consumer, reminding them from time to time if they forget.

(For related information, see Motivational Interviewing section on page 33.)

Collateral information

Psychiatrists and other physicians typically meet with consumers once every few weeks or months and often for short amounts of time. Yet, for some consumers, symptoms of both disorders and side effects of medication may fluctuate daily or weekly. Therefore, psychiatrists and other physicians rely upon other service team members for information about each consumer's progress. Team members can act as "eyes and ears" for physicians and help inform medical decisions. This is especially true for nurses, case managers, and outreach workers who are in touch with consumers regularly in the community.

POSITIVE PERSONAL ATTRIBUTES & SKILLS OF CLINICAL LEADERS

There are personal attributes which create an interpersonal environment that validates each consumer's goals for recovery and encourages the efforts they make in treatment. A few of these attributes are briefly described below.

Patience and persistence

While working with people who have co-occurring disorders, maintain a long-term view of the recovery process. Consumer reluctance about treatment and relapse are a part of the recovery process.

Realistic optimism

Consumers with co-occurring disorders do improve incrementally over time. It is important to convey hope within the team through constant encouragement and by pointing out small steps toward success. Try to focus on prevention of crises (proactive stance) vs. "cleaning up" after crises (reactive stance). It is especially important not to judge or punish consumers for displaying symptoms of their illnesses.

Integration

As much as possible, have an open-door policy to increase your approachability and availability to team members. An egalitarian and diplomatic style conveys respect and the importance of everyone's contribution to the continuity of care for consumers.

Teaching

The process of teaching involves humility and openness to learning new ideas and strategies. A good teacher knows his or her audience, observes team members with consumers, gives timely and relevant information, and provides ongoing feedback.

Networking

You are not in this alone. The team approach helps increase efficiency in and decrease frustration with treatment. Remember that the team reduces risk by becoming an extension of your practice. Other IDDT team leaders are ready with support and advice.

Coordinating

It is important to have a working knowledge of other systems of care in your local community, including but not limited to the following:

- Local emergency department
- Psychiatric units and hospitals
- Criminal justice system
- Vocational services
- Child and family welfare/services
- Residential treatment centers

Find out who the key people are in each system and establish a working relationship with them. This will prevent consumers from "falling through the cracks" that exist between service systems when people in those systems do not communicate effectively with each other. ■

ADVOCACY

HOW DO YOU INFLUENCE ORGANIZATIONAL CHANGE AND SERVICE-SYSTEMS CHANGE?

Behavioral healthcare professionals have the opportunity to provide a strong voice of advocacy for integrated treatment and other evidence-based practices within service organizations, institutions, systems of care, and communities. It is important for administrators, program managers, service team leaders, and medical professionals to work collaboratively for a unified voice of advocacy. This section of the booklet provides some useful strategies.

THE MOTIVATION FOR CHANGE

It is often helpful to utilize stages-of-change and motivational approaches in your advocacy, especially with people who are unfamiliar with or doubtful about the positive outcomes produced by integrated treatment. Listen carefully to each person and try to understand how ready they are for changes to current services. Adjust your approach and response to each person accordingly.

Explore the organization's mission, vision, values, and goals

To raise awareness, help everyone involved with service delivery (e.g., policy makers, administrators, direct-service providers, family members and other advocates) explore whether there are discrepancies between the mission of their service system or organization and current practices. Here are a few basic questions with which to start:

Mission

- What is the purpose of our service system and/or organization with respect to providing services for co-occurring disorders?

Service needs

- What assumptions do we make about people with co-occurring disorders in our community?
- Have we considered which residents of our community may have co-occurring disorders?
- Are there standardized screening and assessment instruments available, and are they being used regularly?
- Are people with co-occurring disorders currently welcomed into treatment for both disorders at the same time and where?
- Do we know the names of these consumers and where and how they are being served?
- Do we know their daily living needs and treatment needs?

Outcomes

- What outcomes do consumers and their family members want to achieve?
- What outcomes data do we collect, analyze, review, and share about this population with our organization's administrative team, direct-service staff, and community stakeholders?
- What outcomes data do we collect, analyze, review, and share about this population with colleagues in other systems who also provide services to them (e.g., homeless services, housing and employment services, hospital emergency rooms, criminal justice)?
- Are the outcomes for this population satisfactory to our organization, to our local community, and to consumers and their families?

ORGANIZATIONAL CHANGE

In community-based and inpatient service organizations, it is the primary role of administrators to provide oversight for the financial well-being of the organization. However, it is the primary role of the clinical director and all clinicians to advocate for the best consumer care.

There are advantages to the long-term clinical perspective of integrated treatment. Research shows that consumers may take two to three years to emerge from the engagement and persuasion stages of treatment. Therefore, it may take two to three years to see improved outcomes. Many consumers who reach the active treatment and relapse-prevention stages maintain these improvements over time. If they do relapse, they often recover quickly because they have a foundation of recovery skills and a supportive network of people.

Physicians & IDDT team meetings

Psychiatrists and other medical professionals should advocate for their own attendance at IDDT team meetings. If physicians do not attend, fidelity to the model, quality of care, and communication may suffer. Organizations that do make attendance a priority send a powerful message to everyone in the organization and the community about the importance of integrated treatment. To advocate for IDDT, you might also consider participating in the following:

- IDDT implementation steering committee
- IDDT fidelity reviews
- Writing fidelity action plans
- Attending and conducting training sessions

(For more information, see pages 42-43.)

SYSTEMS CHANGE

Behavioral healthcare professionals may advocate for consumers who find themselves in non-integrated systems of care. Some strategies are briefly described below.

Pilot projects

Medical professionals and behavioral healthcare professionals who are familiar with the principles, practices, and benefits of integrated treatment may be able to influence the local mental health and/or substance abuse services policymakers and funders to create a pilot project that uses the IDDT model and to support consultation and training for service providers.

Other initiatives

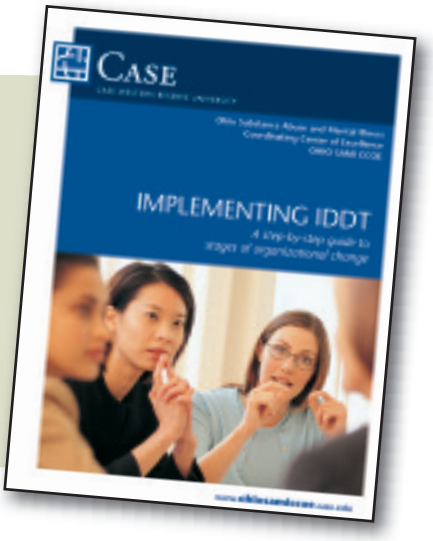
Some important activities for professionals interested in systems change include the following:

- Participate in meetings of mental health and/or substance abuse services policymakers and funders
- Participate in grant-funded demonstration projects and research projects that aim to promote integrated co-occurring treatment
- Speak to the media or to other community stakeholders about the benefits of integrated co-occurring treatment
- Create and/or participate in regional steering committees, which often include representatives from many systems that provide services to or interact with consumers who have co-occurring disorders (e.g., hospitals and emergency rooms, criminal justice, child welfare, education, and vocational rehabilitation). These committees are designed to share resources, learn from other stakeholders, and foster collaboration among systems.

(For more information about systems advocacy, see Delos Reyes and Ronis (2006) and Minkoff in Sources on page 46.) ■

For more information about how to facilitate organizational change and service-systems change, consult this booklet from our website:

Ric Kruszynski, Paul M. Kubek, Patrick E. Boyle, and Lenore A. Kola (2006). *Implementing IDDT: A Step-By-Step Guide to Stages of Organizational Change.* Cleveland: Ohio SAMI CCOE, Case Western Reserve University.



FIDELITY & OUTCOMES

HOW CAN CLINICAL TEAMS IMPROVE THE QUALITY OF INTEGRATED TREATMENT AND OUTCOMES?

Behavioral healthcare professionals make significant contributions to improved outcomes for consumers, the service organization, and service systems in their communities when they help their organization implement IDDT with fidelity to its core components.

THE FIDELITY SCALE

The IDDT fidelity scale is an implementation instrument that guides the clinical change and organizational change processes. It consists of two separate yet related and equally important parts:

- Organizational characteristics (components)—also known as the general organizational index (GOI)
- Treatment characteristics (components)

Successful IDDT programs commit to implementing all components of the model over time. They have resisted the temptation to pick and choose and turn the fidelity scale into an a-la-carte menu of disconnected services.

DEVELOP & MONITOR OUTCOMES

Outcomes data measure the effectiveness of IDDT services. The data enable everyone to step back from their day-today work and ask some important questions, like "How are we doing?" and "Is there something we can do better?" It is essential that organizations invest in a mechanism for collecting, evaluating, and reporting outcomes to everyone involved with IDDT, including the following:

- Consumers
- Family members
- Service providers
- Agency administrators
- Community stakeholders
- Policymakers
- Foundations
- Local communities

An investment in an outcomes process will help your organization and community make an informed decision about future investments in IDDT and other EBPs (see table on page 43).

FIDELITY OVERSIGHT & ADVOCACY

Professionals who advocate for integrated treatment at the organizational level often participate actively on an internal IDDT/EBP *work team*, which is part of the organization's implementation *steering committee*. The internal work team provides oversight of fidelity reviews and fidelity action plans (see below). It also provides continuity of leadership by meeting routinely. The work team and steering committee oversee a number of activities related to IDDT's continuous quality-improvement process, including the following:

- Review fidelity reports
- Revise the fidelity action plan as needed

- Track desired outcomes
- Review outcome reports
- Review and recommend enhancements to administrative and clinical policies and practices
- Identify and minimize barriers to fidelity and improved outcomes
- Plan to secure and sustain funding

FIDELITY REVIEW

The fidelity review (or assessment) provides a formal mechanism for independent evaluation of IDDT services. It is not an audit or accreditation procedure. It is strictly a quality-improvement process that provides the organization with information to make decisions about next steps. Optimally, organizations engage in an *external* IDDT fidelity review about once per year. The review is conducted by trained staff outside the organization. External reviews offer the best possible perspective from outside the organization. The fidelity-review team generates fidelity scores for all items in the scale.

The fidelity review and fidelity action plan (see below) create a continuous quality improvement process—a cycle of planning, implementation, evaluation and service enhancement.

The fidelity-review team presents recommendations and suggestions for each item on the fidelity scale in a fidelity report and works with the organization's steering committee and management team to implement an action plan for improving or maintaining fidelity.

Fidelity action plan

This plan addresses all components of IDDT. It outlines next steps in the organization's journey toward reaching and sustaining high fidelity and improved outcomes. It provides accountability to the internal work team and steering committee, which use the document to compare current activities with stated goals each time it meets. ■

OUTCOMES DATA	Individual client outcomes	Family outcomes	Organization/ program outcomes	Systems outcomes
Quality of life	X	X		
Psychiatric symptoms	X			
Alcohol and other substance use	X			
Abstinence rates	X		X	X
Progress through stages of substance abuse treatment	X		X	X
Educational status	X			
Social connectedness (family and peer relationships)	X	X		
Criminal justice system involvement (arrest and incarceration)	X		X	X
Satisfaction with services	X	X	X	X
Employment (hours worked in competitive employment)	X		X	X
Housing/Independent living status	X		X	X
Hospitalization rates	X		X	X
Service utilization (e.g., episodes of care, case management, treatment groups, individual services)	X		X	X
Crisis/emergency service utilization	X		X	X
Bed days/detox or subacute detox days	X		X	X
Cost-effectiveness			X	X

Source: *SAMHSA (Substance Abuse and Mental Health Services Administration) (2006). National Outcomes Measures (NOM) web site. Rockville: SAMHSA, U.S. Department of Health and Human Services. Retrieved December 30, 2005, from www.nationaloutcomemeasures.samhsa.gov/outcome/index.asp*

TOBACCO & RECOVERY

TOBACCO DEPENDENCE SEEMS MINOR WHEN COMPARED TO ALCOHOL DEPENDENCE AND ADDICTIONS TO ILLICIT DRUGS. WHY BOTHER?

Research shows that more than 75 percent of people diagnosed with a severe mental illness or substance use disorder consume tobacco products. In contrast, the rate of tobacco use in the general population has declined steadily to about 20 percent nationally. Over 44 percent of the cigarettes smoked in the United States are consumed by people with psychiatric disorders.

There is a logical relationship between IDDT and tobacco recovery. Nicotine is listed among the 11 classes of substances in the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders (DSM)*. Therefore, nicotine addiction is a co-occurring substance use disorder. Until recently, though, the harmful effects of tobacco and nicotine have not been systematically addressed in service systems and organizations.

Organizations may begin the process of helping people with mental illness and substance use disorders participate more actively in the process of maintaining their physical health by helping them address a major health risk-factor such as tobacco use.

This section was created with reference to the following, which are cited in Sources on page 46: Lasser, K.; Smeltz, J.; Williams, JM.

HEALTH CONSEQUENCES

- People diagnosed with severe mental illness die, on average, 25 years earlier than their non-mentally ill peers. Many of these deaths are caused by tobacco-related illnesses, such as cancer, heart disease, and emphysema and other lung diseases.

FINANCIAL CONSEQUENCES

- People diagnosed with schizophrenia spend an average of 27 percent of their income on tobacco products.

TREATMENT CONSEQUENCES

- Tobacco interferes with the metabolism of many medications. Therefore, tobacco users often require higher doses of medication to get the intended therapeutic effect. In addition, with higher doses, there is a potential for increased side effects.
- Research shows that simultaneous treatment for alcohol, tobacco & other drugs may increase abstinence by up to 25 percent.

MISCONCEPTIONS AND OTHER BARRIERS

There is a persistent myth among many service providers that tobacco use and nicotine addiction are relatively minor when compared with such heavyweights as heroin, cocaine, and alcohol. These providers believe they are doing consumers a favor by not addressing their smoking or chewing, especially when those consumers are trying to quit the "more serious drugs." Other

barriers to tobacco recovery may include the following:

- Nicotine dependence and tobacco use do not cause the amount or intensity of psychosocial problems (e.g., strained or broken relationships with family, friends, and co-workers) as dependence upon alcohol, cocaine, heroin, or other drugs.
- Many service providers smoke and chew tobacco and may find it difficult to encourage their clients to quit.
- Consumers may be very reluctant to give up tobacco at the same time they are making other major changes in their lives (e.g., reducing and eliminating the use of alcohol, heroin, or cocaine).
- Although conventional wisdom says that consumers should quit using one substance at a time, research shows that individuals who stop smoking or chewing tobacco at the same time they quit other substances may experience an increase in recovery rates.

THE PROBLEM

- Traditionally, behavioral healthcare providers have viewed tobacco treatment as the responsibility of primary healthcare.
- Many tobacco-cessation approaches are designed to help people who are ready to quit (i.e., in the action "stage of change").
- The high rate of tobacco use among people with severe mental illness or substance use disorders indicates that traditional approaches to tobacco cessation have not been very effective for this population.
- Yet, two-thirds of these tobacco users say they would accept help with quitting if that help were made available—and designed to meet their needs.

THE SOLUTION

Tobacco recovery programs are important because they help consumers replace tobacco use with positive lifestyle changes, such as healthy eating, exercise, employment, and tobacco-free social events and activities.

CLINICAL TIPS

There are a few things you can do today to help consumers begin a recovery journey to reduce and eliminate tobacco use and nicotine dependence.

Screening and assessment

Make it a routine to ask every consumer the following questions:

- Do you smoke cigarettes or chew tobacco?
- What aspects of your life would improve if you stopped smoking or using tobacco?
- On a scale of 1 to 10, how interested are you in quitting?

Diagnosis

If the consumer smokes or chews tobacco regularly, include nicotine dependence as a diagnosis on Axis I (see table on page 27.)

Treatment planning

Include a stages-of-change approach to tobacco cessation as a goal in the consumer's treatment plan, if he/she identifies this concern.

Treatment

- Learn about the current and upcoming pharmacological treatments for nicotine dependence
- Learn about the current and upcoming psychosocial treatments for tobacco use and nicotine dependence
- Learn about and utilize a stages-of change approach to tobacco cessation and recovery

TOBACCO: RECOVERY ACROSS THE CONTINUUM (TRAC)

TRAC is a stage-based motivational service model designed specifically to help people diagnosed with serious mental illness and/or substance use disorders to reduce and eventually eliminate the use of tobacco products. TRAC integrates tobacco treatment with existing behavioral healthcare approaches.

TRAC equips service providers with strategies to connect with people in all "stages of change," including those who are either unaware of or ambivalent about the benefits of reducing and eliminating tobacco use as well as those ready to reduce and become tobacco-free.

TRAC was developed by the CEBP through a partnership among the following:

- Ohio Department of Mental Health (ODMH)
- Ohio Department of Alcohol and Drug Addiction Services (ODADAS)
- Ohio Departments of Health (ODH)

Integrated Approach

TRAC utilizes the best available knowledge to address the biopsychosocial needs of people diagnosed with serious mental illness and/or substance use disorders. TRAC integrates core components of several interventions, practice guidelines, and established and emerging empirical research.

Core Principles

There are 10 core principles to the TRAC model that facilitate the organizational change and clinical change that support consumers during their tobacco-recovery journeys:

- Organization-wide effort
- Integrated approach
- Ongoing assessment
- Stage-based approach
- Motivational interventions
- Group and individual services
- Strong interdisciplinary communications
- Involve natural supports
- Psychopharmacological interventions
- Implementation (program) outcomes and intervention (consumer) outcomes

ADVOCACY

Apply the strategies outlined in the "Advocacy" section on pages 40-41 to advocate for the implementation of a tobacco-recovery service model in your service system, organization, and community. ■

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We also wish to recognize and celebrate the individual contributions to service innovation that have been made by individuals at numerous service organizations throughout Ohio, around the country, and in The Netherlands that are implementing the Integrated Dual Disorder Treatment (IDDT) model.

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IDDT STAGE-WISE TREATMENT & "STAGING"

	Stages of Change	Stages of Treatment	*Definition of stage of treatment: Substance use disorder	Definition of stage of treatment: Mental disorder
				Objective criteria have not been established for stages of change or stages of treatment as they relate to mental health symptoms.
			The consumer demonstrates the following behavior …	
1	Pre-Contemplation	Engagement	***ENGAGEMENT*** • Has irregular contact with service providers • No working alliance with service providers • No readiness to change substance use ***Frequency of use*** • Is known to use alcohol, tobacco, and/or other drugs actively	***ENGAGEMENT*** • Not thinking about change (engagement)
2	Contemplation and Preparation	Persuasion	***EARLY PERSUASION*** • Has regular contact and working alliance with service provider, will discuss substance use, but unmotivated to take action • Does not acknowledge negative consequences of substance use ***Frequency of use*** • Continues to use same amount or has reduced use for less than one month (i.e., fewer substances, smaller quantities, or both)	***EARLY PERSUASION*** • Thinking about change (persuasion)
			LATE PERSUASION • Has regular contact and working alliance with service provider, discusses substance use and/or attends a persuasion group, is more motivated to take action • Begins to acknowledge negative consequences of substance use ***Frequency of use*** • Shows evidence of reduced use for at least one month (i.e., fewer substances, smaller quantities, or both)	***LATE PERSUASION*** • Thinking about change (persuasion)
3	Action	Active Treatment	***EARLY ACTIVE TREATMENT*** • Has regular contact and working alliance with service provider, discusses substance use, and is engaged in treatment (attends group and/or individual treatment) • Explores negative consequences of substance use, continues to use, but works toward abstinence as goal ***Frequency of use*** • Shows evidence of reduced use for at least the past 4 weeks (i.e., fewer substances, smaller quantities, or both)	***EARLY ACTIVE TREATMENT*** • Trying out changes (active treatment)
			LATE ACTIVE TREATMENT • Has regular contact and working alliance with service provider, discusses substance use, attends a group, engaged in treatment • Acknowledges negative consequences of substance use, may slip-back or relapse ***Frequency of use*** • Has achieved abstinence for less than 6 months, or has not experienced symptoms of substance abuse or substance dependence for at least 6 months	***LATE ACTIVE TREATMENT*** • Trying out changes (active treatment)
4	Maintenance	Relapse Prevention	***RELAPSE PREVENTION*** • Has regular contact and working alliance with service providers, is engaged in treatment ***Frequency of use*** • No substance use for at least 6 months	***RELAPSE PREVENTION*** • Maintaining the changes (relapse prevention)
			IN REMISSION OR RECOVERY • Has not used substance(s) for more than one year	***IN REMISSION OR RECOVERY*** • Maintaining the changes (relapse prevention)
			*This column was adapted from the Substance Abuse Treatment Scales (SATS). (See Mueser, et. al. (2003) in Sources on page 46.)	

	Clinical focus	Psychosocial interventions	
		Each person in recovery may express a need for meaningful activity like employment at a different time or stage. When this occurs, make it a priority or the centerpiece of psychosocial interventions.	
	For substance use and mental disorders . . .	**Use comprehensive services . . .**	**Use psychosocial approaches to support pharmacological (medication) treatment . . .**
1	***ENGAGEMENT*** • Develop therapeutic alliances and build trust • Assess and explore the impact of substance use and mental disorders. • Learn what is important to consumers and demonstrate an understanding of their values • Gain permission from consumer to share in his/her process of change	***ENGAGEMENT*** • Provide assertive outreach • Provide practical assistance for daily living (e.g., food, clothing, shelter, medicine) • Assess continuously • Develop a relationship with outreach, regular contact • Crisis intervention when necessary	***ENGAGEMENT*** • Offer education to consumer and family about benefits and side effects of current and proposed medication • Use motivational interviewing to explore with consumer the pros and cons of medication use and/or adherence • If prescribed, monitor timeliness of prescriptions and refills to support adherence to treatment
2	***EARLY PERSUASION*** • Maintain and enhance therapeutic alliance • Help consumer identify and express his/her goals • Help consumer develop hope that his or her life can improve	***EARLY PERSUASION*** • Use motivational interviewing/ interventions • Assure consumer that ambivalence to change is normal and the decision to change or not is his or hers to make • Use a pay-off matrix to help consumers tip decisions away from ambivalence and toward positive action • Encourage peer support • Provide support to family members • Offer persuasion groups and/or individual treatment	***EARLY PERSUASION*** • Continue to use motivational interviewing to explore with consumer the pros and cons of medication use and/or adherence • Monitor medication regimen agreed upon with consumer • Encourage consumer to report medication usage honestly and to describe adverse effects • Encourage consumer to make requests for medication changes to medical provider rather than altering the prescription regimens alone • Help consumer identify and resolve barriers to medication adherence • Help consumer use behavioral tailoring to incorporate medication into daily routines (e.g., simplifying med regimen; taking medications during daily activities, such as meals; use prompts like Post-It notes) • Offer education regarding tobacco use and its impact upon relapse and recovery
	LATE PERSUASION • Help consumer develop awareness of symptoms of mental illness and negative effects of substance use upon symptoms and quality of life	***LATE PERSUASION*** • Educate consumer about alcohol, drugs, mental illness, and activities that promote health and wellness • Offer skills-training opportunities • Help evoke change toward healthier choices • Offer persuasion groups and/or individual treatment	***LATE PERSUASION*** Continue to ... • Help consumer identify and resolve barriers to medication adherence • Help consumer use behavioral tailoring to incorporate medication into daily routines (e.g., simplifying med regimen; taking meds during daily activities, such as meals; use prompts like Post-It notes) • Offer education regarding tobacco use and its impact upon relapse and recovery
3	***EARLY ACTIVE TREATMENT*** • Help consumer reduce substance use and attain periods of abstinence • Help consumer acquire skills and support for managing symptoms of both disorders and for pursuing personal goals	***EARLY ACTIVE TREATMENT*** • Teach illness management skills for both disorders • Encourage positive peer support • Encourage lifestyle changes • Utilize cognitive behavioral interventions • Offer family interventions • Encourage self-help and/or 12-step groups and/or individual treatment • Encourage active-treatment groups	***EARLY ACTIVE TREATMENT*** • Continue to support consumer's choices and needs for pharmacological treatment • Offer education regarding tobacco use and its impact upon relapse and recovery • Consider inpatient residential treatment as an option as needed
	LATE ACTIVE TREATMENT Continue to ... • Help consumer reduce substance use and attain periods of abstinence • Help consumer acquire skills and support for managing symptoms of both disorders and for pursuing personal goals	***LATE ACTIVE TREATMENT*** Continue to ... • Encourage lifestyle changes • Utilize cognitive behavioral interventions • Offer family groups and family therapy • Encourage self-help groups and/or individual treatment • Encourage active-treatment groups • Begin to develop a relapse-prevention plan with consumer	***LATE ACTIVE TREATMENT*** • Offer education regarding tobacco use and its impact upon relapse and recovery • Begin to develop a relapse-prevention plan with consumer
4	***RELAPSE PREVENTION*** • Maintain awareness that relapse can and does occur • A "slip" is not a failure; it's a learning opportunity • Help consumer maintain awareness that relapse can occur • Help consumer extend recovery to other areas of life (e.g., social relationships, work) • Shift focus to healthy lifestyle	***RELAPSE PREVENTION*** • Develop a relapse-prevention plan with consumer • Help consumer develop strategies to monitor feelings, thoughts, and behavior • Support consumer as he/she maintains healthy lifestyle changes learned in active treatment • Offer group treatments and social skills training • Encourage self-help groups • Encourage relapse-prevention groups and/or individual treatment • If a consumer experiences a decrease in motivation, use Motivational Interviewing to help consumer recommit to maintaining his or her change	***RELAPSE PREVENTION*** • Help consumer take more responsibility for coordinating his/her medications • Teach consumer skills to monitor, log, and report symptoms and to negotiate with medical provider for changes to prescriptions • Develop relapse-prevention plan with consumer • Support self-sufficiency of consumer: requesting refills directly from medical provider, picking up medications from pharmacy, filling pill-minders (planners), and monitoring side effects • Offer education regarding tobacco use and its impact upon relapse and recovery
	IN REMISSION OR RECOVERY • Help consumer in stable remission develop and use strategies for maintaining recovery • Prepare consumer for a transfer to a lower level of care	***IN REMISSION OR RECOVERY*** • Continue to utilize a full range of recovery support	***IN REMISSION OR RECOVERY*** • Gradually reduce monitoring activities
		• See "Comprehensive Services" column on page 53.	

	Pharmacological interventions	Comprehensive services
	Prescribers re-evaluate medication regimens based upon consumer feedback in all stages of treatment. **Use medication to support psychosocial treatments …**	■ **Integrated substance abuse and mental health counseling** ■ **Stages-of-change approach** ■ **Motivational Interviewing (MI)** ■ **Time-unlimited Services** ■ **Cognitive Behavioral Therapy (CBT)** ■ **Assertive Community Treatment (ACT) and/ or Intensive Case Management (ICM)** • Low caseload • Assertive outreach & engagement • Close monitoring • Team approach • Community-based services ■ **Housing/residential services** Offer a full continuum of housing resources, for example: • Continuum of wet-, damp-, and dry-housing • Residential treatment • Group home • Transitional independent living (includes onsite groups and supervision) • Independent living ■ **Medical services (to promote health)** • Pharmacological treatments • Integrated primary health services • Tobacco recovery (cessation) ■ **Illness Management and Recovery (IMR)** • Psychoeducation • Cognitive behavioral methods for using medication • Relapse prevention services • Coping skills interventions ■ **Group interventions** • Persuasion groups or motivational groups • Social-skills training • Active-treatment groups • Relapse-prevention groups • Family therapy (see family services) • Recreational group activity ■ **Self-help groups** • Double Trouble/ Dual Recovery Anonymous (DRA) • Alcoholics Anonymous (AA) • Narcotics Anonymous (NA) • Cocaine Anonymous (CA) • Depression and Bipolar Support Alliance (DBSA) • Schizophrenia Anonymous (SA) • Emotions Anonymous (EA) ■ **Family services** • Family outreach • Consultations with individual families • Collaborations with NAMI • Family psychoeducation • Multiple family groups • Behavioral Family Therapy (BFT) • Multisystemic Family Therapy (MFT) • Al-Anon ■ **Supported Employment/Individual Placement and Support (SE/IPS)** • Zero exclusion • Consumer preferences are important • Rapid job search • A competitive job is the goal • Employment is integrated with mental-health services • Time-unlimited support • Personalized benefits planning • Job development ■ **Supported Education (SEd)**
1	***ENGAGEMENT*** • Facilitate therapeutic alliance • Reduce acute symptoms of mental disorders and/or substance use disorders • Minimize impairments to consumer's insight and judgment • Minimize withdrawal symptoms • Improve cognitive functioning ***Rx*** • (see below)	
2	***EARLY PERSUASION*** • Stabilize and help decrease psychiatric symptoms to improve cognitive functioning and enhance insight about negative effects of substance use ***Rx*** • Treat psychiatric illness, which may have secondary effects upon cravings/ addiction (e.g., selective serotonin reuptake inhibitors, atypical antipsychotics, buspirone) • Avoid (or judiciously prescribe) medications that may be addictive (e.g., benzodiazepines, amphetamines, opiates) • Discuss pros and cons of nicotine replacement therapies and/or other medications for tobacco cessation and recovery • Explore the relationship between tobacco use and psychotropic medication	
	LATE PERSUASION • (see above)	
3	***EARLY ACTIVE TREATMENT*** • Stabilize and manage psychiatric symptoms and/or symptoms of substance use disorders • Create opportunities for participation in counseling and enhanced social relationships • Provide detox treatment as needed ***Rx*** • Support abstinence (e.g., disulfuram, naltrexone, suboxone) • Reduce craving (e.g., naltrexone) • Avoid meds that may be addictive (see Persuasion stage Rx above) • Discuss pros and cons of nicotine replacement therapies and/or other medications for tobacco cessation and recovery • Explore the relationship between tobacco use and psychotropic medication	
	LATE ACTIVE TREATMENT • (see above)	
4	***RELAPSE PREVENTION*** • Consider medications known to support abstinence and ongoing recovery • Reduce risk of relapse of symptoms of both disorders • Help consumer stay focused on his/her personal recovery goals ***Rx*** • Support abstinence (e.g., disulfiram, naltrexone, suboxone) • Avoid meds that may be addictive (see Persuasion stage Rx above) • Discuss pros and cons of nicotine replacement therapies and/or other medications for tobacco cessation and recovery • Explore the relationship between tobacco use and psychotropic medication	
	IN REMISSION OR RECOVERY	
	• See tables on pages 35 & 36.	

AT-A-GLANCE

Here's a quick overview of stage-wise treatment and the process of staging. Use the table in this publication for both.

The information below is excerpted from the *Clinical Guide for Integrated Dual Disorder Treatment (IDDT)* booklet. Consult pages 28 to 37 for more information. Get a free PDF from our website.

STAGES OF TREATMENT

There are four primary stages of IDDT treatment:

- Engagement
- Persuasion
- Active treatment
- Relapse prevention

The stages of treatment are based upon the Substance Abuse Treatment Scale (SATS). They focus upon each consumer's behavior as it relates to his or her use of alcohol and other drugs.

STAGES OF CHANGE

The stages of change are separate yet related. They are commonly used to describe a process that people experience as they embark on a personal journey to improve the quality of their lives (e.g., diet, exercise, managing symptoms of mental illness and substance use disorders). The stages-of-change suggest that personal change occurs incrementally over time. Thus, big changes like sobriety, symptom management, and an increase in independent living are usually built upon a series of small, overlapping, incremental changes.

STAGING

"Staging" is a process to help you plan treatment after you screen for, assess, and diagnose co-occurring mental illness and substance use disorders among consumers you serve. "Staging" is a word that is commonly used to describe an individual's readiness to make a change and the process of matching a menu of comprehensive services with each consumer's stage of treatment. The table on pages 51-53 has been created to help you with this process. It includes the following:

- Stages of treatment
- Tips for interventions
- A list of comprehensive services

Open here for Stage-Wise Treatment table.

TWO IN ONE

The Cover!

8 PAGES

The stage-wise treatment table that appears inside this document is designed to be used with the *Clinical Guide for Integrated Dual Disorder Treatment (IDDT)* booklet and as a separate clinical tool for service teams. In fact, this document is actually the cover of the booklet, but we have printed it separately to provide you with a lightweight resource. Visit our website to order some copies for your team members. Also use it to inform, educate, and build consensus among collaborators and stakeholders.

The Booklet!

56 PAGES

We are providing the entire *Clinical Guide* as a free PDF download on our website.

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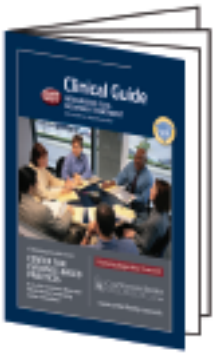

Open here for Stage-Wise Treatment table.

ABOUT US

The Center for Evidence-Based Practices at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices and emerging best practices for the treatment and recovery of people with mental illness and substance use disorders. The Center helps service systems, organizations, and providers implement and sustain the practices, maintain fidelity to the practices, and develop collaborations within local communities that enhance the quality of life for consumers and their families. The Center provides these services:

- Service systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Professional peer-networking
- Evaluation (fidelity and outcomes)
- Research

The Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE) is an initiative of the Center for Evidence-Based Practices.

The *Clinical Guide for Integrated Dual Disorder Treatment (IDDT)* is available as a free PDF download from our website.

This booklet is part of an evolving training and consultation process from the Center for Evidence-Based Practices and its Ohio SAMI CCOE initiative. It is written for direct-service providers who want to implement and sustain Integrated Dual Disorder Treatment (IDDT), the evidence-based practice. It is also written for administrators, policymakers, and advocates.

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The **Center for Evidence-Based Practices** at Case Western Reserve University is a partnership between the **Mandel School of Applied Social Sciences** at Case Western Reserve and the **Department of Psychiatry at the School of Medicine.** The partnership is in collaboration with and supported by the **Ohio Department of Mental Health** and the **Ohio Department of Alcohol and Drug Addiction Services.**

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