Chapter: 2	Section: 2	Subject: 10

CHAPTER: Board Services and Program Administration		
SECTION: Assessment, Service Planning and Documentation		
SUBJECT: Co-Occurring Substance Abuse and Mental Illness Treatment		
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I. PURPOSE: The purpose of this policy is to provide best practice guidelines in the provision of integrated co-occurring substance abuse and mental health treatment services.

II. APPLICATION: These procedures apply to specialized Integrated Dual Diagnosis Treatment (IDDT) and general Co-occurring Treatment services provided within the treatment service array of WMCMH unless stated otherwise.

III. REQUIRED BY: Not applicable

IV. DEFINITIONS:

Co-occurring Disorder: A co-occurring disorder is present when an individual has both a Substance Use Disorder and a Mental Health Disorder at the same time, regardless of the severity of each disorder. Both disorders are considered primary and equally valid and important in the treatment process.

Integrated Dual Diagnosis Treatment: Integrated Dual Disorder Treatment (IDDT) is an evidenced based practice that improves the quality of life for people with severe (Quadrant IV) co-occurring mental health and substance abuse disorders by integrating substance abuse services with mental health services. The treatment model utilizes a combination of pharmacological, psychological, educational, and social interventions to address the needs of consumers and their caregivers (family and friends). The goal of the intervention model is genuine and meaningful recovery for the consumer from both disorders.

Drug Screening/Testing: Any method of scientific testing used to determine the presence of substances in a person's system. Methods of testing include collecting and analyzing samples of blood, urine, saliva, or hair.

Treatment Non-Responding: A person is considered to not be responding to treatment when any of the following is true: 1) There is no apparent positive movement (in stage of treatment and stage of change) AND/OR worsening of symptoms after one year of consistent engagement in IDDT/COD treatment. 2) There is no apparent positive movement or worsening of symptoms AND the consumer is disengaging from IDDT/COD services at any point in treatment.

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V. POLICY: It is the policy of WMCMH to provide integrated co-occurring Substance Abuse and Mental Health treatment services.

VI. PROCEDURES:

1. Conducting Treatment Reviews for Persons with Co-occurring Disorders (This procedure applies to both consumers in the Traditional Mental Health Services and in the Outpatient SUD and Mild/Moderate Mental Health Treatment Programs.)

    a. Basic COD Case Review Guidelines: As with any person in treatment, it may be clinically valuable to participate in individual and/or team case reviews. The purpose of a verbal individual or team review is to evaluate the current clinical framework/approach, interventions, and progress in an effort to make necessary adjustments to improve services and outcomes. Helpful questions related to Co-occurring Treatment may include the following:
        i. What is the individual needing from WMCMH/What do they want? How does that relate to what you as a clinician want?
        ii. What is the clinician doing to help the individual move in that direction? What might the clinician be doing that is keeping the individual from moving in that direction?
        iii. How is what the clinician is doing working?
        iv. What is the individual's s perception of the problem? What is the clinician's perception of the problem?
        v. What is the stage of change for the individual and the clinician?

2. Re-evaluation of the Clinical Approach for Cases with Limited Outcomes (This procedure applies to both consumers in the Traditional Mental Health Services and in Outpatient SUD and Mild/Moderate Mental Health Treatment Programs.)

    The purpose of these procedures are to provide a process that staff members are to implement when an individual does not appear to be progressing toward his/her stated treatment outcomes at the pace that would be clinically expected.

    a. Indicators that an individual is not making expected progress toward outcomes:
        i. There is no measurable positive movement in the individuals' Stage of Change AND/OR worsening of symptoms when the amount of time in treatment is longer than is clinically expected for progress toward outcomes to have occurred. This is a clinical determination based

upon the severity of the issues, the treatment interventions utilized, and other clinical and/or situational factors.

OR

ii. There is no measurable positive movement toward outcomes or worsening of symptoms AND the individual is disengaging from services at any point in treatment.

b. Available Resources for re-evaluating the Clinical Approach: Below is a list of options that a clinician has available to assist in re-evaluating the current clinical approach. The purpose of each step is the same: to identify alternative strategies to utilize with an individual when there does not appear to be measurable progress toward their treatment outcomes. The steps should routinely be followed in the sequence presented, unless some situational factor warrants more intense consultation sooner in the process.

i. Step 1: Supervisor Consultation - Staff will consult with his/her direct supervisor to discuss the clinical concerns. Through a consultation process the Supervisor will work with clinical staff to identify whether the apparent lack of progress toward outcomes is indeed outside of what would be expected given the situation. If so, a thorough case review will be conducted and treatment strategy adjustments will be identified or a plan will be made for further consultation.

ii. Step 2: Treatment Team and/or Natural Supports Consultation - With the help of the supervisor, it may be determined that consultation with some or all of the individuals involved in the treatment and support of the individual is needed. The clinician will facilitate a meeting and will include those persons involved in the recovery process of this particular person. Individuals could include:

1. The individual who is involved in treatment
2. Any/All CMH Treatment Team Members
3. Other professional in the community who are treating the individual.
4. Natural supports of the individual (family, friends, etc.).

Note: At this point, this group may consider more intensive alternative interventions that are available such as: residential placements, various legal contingencies, Alternative Treatment Order leverages (ATO Policy 2.7.1),

payee-ships, medications, alternative housing, referral to a different treatment team, etc., as clinically appropriate, beneficial, and least restrictive.

iii. Step 3: Clinical Oversight Committee Consultation - As outlined in the Administrative Manual Policy 2.1.1, one of the duties of the Clinical Oversight Committee (COC) is to "*To conduct special case reviews: death reviews, treatment issues, diagnostic reviews, sentinel events, review root cause analysis, conflicting treatment issues."*

A clinician, in coordination with his/her supervisor, may request consultation with the COC. Clinical staff requesting a consultation with COC will be required to present the case, providing overview and outcomes of all previous treatment applications, current and past medication/medical interventions and all other pertinent information that assists the committee in their consultation duties, and expected outcomes. Recommendations will be made.

iv. Step 4: External Consultation – In some instances, the Clinical Oversight Committee may recommend conducting a consultation with an external individual/group that is considered an "expert" or qualified resource in the discipline or problem area involved in the case. Arrangements and planning for the consultation will be made in coordination with the Clinical Director/Designee, the Supervisor, and the clinician involved in this case. The clinician will ensure that he/she is sufficiently prepared for the consultation through obtaining necessary releases of information, creating a clear case presentation with all critical history, road blocks, and facts, as well as an identified outcome for the meeting with the expert.

c. Documentation of Consultations: Clinicians shall document in a consumer progress note the information from the consultations that were conducted. Included in the notes shall be those in attendance, recommendations made, and any other relevant details. This progress note shall be the record of the consultation event, as the notes from the consultation are not routinely included in the consumer record.

d. Prescriber Consultation Procedures (This procedure applies only to Consumers in Traditional CMH Services, and not those in SUD and Mild/ Moderate MH Treatment Services): Prescribers are encouraged to utilize

both internal peer and external expert consultation mechanisms to assist in making psychopharmacological decisions regarding challenging individuals. Consultation provides a framework for obtaining clinical support, as well as for reviewing clinical decision making from a risk management standpoint. Furthermore, work with people who have co-occurring disorders can be both frustrating and very rewarding, and the peer consultation process can be a vehicle for both recognizing special efforts by clinicians, as well as to support the clinical team when dealing with particularly challenging cases. Examples of appropriate cases for expert or peer consultation include (but are not limited to): 1) Continuation of treatment with benzodiazepines (beyond detoxification) in patients with known substance dependence. 2) Discontinuation of psychiatric medications for a substance-using patient with a serious, persistent psychiatric illness. 3) Unilateral termination of clinical care for any patient with CODs.

a. Peer consultations may be provided either individually or in team meetings as desired by the prescriber. The participants, date, time, and content of the consultation should be documented in the identified consumer's clinical record.

b. If following a peer consultation, expert consultation is still deemed warranted by the prescriber, he/she will initiate such a consultation through qualified resources/contacts in the psychiatric field. The participants, date, time, and content of the consultation should be documented in the identified consumer's clinical record.

3. Guidelines for Suspicion of Consumer Intoxication (This procedure applies to both consumers in the Traditional Mental Health Services and in the Outpatient SUD and Mild/Moderate Mental Health Treatment Programs.)

   The following guidelines are to be followed to determine the best course of action in situations where a consumer appears to be under the influence of a substance and presents for a CMH appointment/activity:

   a. Planned services are not necessarily denied or delayed due to known or suspected substance use when a person presents for services. The overall functioning of an individual determines whether to continue with a planned service.

b. Conduct a mental status evaluation to determine the mental functioning of the individual. Consider various causes for the functioning concerns. Question the individual concerning substances used, amounts, and when used. Seek to rule out any other causes of the individual's behavior that aroused suspicion of use.

c. Provide the service when the individual's functioning appears to be within the normal range. The use of substances should be discussed in the service. Appropriate interventions should be identified and used to directly address the confirmed presence of substance use.

d. If the service is a group treatment event, it may be best to discuss and process the situation within the group. The group may benefit from honest dialogue about the topic of attending treatment services while under the influence. It should be established that this is not a healthy norm with the reasons identified and openly discussed.

e. When it is determined that the individual's functioning is significantly compromised by substance use to the extent that it precludes the individual from participating successfully in a service, the service may be delayed or rescheduled until the individual is functioning well again. The staff member must facilitate the identification of an appropriate location for the individual to be and arrange for safe transportation to that location. Depending on the condition of the individual, this may include the Hospital Emergency Room, Detoxification Services, a relative's or friend's home, the individual's home, or some other identified safe location. It is imperative that the issue of use be thoroughly addressed at the next contact.

f. Always attempt to dissuade an individual who is known or is suspected of being under the influence of a substance from operating a vehicle. Let the individual know that you will need to notify the police if he/she chooses to drive. Immediately report to the police when an individual who appears to be under the influence shows intent or makes an attempt to operate the vehicle. Clearly note the contents of the event in the consumer's record.

g. Follow the procedures found in the Violence Free Work-place Policy when an individual under the influence appears to be at risk for violence.

4. Substance Screening/Testing Procedures (This procedure applies only to Consumers in Traditional CMH Services, and not those in Outpatient SUD and Mild/Moderate Mental Health Treatment Programs.)

   The following guidelines are to be followed to determine the best course of action for Screening/Testing for substance use of individuals in or seeking service from WMCMH:

   a. WMCMH does <u>not</u> routinely practice screening or testing for the presence of substances in one's system. WMCMH does not provide on-site testing.

   b. A substance screening/test is considered a medical/laboratory process. The test must be authorized by an authorized Health Service Team Member. The test may be requested by any staff member, when the information gained from the substance test would benefit the overall treatment process. The service is provided by an external agency.

   c. Clinical Uses for Positive Screening Results: When an individual tests positive for a substance, it is to be seen as an opportunity to re-assess and change the treatment plan for relapse or poor clinical outcome. It is not an occasion for clinical consequences, suspension or discharge. Just as physicians do not discharge a patient for displaying symptoms of increased blood pressure and mental health clinicians do not suspend a consumer who becomes psychotic or depressed or manic, we do not impose relationship or clinical consequences for continued or return to use. At the same time, it is important to allow other natural consequences to play out (i.e., probation violations, loss of license, job related, etc.).

   d. Individuals who are court ordered to participate in substance use screening must seek testing at an agency other than WMCMH if it is a requirement of the court order. The Responsible Care Manager may assist the individual in finding an external substance testing service. WMCMH may request the results of such testing and, when received, should be placed in the consumer's Electronic Record.

VII. SUPPORTING DOCUMENTS:

Appendix 2-2-10A: Criteria for IDDT Team Designated Substance Abuse Specialist
Appendix 2-2-10B: Assessment Guidelines
Appendix 2-2-10C: Clinical Training and Competency Guidelines for Co-occurring Mental Health and Substance Use Disorders
Appendix 2-2-10D: Quarterly IDDT Case Review Form
Appendix 2-2-10E: Matching Stage of Change and Treatment

2-2-10 COD
Revised 2/11, 11/11, 11/12, 7/14, 1/17, 9/18

Appendix 2-2-10A

Criteria for Designated Substance Abuse Specialist for IDDT Multi-disciplinary Team:

An individual designated as an IDDT Team Substance Abuse Specialist must meet the following criteria:

1. Demonstrate **Advanced Level skills, attitudes, and values** that are in alignment with principles and practices of the Co-occurring Disorder Treatment Philosophy of WMCMHS. Competency areas include: maintaining a welcoming, empathic, and hopeful stance, knowledge of COD population needs and barriers, skills in crisis response, screening, assessment, and knowledge and skills in best clinical practice, change and recovery models, integrated planning and treatment, recovery facilitation, and coordination of services. See the Clinical Training and Competency Guidelines for Co-occurring Mental Health and Substance Use Disorders for greater detail.

2. The Substance Abuse Specialist must meet the following criteria: Be certified through the Michigan Certification Board of Addiction Professions (MCBAP) and have one or more of the following credentials: Certified Addictions Counselor-Level 1 (CAC-1), Michigan (CAC-M), Level II (CAC-II), or IC & RC (CAC-R), or Certified Advanced Addictions Counselor (CAAC-M), Certified Clinical Supervisor (CCS), Certified Clinical Supervisor-IC & RC (CCS-R), Certified Clinical Supervisor-Michigan (CCS-M), or Certified Criminal Justice Professional.

3. Must have an ability to actively participate in multi-disciplinary team discussions and provide substance use disorder recovery perspectives for team consideration.

Appendix 2-2-10B

West Michigan CMH Co-occurring Disorders Initiative

Consumer ACCESS Principles and Practices:

Guidelines for Assessment, Referral, Differential Diagnoses and Identification of Co-morbid Conditions for
Co-occurring Mental Health and Substance Use Disorders

May 2007

West Michigan CMH ACCESS PRINCIPLES AND PRACTICES

Preamble: Intended Uses/Purposes

- These guidelines are intended for use by clinical supervisors and program administrators to support the planning and development of supervision and training for clinical staff expected to work with persons who have co-occurring mental health and substance use disorders.
- These guidelines are intended for use by individual clinicians responsible for consumer access. The guidelines explain best practices for access staff to utilize, important frameworks to consider when making clinical decisions, and basic information on various program models that may be available for referral.
- These guidelines are intended for use as a common set of standards related to consumer access across the regional co-occurring treatment system. The document contains a set of agreed upon principles, definitions, and practices related to consumer access. It will be useful to guide communication between organizations within the greater co-occurring treatment system to better create solutions to procedural or particular clinical concerns.
- These guidelines are intended for use by organizations that make up the broader co-occurring treatment system as well as the coordinating bodies that seek to integrate all co-occurring related services to plan, develop, and coordinate the structures and procedures that support such principles and practices.

A. Principles of Diagnostic Assessment: Screening, Detection, and Diagnosis

1. Welcoming expectation: Because of the high prevalence of co-morbidity, routine assessment in all settings should be based on the assumption that any consumer is likely to have a co-morbid condition. Direct communication to the individual that such a presentation is both welcome and expected will facilitate honest disclosure.

2. Access to assessment: Access to assessment or to any service should not require individuals to self-define as mental health OR substance disordered before arrival. Assessment should routinely expect that all individuals may have co-morbid disorders, and that the assessment process may need to be ongoing in order to accurately determine what disorders are present, and what interventions are required. A longer evaluation period may result in extending beyond the State of Michigan 14 day treatment access guideline. The rationale for going beyond the 14 days must be clearly articulated in clinical documentation. Arbitrary barriers to mental health assessment based on alcohol level or length of sobriety should be eliminated. Similarly, no one should be denied access to substance disorder assessment or treatment due to the presence of a

co-morbid psychiatric disorder and/or the presence of a regime of non-addictive psychotropic medication.

3. Structured Assessment Process: Accurate diagnostic assessment for individuals with co-occurring disorders is complicated by the difficulty of distinguishing symptom patterns that result from primary psychiatric illness from symptom patterns that are caused or exacerbated by primary substance use disorders. In many individuals with co-morbidity, both psychiatric and substance disorders are simultaneously and interactively contributing to symptoms at the point of assessment, particularly if assessment occurs when the consumer is acutely decompensated. Consequently, differential diagnostic assessment requires a careful, structured approach to assessment, often over a period of time, in order to best elucidate diagnosis accurately.

4. Accessibility and Flexibility: Assessment begins at the point of clinical contact, regardless of the individual's clinical presentation. Initiation of assessment should not be made conditional on arbitrary criteria such as length of abstinence, non-intoxicated alcohol level, negative drug screen, absence of psychiatric medication, and so on. Although in some individuals with co-occurring disorder, establishing an accurate diagnosis of one disorder requires the other disorder to be at baseline, in most cases diagnosis can be reasonably established by history (see below). Moreover, treatment must usually be initiated when neither disorder is at baseline; consequently, initial diagnoses are often presumptive, and the initial goal of assessment is to engage the individual in an ongoing process of continual reassessment as treatment progresses, during which diagnoses may be continually revised as new data emerge.

5. Screening and Detection:
   a. Screening tools in the mental health setting for substance disorders may include the following: screening tools that include checklists of substances (including over the counter preparations, caffeine, nicotine, and gambling with amounts and patterns of use for each); screening tools validated for use in people with mental illness (e.g., CAGE, MAST/DAST, MIDAS, DALI, CRAFFT for adolescents); and selective use of urine screens, particularly for adolescents and for unreliable historians with puzzling presentations.

   b. For mental health screening in substance treatment settings, the use of symptom checklists (e.g., Brief Psychiatric Symptom Inventory, MINI, Project Return Mental Health Screening Form III, SCL-90) can be helpful to facilitate referral for a more comprehensive mental health diagnostic evaluation.

6. Collateral Contact: Screening and assessment should routinely incorporate obtaining permission to contact all available collaterals, including family, friends, case manager, probation officer, protective service worker, and other service providers, as well as obtaining records of previous treatment episodes.

7. Diagnostic Determination:
   a. Diagnosis of either mental illness or substance use disorder can rarely be established only by assessment of current substance use, mental health symptoms,

or mental status exam. In most cases, diagnosis is more reliably established by obtaining a good history that is integrated, longitudinal, and strength-based.

b. Diagnosis of substance use disorders involves review of past and current patterns of substance use, and observing whether those patterns meet criteria for substance dependence or substance abuse.

c. Diagnosis of substance dependence is frequently based on evidence of lack of control of substance use in the face of clear harmful consequences, whether or not tolerance and withdrawal symptoms are present. Once substance dependence has been identified in the past that diagnosis persists, even if the person currently exhibits reduced use or abstinence.

d. Diagnosis of substance abuse requires exclusion of substance dependence, and identifying a pattern of harmful use in relation to the individual's own context. For a person with a mental illness, any controlled use of substances that interferes with treatment or outcome can be defined as abuse, and the extent of use that would be considered problematic is inversely related to the severity of the psychiatric disorder or disability. For individuals with severe mental illness who are disabled at baseline, any persistent use of substances is likely to be considered abuse, even though harmful effects may not be apparent on each occasion.

e. Diagnosis of non-substance related psychiatric disorders similarly requires careful review of past and current patterns of mental health symptoms, in relation to presence or absence of appropriate medication and periods of substance abstinence or reduced use. Presence of symptoms meeting criteria for DSM V psychiatric disorder during periods of abstinence or reduced use that exceed the resolution period for those symptoms based on the type and extent of substance use (see SUPS Table in Appendix A) meet presumptive criteria for mental illness.

f. All diagnoses should be initially considered to be presumptive, and subject to continual reevaluation and revision during the course of continuing treatment.

g. Whenever a psychiatric disorder and a substance disorder co-exist, even if the psychiatric disorder is substance-induced, both disorders should be considered primary for clinical purposes, in the sense that each disorder requires appropriately intensive primary diagnosis specific treatment simultaneously. However, at the time of this document's publication, state reporting guidelines do not have a co-occurring disorder designation nor does it allow for the assignment of two primary diagnoses simultaneously.

8. Severe and Persistent Mental Illness (SPMI) Determination: SPMI determination requires establishing (using the assessment methodology in the previous paragraph) a presumptive (NOT necessarily definitive) diagnosis of a SPMI eligible psychiatric disorder, persistence of that disorder, and functional incapacity in accordance with state guidelines for SPMI determination. If necessary, the SUPS Table (Appendix A) may be utilized to assess the resolution period after which substance-related contribution to

symptomatology and functional incapacity are likely to be significantly reduced or eliminated.

9. External Referral through "Warm Transfer": It is an expectation that following the screening and/or the assessment process there will be occasions when it will be determined that an individual will be most appropriately served in a service that is provided by an external organization. It is the responsibility of the referring clinician/organization to "Warmly Transfer" the individual to that external organization. This process is marked by proactive linking to the service through aiding in the scheduling of the appointment with the individual, providing clinical information to the external organization promptly, providing a clear rationale for the transfer to the individual in a positive and hopeful manner, a follow-up contact within 1 week to ensure that the individual successfully connected with the external organization, and other similar practices.

B. Differential Diagnoses

1. Substance Disorder: Distinguish substance use, substance abuse, and substance dependence. Distinguish types and categories of substances.

2. Psychiatric Disorder: Distinguish substance induced psychiatric disorder, non-SPMI psychiatric disorder, SPMI psychiatric disorder.

3. Quadrant Model of Co-occurring Disorder Subtypes: Subtypes of co-occurring disorders affects locus of responsibility for treatment of the person. Individuals who are severely and persistently mentally ill (SPMI) are commonly eligible for types of services provided in the mental health system (including continuing care management) that individuals with non-SPMI symptoms disorders may not be eligible to receive. Non-SPMI individuals require specific mechanisms for providing such continuity of care or care management through other available means. Similarly, individuals with substance dependence are more likely to be appropriate for involvement in addiction episodes of care in the addiction system than are individuals with only substance abuse. It is recognized that special contracts with some insurance carriers may supersede the preceding use of sub-typing for locus of responsibility.

   A four-cell table is used for identifying diagnostic subtypes of co-occurring disorders. The identification of subtypes is helpful for determining locus of responsibility (Community Mental Health Systems vs. Substance Abuse Treatment Providers) that is most appropriate as well as informing decisions for the best level of care. Following is an explanation of the quadrant model.

   Quadrant IV: High Psych-SPMI / High SA –Substance Dependence (high-high)
   Quadrant III: Low Psych or Non-SPMI or Substance - Induced Disorder / High SA - Substance Dependence - Severe Abuse (low-high)
   Quadrant II: High Psych - SPMI /Low SA (high-low)
   Quadrant I: Low Psych - Non SPMI / Low SA (low-low)
   (See Appendix B: Quadrant Model)

CMH Responsibility	SA Treatment Responsibility
Quadrant IV: High Psych / High Substance	Quadrant III: Low-Moderate Psych / High Substance
Quadrant II: High Psych /Low-Moderate Substance	Quadrant I: Low-Moderate Psych / Low-Moderate Substance

C. Assessment of Common Co-morbid Conditions

1. Trauma related disorders: Individuals with co-occurring psychiatric disorders (SPMI) and substance disorders have a high prevalence of trauma histories and trauma related symptoms, women (85%) more so than men (50%). Use of available trauma-screening tools for both men and women (e.g., PTSD – Checklist: Civilian Version, Military Version, and Stressor Specific Version; PTSD Screen; Traumatic Antecedent Questionnaire – TAQ, etc.) and ensuring that the engagement and assessment procedures are trauma - informed and trauma-sensitive are highly recommended.

2. Cognitive disorders: Individuals with co-occurring disorders have a high risk of co-morbid cognitive impairment, with causes ranging from congenital conditions (ADD, learning disabilities) to sequela of substance use, medical conditions, and/or head injuries. Assessment of cognitive impairment (e.g., with the Mini Mental Status Exam and with specific assessment of reading skills and auditory/ visual learning capacity) is important in modifying treatment in accordance with the individual's ability to learn most effectively.

3. Personality traits and disorders: Individuals with co-occurring mental health disorders will frequently exhibit symptoms and behavior characteristics of other disorders. At times, these dysfunctional personality traits will resolve as recovery progresses; at times they represent enduring personality disorders. Diagnosis of a personality disorder is based on patterns of dysfunctional behavior that are present either prior to onset of substance disorder, or during periods of abstinence, and are not simply the result of the mental illness or substance disorder.

4. Medical conditions: Individuals with co-occurring disorders are a high-risk population for multiple medical conditions, most notably sexually transmitted diseases. Obtaining medical history and medical records is an important component of diagnostic assessment.

D. Additional Assessment to Determine Treatment Needs

1. Phase of Recovery/Stage of Change/Stage of Treatment:
   The literature on co-occurring disorders has identified:
   Four phases of recovery (Minkoff, 1989):
   1. Acute stabilization;
   2. Motivational enhancement/engagement;

3. Prolonged stabilization (active treatment/relapse prevention);
4. Rehabilitation and recovery

Five stages of change (Prochaska & DiClemente, 1992):

1. Pre-contemplation;
2. Contemplation;
3. Preparation;
4. Action;
5. Maintenance

Four stages of treatment for seriously mentally ill individuals with substance disorders (Osher & Kofoed, 1989):

1. Engagement;
2. Persuasion;
3. Active treatment;
4. Relapse prevention

Research of the latter two groups clearly states that effective interventions must be stage specific. Consequently, stage specific assessment is required. The Substance Abuse Treatment Scale (McHugo, et al, 1995) is validated for SPMI populations; the URICA (DiClemente) and Readiness to Change Scale (Rollnick, et al) with less seriously mentally ill populations. (Appendix A.)

2. Multidimensional Assessment: Significant research (McLellan, et al) has identified the value of problem-service matching for individuals with substance disorders, including co-occurring psychiatric disorders. Use of multidimensional assessment tools like the Addiction Severity Index (ASI) or the GAIN offer the opportunity to assess problems in multiple dimensions for the purpose of service matching. The ASI is not as well validated in dual diagnosis populations, however, and does not permit integration of dimensions, or connection of dimensional problems to a particular disorder.

3. Continuous Integrated Treatment Relationship: One of the priorities of treatment is to establish a primary treatment relationship. Assessment for the presence and quality of such a relationship is a necessary prerequisite for treatment planning.

4. Family or Caregiver Support: Available supports supply both assistance and contingencies for mobilizing treatment progress.

5. Extent of Impairment: Assess strengths and disabilities to determine extent to which individuals require care and support unconditionally, and in what areas (housing, money management, ADLs). Also, assess capacity to learn recovery skills and to participate in substance disorder treatment.

6. External Contingencies: Evaluate for presence of legal involvement, child protective service involvement, or other external contingencies. Also evaluate for possible contingencies within existing mental health or substance program settings, including payees. . (Ries & Comtois, 1997).

7. Level of Care: In addition to the required Service Selection Guidelines, assessment of level of care may require the use of multidimensional assessment instruments, such as the ASAM for addiction related presentations, and LOCUS for mental health related presentations. Both instruments have capacity to address co-morbidity in level of care assessment.

E. Program Types

1. Program Categories (ASAM 2001; Minkoff, 2000): Within any system of care, available programmatic interventions can be categorized according to dual diagnosis capability. The expectation is that all programs in either system evolve to become at least **Dual Diagnosis Capable - Chemical Dependency, Dual Diagnosis Capable – Mental Health (DDC-CD; DDC-MH)**, and a subgroup of services is designed to be **Dual Diagnosis Enhanced (DDE-CD; DDE-MH).**

    a. DDC-CD: Substance Use Disorder Treatment Programs that welcome individuals with co-occurring disorders whose conditions are sufficiently stable so that neither symptoms nor disability significantly interfere with standard treatment. Makes provision for co-morbidity in program mission, screening, assessment, treatment planning, psychopharmacology policies, program content, discharge planning, and staff competency and training.

    b. DDC-MH: Mental Health Treatment Programs that welcome individuals with active substance use disorders for Mental Health treatment. Makes provisions for co-morbidity as above. Incorporates integrated continuity of case management and/or stage specific programming, depending on type of program.

    c. DDE-CD: DDC program enhanced to accommodate individuals with sub-acute symptomatology or moderate disability. Enhanced mental health staffing and programming, increased levels of staffing, staff competency, and supervision. Increased coordination with continuing mental health or integrated treatment settings.

    d. DDE-MH: MH program with increased substance related staffing skill or programmatic design: e.g., dual diagnosis inpatient unit, providing addiction programming in a psychiatrically managed setting; intensive dual diagnosis case management teams (CTT), providing pre-motivational engagement and stage-specific treatment for the most impaired and disengaged individuals with active substance disorders; comprehensive housing or day programs, providing multiple types of stage-specific treatment interventions and substance-related expectations.

F. Program Models

1. Outpatient Individual and Group Services: Low intensity intervention may be provided by individual outpatient clinicians (plus psychopharmacologists) in outpatient clinic settings. Found in both Mental Health and Substance Abuse Systems and provide DDC or DDE services in traditional individual and/or group formats; includes assessment and referral services as well. Focus is on skills training, motivational enhancement,

education, and relapse prevention for both disorders. Substance Abuse Treatment may include an Intensive Outpatient Program (IOP), which routinely consists of 9 hours of group treatment and various degrees of individual and/or family interventions.

2. Continuous Integrated Case Management: Ranges from high intensity to low intensity, and DDC or DDE. High intensity DDE programs include the integrated ACT teams. Moderate intensity programs include DDC or DDE case management teams.

3. Continuous Recovery Support: Dual Recovery Clubhouse programs (DDE) or Clubhouse programs with dual recovery supports or tracks (DDC); Dual Recovery self-help programs.

4. Emergency Triage/ Crisis Intervention (DDC): Welcomes any type of mental health and/or substance presentation, provides initial triage, level of care assessment, and crisis intervention and/or referral. Example: Emergency Department of a local hospital and may include CMH emergency on-call services.

5. Crisis Stabilization Beds (DDC): Temporary hospital diversion in staffed setting for individuals with psychiatric presentations who may be actively using substances, but do not require medically monitored detox.

6. Psychiatric Inpatient Unit or Partial Hospital (DDC or DDE): The former does routine assessment, engagement, motivational enhancement, and stage-specific groups; the latter provides more sophisticated assessment plus addiction treatment in a psychiatrically managed setting. DDE programs have also been designed and implemented in state hospitals for individuals in long -term care.

7. Detoxification programs (DDC or DDE). Specialized psychiatrically enhanced detox can provide supervised detoxification for individuals who may have psychiatric exacerbations during episodes of acute substance intoxication (e.g., suicidality, aggressive impulsivity, psychosis) but who can be safe in an unlocked staffed setting.

8. Psychiatric Day Treatment (DDC or DDE): Intermediate to long- term programs for psychiatric support that provide varying degrees of stage specific programming and integrated case management. DDE programs have more sophisticated staff, more linkages with substance programming, and a full range of stage-specific groups.

9. Addiction Partial Hospitalization and Residential (DDC or DDE): Episodes of abstinence-oriented active addiction treatment in settings with varying degrees of psychiatric capability. Programs can be very long term (years), such as Modified Therapeutic Community, or short term (one to two weeks, up to 90 days).

10. Psychiatric Housing Programs: Provide housing supports for individuals with psychiatric disabilities. Programs need to be matched according to stage of change:

    a. Abstinence-expected (“dry”) housing: This model is most appropriate for individuals with co-morbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. Such models may

range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than “one strike and you’re out”.

b. Abstinence-encouraged (“damp”) housing: This model is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively is discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than substance use per se. Motivational enhancement interventions are usually built in to program design.

c. Consumer-choice (“wet”) housing: This model has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (Tsemberis & Eisenberg, 2000: “Pathways to Housing Program”). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

APPENDIX A

SUBSTANCE USE/PSYCHIATRIC SYMPTOMATOLOGY TABLE

The psychiatric symptomatology table is a guideline only and is not to be used as a substitute for professional clinical judgment.

Category of Substance	**Type of symptoms seen with use pattern**			Resolution Period
	Mild Use *Uses no more than 1 – 2 times/wk; does not use to severe intoxication; no observable impairment.*	Moderate Use *Uses regularly, but not usually to severe intoxication; and/or episodes of severe intoxication occur, but once/wk or less; and/or presence of negative outcomes (hangover, money loss), but not severe.*	Heavy Use *Uses regularly (more than 2x/wk) to point of severe intoxication; significant impairment, negative outcomes noted, such as ER visits, fights, can't pay rent, medical complications of substance dependence (liver disease, hemorrhage, etc.)*	*Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis.*
Alcohol **Benzodiazepines** **Sedatives**	None	Anxiety, depression, not dysfunctional.	Hallucinations, not psychosis. *Patient usually reports hearing "voices," content non-bizarre, good reality testing, no thought disorder or bizarre behavior.* Anxiety Mood instability. *Patients occasionally can develop a first true manic episode during withdrawal.* Personality Disorder	30 days 30-90 days *Most severe symptoms will resolve (if they do) within 30 days – disability/fragility may persist longer.*

Stimulants (Cocaine, methamphetamine)	Mild anxiety, depression	Anxiety/panic, depression, mood instability	More severe anxiety & depression	30 days (mild/moderate)
			Personality disorder symptoms	30-90 days (heavy)
			Paranoid psychosis	30 days
Hallucinogens (Mescaline, LSD, peyote)	Anxiety & depression, occasional psychosis or severe panic *A single episode of hallucinogen use can occasionally precipitate psychosis or severe panic. This may also happen with methamphetamine.*	Anxiety & depression Flashbacks/hallucinate experiences Sometimes, psychosis, panic, mood instability	Psychosis Severe panic, mood instability	Usually 30 days For heavy marijuana users, persistent anxiety, panic attacks, and mood/thought alteration may last up to 90 days. Up to 90 days
Opiates	None	Mild-moderate anxiety and depression	More severe anxiety and depression, personality disorder symptoms	60-90 days

West Michigan CMH Co-occurring Disorders Initiative

Category of Substance	**Type of symptoms seen with use pattern**			Resolution Period
	Mild Use *Smoking a single marijuana cigarette 1 – 2 times/wk*	Moderate Use *One to two marijuana cigarettes 3 – 5 times/wk*	Heavy Use *Two or more marijuana cigarettes daily*	*Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis.*
Marijuana (cannabis sativa)	None	Mental confusion, agitation, feelings of panic	Acute toxic psychosis, paranoia, disorientation, severe agitation, depersonalization	Moderate – 24 to 72 hours Heavy – 30 to 60 days

Table developed by:
The Arizona Department of Health Services
Division of Behavioral Health Services
April 2003

West Michigan CMH Co-occurring Disorders Initiative

Appendix B

Quadrant Model

A four-cell table used for identifying diagnostic subtypes of co-occurring disorder. The identification of subtypes is helpful for determining what service specializations need to be involved and when, and what level of care is appropriate.

- Quadrant IV: High Psych / High Substance
  a) Individuals with serious and persistent mental illness, who also have alcoholism and/or drug addiction, and who need treatment for addiction, for mental illness, or for both. This may include sober individuals who may benefit from psychiatric treatment in a setting that also provides sobriety support programs.

  b) Individuals with severe acute psychiatric disturbance (non-SPMI) and substance dependence.

- Quadrant III : Low-Moderate Psych / High Substance
  Individuals with alcoholism and/or drug addiction who have significant psychiatric symptomatology and /or disability but who do not have serious and persistent mental illness. Includes both substance-induced psychiatric disorders and substance-exacerbated psychiatric disorders.

- Quadrant II: High Psych /Low-Moderate Substance
  Individuals with serious and persistent mental illness (e.g. Schizophrenia, Major Affective Disorders with Psychosis, Serious PTSD) which is complicated by substance abuse, whether or not the patient sees substances as a problem.

- Quadrant I: Low-Moderate Psych / Low-Moderate Substance
  Individuals who usually present in outpatient setting with various combinations of psychiatric symptoms (e.g. anxiety, depression, family conflict) and patterns of substance misuse and abuse, but not clear-cut substance dependence.

CMH Responsibility	SA Treatment Responsibility
Quadrant IV: High Psych / High Substance	Quadrant III: Low-Moderate Psych / High Substance
Quadrant II: High Psych /Low-Moderate Substance	Quadrant I: Low-Moderate Psych / Low-Moderate Substance

Appendix 2-2-10C

West Michigan CMH Co-occurring Disorders Initiative

Clinical Training and Competency Guidelines for Co-occurring Mental Health and Substance Use Disorders

January 2007

Clinical Training and Competency Guidelines

Preamble: Intended Uses/Purposes

- These guidelines are intended for use by trainers, clinical supervisors and program administrators to support the planning and development of training for clinical staff expected to work with persons who have co-occurring mental health and substance use disorders[1].

- This document identifies nine areas of clinical competency applicable to "Dual Diagnosis Capable" programs[2] depending upon the program's existing scope of practice or area of service specialization. The focus is on respectful and welcoming practice, safety and clinical evaluation, client[3] engagement and motivation, treatment/rehabilitation[4] planning, accommodation within existing program constraints and parameters, and coordination of care.

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[1] Co-occurring disorders refers to the presence of both mental health and substance use issues concurrently, although this does not necessarily mean that both have to be currently active. Problems may be identified as co-occurring even if one is seen as having been active in the past only. This would provide a marker of risk for re-activation. The term "disorder", as it is used in this document, is intended as a generalized reference to any problem associated with either mental health or substance use deemed serious enough to warrant attention or intervention by a helping professional, whether a diagnosis or other formal clinical designation has been established or not. The terms "disorder" or "problem" may thus be understood as referring to issues identified in a clinical evaluation process so that they may be addressed in subsequent treatment/rehabilitation planning.

[2] Dual Diagnosis Capable (DDC) programs are modified to address the needs of persons with moderate levels of co-occurring disorder. Basic modifications for all programs would include welcoming policy and practices, and universal screening and assessment. Depending on the range of services that are part of the normal scope of practice for a given program, modifications may also include integrated treatment/rehabilitation planning, supportive psychopharmacology policies, augmented program content, and inter-program coordination of care efforts. A program would be considered DDC to the extent that it addresses the needs of these persons within the context of, and employs modifications that fit with, its normal range of services functions.

[4] In the interdisciplinary context of the Co-occurring Disorders Initiative, the terms "rehabilitation" and "treatment" tend to have varied and overlapping meanings and are used differently among the various participating agencies and programs. The range of services addressed by these Clinical Training and Competency Guidelines also would include both treatment and rehabilitation where they are viewed as distinct. In order to accommodate the preferred language of various programs, the terms are presented here as interchangeable (treatment/rehabilitation). It should also be noted that agencies/programs may refer to their clinical service plans as treatment plans, rehabilitation plan or service plans.

- Dual Diagnosis Capability (DDC) is a system level objective. As such, these guidelines identify a range of competencies that should be generally available across the service system. All competencies need not apply to all programs or all clinicians within all programs. The long-term goal is that eventually every program within the broader addictions and mental health service system will be able to offer services that support DDC standards. Within such a system, however, programs will vary in terms of specialization and scope of practice. Although all programs within the broader system of care should eventually be welcoming, for instance, not every program will necessarily offer the range of clinical services described in the Clinical Training and Competency Guidelines. Programs are expected to use the guidelines selectively where they are applicable to their defined scope of practice or specialized niche within the larger system of services. *Appendix A, Clinical Training Guidelines Application Levels*, provides a tool to assist programs in their selection of applications appropriate for them.

- The guidelines are intended to be supplementary to other clinical competency guidelines that address areas of clinical practice particular to either mental health or addiction treatment/rehabilitation, or basic professional and ethical responsibilities. While the guidelines include competencies related to client engagement and incremental change strategies, they do not categorically address counseling and treatment/rehabilitation methods used in mental health and addiction, including pharmacological /medical/psychiatric intervention. Neither do they include ethical or legal competencies that are assumed as part of existing clinical standards for mental health and addiction service providers.

- These guidelines are intended to provide direction for long-term planning related to the development of dual diagnosis clinical competencies and training requirements at program, agency and system levels. They are not tied to any specific implementation schedule or timelines. They are also not intended for use as performance standards in program evaluation or staff appraisal.

- The descriptive attitude, value, knowledge and skill statements for each of the competencies listed below are intended as examples of a range of applicable competencies and should not be viewed as an exhaustive or comprehensive list.

West Michigan CMH Co-occurring Disorders Initiative
Clinical Training and Competency Guidelines*

1. Welcoming, Empathic and Hopeful Stance

Demonstrate a welcoming, empathic, and hopeful attitude in the provision of services to individuals with co-occurring disorders.

2. COD Population Needs and Barriers

Demonstrate a working knowledge of the needs and concerns of individuals with co-occurring disorders as a special population.

3. Mental Health and Addiction Clinical Knowledge and Best Practices

Demonstrate basic knowledge of etiology for mental health and substance use disorders and best practices in treatment/rehabilitation for co-occurring disorders.

4. Change and Recovery Models

Demonstrate an understanding of change and recovery models use in the treatment/rehabilitation of mental health and substance use disorders.

5. Crisis Response

Demonstrate practical knowledge on a range of crisis prevention, intervention, and resolution approaches.

6. Screening and Assessment

Demonstrate ability to complete basic screening for co-occurring disorders and an integrated, longitudinal, strength-based assessment.

7. Integrated Treatment/Rehabilitation Plans

Demonstrate the ability to design, implement and ensure highly individualized, integrated treatment / rehabilitation, discharge and continuing care plans.

8. Coordination of Services

Demonstrate knowledge and skills to facilitate the client's experience of integrated, continuous and coordinated service.

9. Facilitation of Recovery

Demonstrate ability to facilitate client learning and recovery.

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* Programs are expected to use these guidelines selectively where they are applicable to their defined scope of practice or specialized niche within the larger system of services.

West Michigan CMH Co-occurring Mental Health and Substance Use Disorders Initiative
January 2007

Detail Description of Clinical Training Guidelines

Each of these training guidelines is elaborated below in terms of descriptive statements organized under two categories: attitudes and values; and, knowledge and skill.

1. **Demonstrate a welcoming, empathic and hopeful attitude in the provision of services to persons with co-occurring disorders.**

   Attitude/Value

   - Belief that it is important to welcome individuals with co-occurring disorders into helping services regardless of the severity or acuity of their disorders.
   - Belief that both addictive and mental health disorders are equally valid and significant, and that treatment/rehabilitation of both disorders is equally important.
   - Belief that recovery is possible for anyone with a co-occurring disorder, and a hopeful vision of recovery is important established at the outset.

- The opportunity to access help or continue in a helping relationship be available regardless of the individual's level of motivation, cooperation or compliance.
- Individuals with co-occurring disorders are seen as people with significant strengths and capacities.
- A strong desire to understand and respect the individual's point of view as well as their definition of needs and success.
- Appreciates and respects the pace of change set by the individual and is comfortable with lapses and stage recycling.
- Belief that families and friends can be valuable collaborators in treatment/rehabilitation and are approached with the same welcoming attitudes with which one approaches the individual is important.

Knowledge/ Skill

- The ability to engage individuals with co-occurring disorders in a welcoming, hopeful, empathic, and accepting manner.

2. Demonstrate a working knowledge of the needs and concerns of persons with co-occurring disorders as a special population.

Attitude/Value

- Appreciates the diversity of backgrounds, circumstances, capacities and strengths among individuals with co-occurring disorders.

Knowledge/Skills

- Understands the complexity and interconnectedness of issues (social, emotional, physical, and/or spiritual) facing individuals with co-occurring disorders.
- Familiarity with epidemiological data on the prevalence of co-occurring disorders.
- Understanding of service system issues related to the treatment/rehabilitation of individuals with co-occurring disorders, and of barriers to service integration.
- Familiarity with evidence supporting the effectiveness of integrated, continuous treatment/rehabilitation approaches.
- Ability to identify population subtypes according to definitions contained in the Quadrant Model.

3. Demonstrate basic knowledge of etiology for mental health and substance use disorders and best practices in treatment/rehabilitation for co-occurring disorders.

Attitude/Value

- Appreciates the role and value of pharmacological interventions in the treatment/rehabilitation of both mental health and substance use disorders.

Knowledge/ Skill

- Familiarity with diagnostic categories for mental health and substance use disorders, including distinction between substance use, abuse, and dependence.

- Knowledge regarding duration, functionality, and disability associated with mental health and substance disorders, separately and together.
- Familiarity with bio-psycho-social etiology of both disorders, and how each can contribute to the cause and exacerbate the symptoms of the other.
- Familiarity with typical patterns of substance use among individuals with various mental health disorders, effects of substances on symptoms, and the benefits/consequences of use.
- Knowledge of signs and symptoms of intoxication from common substances
- Familiarity with current best practices in treatment/rehabilitation for mental health, substance use and co-occurring disorders.
- Awareness of basic types of medications used for stabilization of mental health disorders.
- Understanding of the need for continuation of prescribed psychotropic medication for individuals with serious and persistent mental health disorders and active substance use disorders
- Awareness of various pharmacological strategies in addiction treatment/rehabilitation, including methadone maintenance.
- Ability to describe and discuss substance withdrawal symptoms and the process of withdrawal, with individuals and families.

4. **Demonstrate an understanding of change and recovery models use in the treatment/rehabilitation of mental health and substance use disorders.**

Attitude/Value

- Appreciates that co-occurring disorders involve long-term processes of recovery and require a flexible approach to matching treatment / rehabilitation modalities to the individual's presenting needs, interests and goals.
- Recognizes the importance of small gains, and that maintaining functional stability alone is valuable, difficult work.
- Accepts that individuals with co-occurring disorders can be addressed using a common language and treatment/rehabilitation philosophy.
- Appreciates that the family's role can be important in the individual's life and that family involvement in the treatment/rehabilitation process may be valuable.

Knowledge/ Skill

- Knowledge of mental health recovery and empowerment models.
- Knowledge of stages of treatment, phases of recovery, and stages of change models.

5. Demonstrate practical knowledge on a range of crisis prevention, intervention, and resolution approaches.

Attitude/Value

- Appreciates that what constitutes a crisis is based on the perceptions of the individual in distress and may often include issues related to housing, employment, or access to other basic requirements.
- Appreciates the primacy of the individual's perception of crisis.

Knowledge/ Skill

- Familiarity with crisis response services (e.g., mobile crisis and crisis stabilization) and ability to utilize community resources to resolve a client's crisis.
- General knowledge of crisis intervention theory.
- General knowledge of the provisions and implications of the Mental Health Code and other relevant statutes as they pertain to responding to mental health crises.
- Knowledge of signs and symptoms that indicate the need for a risk assessment or psychiatric evaluation.
- Knowledge regarding high risk of suicide and violence in individuals with co-occurring disorders.
- Ability to perform a basic suicide risk assessment and act appropriately upon the assessment information.
- Knowledge and skills in the prevention and management of aggressive behaviors.
- Ability to recognize possible medical risk, including severe drug and alcohol intoxication or withdrawal, and arrange appropriate interventions

6. **Demonstrate ability to complete basic screening for co-occurring disorders and an integrated, longitudinal**, **strength-based assessment.**

Attitude/Value

- Recognizes the value of an integrated, longitudinal, strength-based assessment process.
- Recognizes the importance of learning about and emphasizing the individual's view of the problem, their goals and their ideas about what is most likely to work for them.
- Recognizes the potential value of voluntary involvement of family and collaterals in the assessment process.

Knowledge/ Skill

- Familiarity with the components of an integrated, longitudinal, strength-based assessment process.
- Familiarity with screening tools, and ability to use tools to identify the presence of co-occurring disorders.
- Ability to complete stage of change and stage of treatment assessments.
- Familiarity with at least one tool for level of care assessment for co-occurring disorders.
- Ability to solicit collateral input and corroboration from family/natural supports.
- Understands that the assessment of co-occurring disorders is a process that evolves over time.
- Ability to identify risk for mental health destabilization and need for stabilization.
- Ability to identify risk for substance withdrawal and the need for detoxification.
- Ability to identify the Quadrant subtype applicable to various clients.

7. **Demonstrate the ability to design, implement and ensure highly individualized, integrated treatment/rehabilitation, discharge and continuing care plans.**

Attitude/Value

- Appreciates that when mental health disorders and substance use disorders co-exist, both disorders are important to address concurrently with specific treatment/rehabilitation services of appropriate intensity.
- Appreciates that it is more important to emphasize appropriate concurrent responses to each disorder than to focus on the interactions between the disorders.
- Appreciates that there is no one correct program, that interventions should always be matched according to identified client needs, goals and interests and the range of available program options.
- Appreciates that harm reduction and abstinence orientations are both valuable interventions when appropriately matched to client needs and interests.

Knowledge/ Skill

- Knowledge of basic stage-specific strategies for the individuals.
- Ability to develop an integrated treatment/rehab plan for simultaneous, phase-specific treatment of co-occurring disorders, consistent with the acuity, severity, and disability of each disorder.
- Ability to incorporate interventions for one disorder into the setting for treatment of the other disorder.
- Ability to facilitate planning with the individual based upon their strengths, resources, and capabilities and their personal goals, choices, and preferences.
- Ability to use criteria for treatment matching and apply that knowledge to the development of a specific treatment/rehabilitation plan.
- Ability to assist the individual to identify practical ways to achieve their personal goals (including those related to overcoming barriers to change).

8. **Demonstrate knowledge and skills to facilitate client experience of integrated, continuous and coordinated service**.

Attitude/Value

- Appreciates the importance of facilitating the placement of the individual in the least restrictive treatment/rehabilitation environment in which s/he can be successful in recovery.

Knowledge/ Skill

- Awareness of characteristics, capabilities and admission criteria of various programs within the system and how to access them.
- Knowledge regarding peer recovery programs for both addictions (e.g., 12 Step) and mental health, as well as co-occurring disorders (Dual Recovery Anonymous).
- Understanding of the role of specific treatment/rehabilitation interventions in the overall course of dual recovery.
- Knowledge of various support resources in the areas of housing, financial services, and vocational issues.

- Ability to work collaboratively with other service providers to facilitate a continuous integrated treatment/rehabilitation process across stages of treatment and levels of care.
- Ability to provide current and accurate information regarding treatment/rehabilitation options and resources for persons with co-occurring disorders.
- Ability to facilitate appropriate service connections to address the needs of the client that cannot be met by the clinician own program.
- Ability to integrate discussion of treatment/rehabilitation recommendations for two primary disorders within the context of a single treatment relationship.
- Ability to discuss negotiated treatment/rehabilitation goals with family members, and to educate family members about stage specific treatment/rehabilitation strategies.
- Ability to advocate for resources that meet specific individual needs of the client.

9. Demonstrate ability to facilitate client learning and recovery.

Attitude/Value

- Believes that the most important role in helping persons with co-occurring disorders, beyond that of supporting the attainment of physical and mental stability, is to facilitate recovery, self-determination, and functional self-sufficiency.
- Believes that, to the greatest extent possible, persons with co-occurring disorders should be supported in taking responsibility for and control over their personal recovery process.
- Appreciates that within the context of any helping relationship, supportive case management needs to be balanced with empathic detachment.
- Appreciates that individuals need to be encouraged to acknowledge and use their strengths.
- Appreciates the need to support incremental progress, recognizing that success usually requires many small steps.
- Appreciates the importance of supporting individual self-determination, understanding that sustained recovery cannot be attained by external control.
- Appreciates that lapses, relapses or recycling are not failures but opportunities for learning.
- Believes that rigidity should be avoided and flexibility valued, that here is no one “right way” to recover.

Knowledge/ Skill

- Understands adult learning theory and its application to working with co-occurring clients in groups.
- Familiarity with application of Motivational Interviewing and harm reduction strategies to both mental health and substance disorders.
- Knowledge regarding application of behavioral contracting, and contingency learning strategies.
- Ability to engage with the individual in a learning process and facilitate the identification of next-step objectives.
- Familiarity with relapse prevention and social skills training interventions.

- Ability to assist individuals in utilizing peer recovery programs for either or both disorders.
- Understanding of how to modify treatment/rehabilitation approaches for individuals with cognitive and/or learning disabilities.
- Familiarity with principles of trauma recovery and ability to modify treatment/rehabilitation approaches to better meet the needs of individuals with significant post-traumatic stress and/or abuse history.
- Ability to facilitate groups for persons with co-occurring disorders utilizing a blended approach (i.e., addressing both mental health and substance use issues).
- Ability to maintain an appropriate balance of empathic detachment and supportive care in order to promote client self-determination.

APPENDIX A
Clinical Training Guidelines
Application Levels

The Clinical Training and Competency Guidelines identify a range of competencies that should be generally available across the service system. All competencies need not apply to all programs or all clinicians within all programs. The long-term goal is that eventually every program within the broader addictions and mental health service system will be able to offer services that support DDC standards. Within such a system, however, programs will vary in terms of specialization and scope of practice. Although all programs within the broader system of care should eventually be welcoming, for instance, not every program will necessarily offer the range of clinical services described in the Clinical Training and Competency Guidelines. Programs are expected to use the guidelines selectively where they are applicable to their defined scope of practice or specialized niche within the larger system of services. The following Applications Levels and Application Grid are provided as tool to assist programs in their selection of applications appropriate for them.

The following application levels, which are based on common work functions or roles in programs that serve persons with co-occurring disorders, are offered as suggested guidelines for selective application of the Clinical Training Guidelines to specific training situations:

Core Level:

Would apply to everyone within a service setting who has regular contact with individuals regardless of their role (e.g.; reception, peer helpers or counseling).

Basic Service Level:

Would apply to all those who are regularly involved in treatment/rehab intake and support services roles with individuals (e.g., takes intake information, conduct screens, triage, etc.). This level would be subject to internal variation in applicability depending on the type of service each role provides and specific needs particular to the clinical focus (mental health or substance abuse).

Advanced Level:

Would apply to treatment/rehab clinicians who conduct in-depth assessments, develop treatment/rehab plans and provide treatment/rehab services. This level would be subject to internal variation in applicability depending on the type of service each role provides and specific needs particular to the clinical focus (mental health or substance abuse).

Co-occurring Disorders Clinical Training Guidelines Suggested Applications Levels
Common Work Functions and Roles in Programs that Service Persons with COD

Training Guidelines	Core	Basic MH	Basic SA	Advanced MH	Advanced SA
Welcoming, Empathic and Hopeful Stance					
COD Population Needs and Barriers					
Crisis Response					
Screening					
Assessment					
Clinical Knowledge and Best Practice					
Change and Recovery Models					
Integrated Treatment/Rehab Plans					
Facilitation of Recovery					
Coordination of Service					

Core Level: Would apply to everyone within a service setting who has regular contact with individuals regardless of their role (e.g.; reception, peer helpers or counseling).

Service Level: Would apply to all those who are regularly involved in treatment/rehab intake and support services roles with individuals (e.g., takes intake information, conduct screens, triage, etc.). This level would be subject to internal variation in applicability depending on the type of service each role provides and specific needs particular to the clinical focus (mental health or substance abuse).

Advanced level: Would apply to treatment/rehab clinicians who conduct in-depth assessments, develop treatment/rehab plans and provide treatment/rehab services. This level would be subject to internal variation in applicability depending on the type of service each role provides and specific needs particular to the clinical focus (mental health or substance abuse).

WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM

ACT IDDT Program Quarterly Progress Summary

CONSUMER NAME: **CLIENT ID:** 500000

Date Completed: **Completed By:**

Review Number:

Dates Covered: **Thru:**

1. Stage of Change:

Substance Use: **Mental Illness:**

2. Stage of Treatment:

Substance Use: **Mental Illness:**

3. To what degree do current treatment plans, goals, objectives and interventions match the stage of change and treatment for each diagnosis:

Goals and objectives for Mental Illness:

Comments:

Goals and objectives for Substance Use:

Comments:

4. Has there been a change in diagnosis? ☐ **Yes** ☐ **No**

If yes, identify: Diagnosis (DSM IV #) Axis I

Primary:

Secondary:

Tertiary:

5. Was the consumer medication adherent? ☐ **Yes** ☐ **No** ☐ **Partial Adherence**

6. Was Consumer discharged from the team? ☐ **Yes** ☐ **No**

Date:

7. Reason for discharge:

Other:

8. Number of sober days in review period (90 day

9. Longest continuous period of sobriety in review period (90 day

10. Psychiatric Hospitalization? ☐ **Yes** ☐ **No**

Number of admissions: **Number of days**

Date of Admission: **Thru:**

Was admission related to substance use? ☐ **Yes** ☐ **No**

Was admission related to non-adherence with medication? ☐ **Yes** ☐ **No**

Reason for admission:

11. Inpatient AOD treatment to include detox and residential? ☐ **Yes** ☐ **No**

Number of admissions: **Number of days**

Date of Admission: **Thru:**

CONSUMER NAME: **CLIENT ID:** 500000

Was admission related to mental illness? ☐ Yes ☐ No

Was admission related to non-adherence with medication? ☐ Yes ☐ No

12. Incarcerations? ☐ Yes ☐ No

Number of incarcerations: Number of days

Date of incarceration: Thru:

Was it for a new charge? ☐ Yes ☐ No

Was it for violation of probation/parole? ☐ Yes ☐ No

Was admission related to substance use? ☐ Yes ☐ No

Was admission related to non-adherence with medication? ☐ Yes ☐ No

13. Current Legal Status:

Comments:

14. Housing

How many times has the consumer moved in review period?:

Has this person been evicted as a result of substance use? ☐ Yes ☐ No

Has this person been evicted as a result of mental illness? ☐ Yes ☐ No

How many days was the person homeless?:

Living situation at end of review period:

Other:

15. Employment: How many days was the person employed in either competitive or non-competitive employment

16. Is the consumer involved with WMCMHS supported employment?: ☐ Yes ☐ No

17. Is consumer involved with Michigan Rehab Services?: ☐ Yes ☐ No

18. What is the most important life goal for the consumer at this time?:

19. Identify the overall largest accomplishment experienced by the consumer during the review period:

If other, specify:

20. Is consumer a treatment non-responder?: ☐ Yes ☐ No

21. Does the team feel stuck?: ☐ Yes ☐ No

22. If yes to either of the above, what strategies will be employed to intervene?:

23. Identify any changes in treatment strategies?:

24. Participants in case consultation:

West Michigan CMH Co-occurring Disorders Initiative

Appendix 2-2-10E

Matching Stages of Change and Treatment – Treatment Goal, Intervention and Technique

<table>
<tr><th>STAGES OF CHANGE/TREATMENT</th><th>TX GOALS</th><th>TYPES OF INTERVENTIONS, TECHNIQUES AND PRINCIPLES</th></tr>
<tr><td rowspan="2">Stage of change:
Pre-contemplation

Stage of treatment:
Pre-engagement / engagement

Individual's Conflict:
I don't see how my substance use warrants concern.</td><td>• Establish working alliance

• Increase awareness of the impact of substance use on the client's life.

• Create doubt about the commonly held belief that substance abuse is "harmless."

• Lead to conviction that substance abuse is having, or will in the future have, significant negative results.</td><td rowspan="2">• Interventions
1. Outreach/relationship building
2. Crisis intervention
3. Interventions to address needs related to: safety/dangerousness, food, clothing, shelter, medical needs
4. Assessments: CRS, Longitudinal, Contextual/Functional Interview, Functional Analysis Summary & SATS
5. Motivational Counseling
6. Educate and support services to collaterals/significant others to enhance their skills in supporting client commitment to change.
7. Self Help
• Strategies used during the pre-contemplation stage
1. Establish rapport, and build trust OARS
2. Agree on direction and ask permission to address the topic of change
3. Explore the meaning of the events that brought the client to treatment or the results of previous treatments
4. Obtain the individual's perceptions of the problem
5. Elicit, listen to, and acknowledge the aspects of substance abuse
6. Elicit description of a typical day</td></tr>
<tr><td>PRINCIPLES</td></tr>
</table>

	• Establish and maintain rapport • Express empathy • Develop discrepancy • Avoid argumentation • Roll with resistance • Support self-efficacy • The individual is responsible for change	7. Provide constructive feedback about the risks and benefits associated with their own substance use/abuse for each substance **Longitudinal Assessment, Functional Assessment** 8. Offer factual information about the risks of substance use 9. Create doubt and evoke concern about substance use **Payoff Matrix** 10. Provide personalized feedback about assessment findings **CSRS, Longitudinal, Functional** 11. Assess readiness to change – **SATS, Importance Ruler** 12. Examine discrepancies between the individual's and others' perceptions of the problem behavior 13. Express concern and keep the door open 14. Support the individual's resolve to change the negative behavior pattern 15. Identifying the individuals concrete and emotional obstacles to change 16. Identify the individual's social and individual coping resources that lead to a substance-free lifestyle 17. Positively describe the steps used by the collaterals/SO that have been successful 18. Reinforce positive comments made by the collaterals/SO re: the individual's current change efforts 19. Discuss future ways the individual might benefit from the collaterals/SO efforts to facilitate change

West Michigan CMH Co-occurring Disorders Initiative

STAGES OF CHANGE & TREATMENT	TX GOALS	TYPES OF INTERVENTIONS, STRATEGIES AND PRINCIPLES
Stage of change: <u>Contemplation</u> **<u>Stage of treatment: Early Persuasion</u>** **The Individual's Conflict:** I can picture how quitting substance use would improve my self-esteem but I can't imagine never shooting up again.	• Create ambivalence regarding the need to continue as is or to change. (The ultimate purpose is to help clients recognize and weigh the negative aspects of substance use so that the scale tips toward beneficial behavior.) • Acknowledge the extrinsic motivators pushing the individual to change or that brought him/her to treatment. • Help the individual discover intrinsic motivators, which typically move the individual from contemplating change to acting. Intrinsic motivation often begins when individuals recognize the discrepancies between where they are" and "where they want to be." PRINCIPLES • Maintain rapport • Express empathy • Develop discrepancy • Avoid argumentation • Roll with Resistance • Support Self-Efficacy • The individual is responsible for change	• Assessment and Interventions 1. Outreach/relationship building 2. Crisis intervention, interventions to address immediate needs related to: 1) safety/dangerousness, 2) food, 3) clothing, 4) shelter and 5) medical needs 3. Assessment: Functional Analysis, SATS 4. Motivational counseling 5. Educate and support services to collaterals/significant others to enhance their sills in supporting the individual commitment to change 6. Practical skills training, e.g., self help • Strategies used during the Contemplation Stage 1. Develop Discrepancy – This strategy is provided to help individuals consider the plus and minus aspects of their substance to: a) Accentuate costs of the individual's substance use, b) Lessen, when possible, the perceived rewards of substance use, c) Make the benefits of change apparent & d) Identify and attenuate, if possible, potential obstacles to change use **<u>Rating items in Payoff Matrix, Functional Analysis, Values Cards</u>**. 2. Identify triggers, and identify confident situations. 3. Focus on self-efficacy. **<u>Review past and present successes</u>**. 4. Assess readiness to change. **<u>Readiness to Change Measure</u>**. 5. Provide feedback on assessments (again) 6. Ask permission to give information and advice 7. Address perceived and realistic consequences of losing way of living and grief reactions/process 8. Emphasize Personal Choice and Responsibility 9. Goal setting **<u>Values Cards, Hypothetical Change, Looking forward</u>** 10. Reflective listening, asking open-ended questions to help the individual identify intrinsic motivators. For individuals who were coerced into entering TX, identify and strengthen intrinsic motivation so that change can come from within, rather than from external threats. **<u>Values Cards, Goal Setting, Hypothetical Change</u>** 11. Reframing an individual's negative statement about perceived coercion by re-expressing the statements w/positive spin. 12. Elicit and summarize self-motivational statements **<u>Envisioning</u>**

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Stage of change: Preparation **Stage of treatment: Late persuasion** **The Individual's Conflict:** I am feeling good about setting a quit date, but I am wondering if I have the courage to follow through.	• Strengthen the individual's commitment to change make a firm decision to change • Help the individual develop self-efficacy, e.g., the individual shows optimism that he/she can take action to change substance use behavior. • Identify potential change strategies and choose the most appropriate one for their circumstances. • Formulate steps to reach goals PRINCIPLES • Maintain rapport • Express empathy • Develop discrepancy • Avoid argumentation • Roll with resistance • Support self-efficacy • The individual is responsible for change	1. Interventions 1. Crisis interventions 2. Assessment and assessment feedback, Critical Assessment tool, Functional Analysis, SATS 3. Goal-setting: this is the exploring and envisioning activities characteristic of the early and middle preparation stage. The process of talking about & setting goals strengthens commitment to change 4. Motivational counseling 5. Educate, support services to collaterals/family/peers/significant others to enhance skills in supporting client commitment to change 6. Practical skills training related to goal setting and self-efficacy 7. Persuasion group 8. Self help • Strategies used during the preparation stage 1. Reinforce self-efficacy/enhance confidence 2. Clarify the individual's own goals and strategies for change, **Change Plan Worksheet** 3. Discuss the range of different treatment options and community resources available to meet the individual's multiple needs 4. With permission, offer expertise and advise 5. Identify & lower barriers to change by anticipating possible family, health, system problems, e.g., finances, child care, work, transportation or other potential barriers problems 6. Help the individual enlist social support (e.g., mentoring groups, churches, recreational centers) 7. Help the individual engage in meaningful or pleasurable non substance related activities 8. Educate about treatment, their role in treatment and their expectations 9. Elicit from the individual what has worked in the past either for him or others whom he knows 10. Have individual's publicly announce their change plans to significant others in their lives 11. Identify specific, measurable changes that signal the individual is ready to change. The individual's recognition of important discrepancies in their lives is too uncomfortable a state to remain in for long, and unless change has begun, they can retreat to using defenses such as minimizing or denying to decrease the discomfort. 12. Create sober rituals

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Stage of change: Action **Stage of treatment: Early treatment / late treatment** **The Individual's Conflict:** Staying clean for the past few weeks really makes me feel good, but part of me wants to celebrate by getting loaded.	• Carry out change strategies. • Provide support and encouragement to maintain gains achieved • Reduce ambivalence in transitions from thought to action. PRINCIPLES	TREATMENT • Interventions 1. Crisis interventions 2. Motivational counseling 3. Educate, support services to collaterals/family/peers/significant others to enhance skills in supporting client commitment to change 4. Practical skills training related to goal setting and self-efficacy 5. Persuasion group 6. Self help 7. Medication therapy 8. Family problems solving 9. Cognitive behavioral skills training/counselor • Strategies used during action stage 1. Encourage and reinforce previous accomplishments 2. Further investigate and resolve barriers to treatment

	• Maintain rapport • Express empathy • Develop Discrepancy • Avoid argumentation • Roll with Resistance • Support Self-Efficacy • The Individual is responsible for change	3. Continue to educate individuals into their role in the treatment process 4. Explore what the individual expect from treatment and determine discrepancies 5. Prepare individuals so that they know there may be some embarrassing, emotionally awkward, and uncomfortable moments but that such moments are a normal part of the recovery process 6. Increase congruence between intrinsic and extrinsic motivation 7. Examine noncompliant behavior in the context of ambivalence or dissatisfaction with treatment 8. Reach out to demonstrate continuing personal concern and interest to encourage clients to remain in the program 9. Help individuals to recognize stressful situations **Stress management** 10. Engage individuals in treatment and reinforce the importance of remaining in recovery 11. Track positive changes 12. Generate ideas for self-rewards 13. Support a realistic view of change through small steps 14. Acknowledge difficulties for individuals in early stages of change 15. Help the individual identify high-risk situations and develop appropriate coping strategies **revisit functional analyses, refusal skills** 16. Assist the individual in finding new reinforcers of positive change

STAGES OF CHANGE & TREATMENT	**TX GOALS**	**TYPES OF INTERVENTIONS, STRATEGIES AND PRINCIPLES**
Stage of change: Maintenance **Stage of treatment: Relapse prevention** **The Individual's Conflict:** These recent months of abstinence have made me feel that I'm progressing	Reinforce new skills that help maintain recovery and a healthy lifestyle PRINCIPLES	• Interventions 1. Crisis Interventions 2. Continued goal-setting 3. Motivational counseling 4. Continue educate and support services to collaterals/family/peers/significant others 5. Practical skills training related to goal setting and self-efficacy 6. Persuasion group 7. Self help 8. Medication therapy 9. Family problem solving 10. Cognitive behavioral skills training/counselor 11. Services to expand recovery to other areas

toward recovery, but I'm still wondering whether abstinence is really necessary.	• Maintain rapport • Express empathy • Develop discrepancy • Avoid argumentation • Roll with resistance • Support self-efficacy • The individual is responsible for change	12. Develop relapse prevention plan, continuing skill training • Strategies used during maintenance stage 1. Clinicians can help this change process by using competing reinforcers. (A competing reinforcer is anything the individual enjoys that is or can become a healthy alternative to drugs or alcohol as a source of satisfaction. 2. Help the individual identify and sample substance-free sources of pleasure – i.e., new reinforcers that will win out over substances over time. 3. Support lifestyle changes 4. Affirm the individual's resolve and self-efficacy 5. Help the individual practice and use new coping strategies to avoid a return to substance use 6. Maintain supportive contact 7. Identify risky situations **Relapse prevention plan** 8. Find their sources of support 9. Review and document progress
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Stage of change: Reoccurrence **Stage of treatment: Relapse prevention**	Get help to recover as quickly as possible and reenter the change process.	Review relapse prevention plan, continuing skills training, expanding recovery to other areas. Help climbing interchange cycle and commend commitment towards positive change, explore experience and view as learning opportunity, assist in development of alternative coping strategies, maintain support of contact.