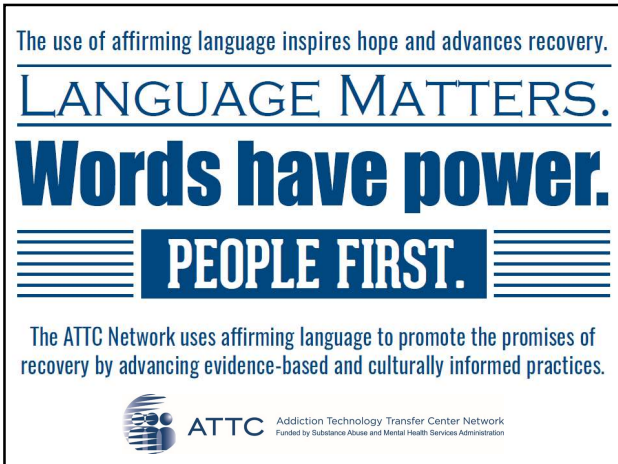
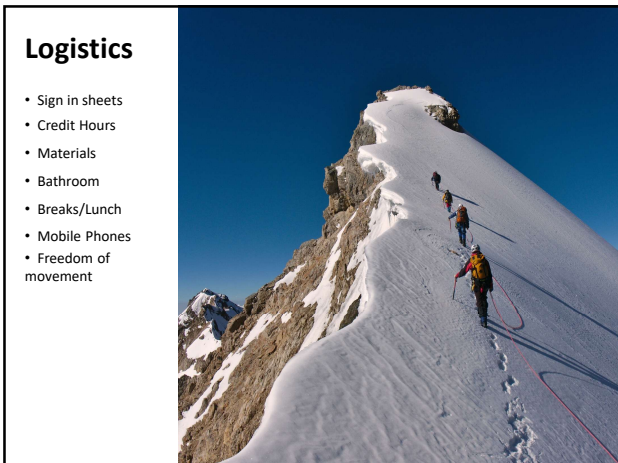


1



2



3



Introductions

- Your Name, Agency, Position
- Hopes for this training

4

Course Objectives

1. Familiarize participants with the prevalence of co-occurring mental health and substance use disorders in their treatment population.
2. Examine ways to assess for co-occurring disorders.
3. Work through different treatment planning scenarios for co-occurring disorders.
4. Review evidence-based practices for treating co-occurring disorders.

5

Prevalence of Substance Use in people with mental health disorders

- About one third of adults 18 and older (36%) with any mental health disorders in the past year such as depression, schizophrenia, bipolar, or anxiety disorder, also have a co-occurring substance use disorder (SUD).
- About half (48%) of adults 18 and older with serious mental illness in the past year also have a cooccurring substance use disorder.

• NSDUH, 2022

6

Prevalence of Mental Health in people with Substance Use Disorders

- In 2022 about half (47%) of people with SUD in the past year have also had a co-occurring Mental Health disorder.
- Since we began tracking the prevalence of co-occurring disorders in the 1980's, studies have constantly shown that between 50% and 70% of substance abusers also have a co-occurring mental health disorder.

• NSDUH, 2022

7

Why Are Co-Occurring Disorders so Common

Three Competing Hypotheses

- Self Medication
 - It is not necessary that the drug actually yields the desired effect, but only that the person believes it does.
- Super sensitivity to Alcohol and Drugs
- Common Factors

Miller, Forchimes & Zweben, 2019

8

Mental Health Disorders Most Often Associated with Co-Occurring SUD

Schizophrenia, Schizoaffective (nearly 55%)	Major Depression (58%)	Bipolar (65%)
Posttraumatic Stress Disorder (26-52%)	Anxiety Disorders (37%)	Developmental Disorders • ADHD (23%)
Personality Disorders (35-65%) • BPD (50-60%)		

TIP 42, 2020

9

The Complex, Unstable, and Bidirectional Nature of COD's

- The problem in trying to figure out what came first, SUD or MH.
- COD's are usually Bi-Directional
- Other factors (E.g. Chronic Pain, HIV...) can influence SUD and MH.

10



11

Biopsychosocial Sources of Information in the Assessment of COD's		
Topic Area	SUD Areas of Assessment	Mental Health Disorder Areas of Assessment
Biological	<ul style="list-style-type: none"> • Alcohol on Breath • Positive Urine Tests • Withdrawal Symptoms • Injuries and Trauma • Medical Signs and Symptoms of Toxicity and Withdrawal 	<ul style="list-style-type: none"> • Abnormal laboratory test (e.g. MRI) • Neurological exams • Use of Psychiatric medications

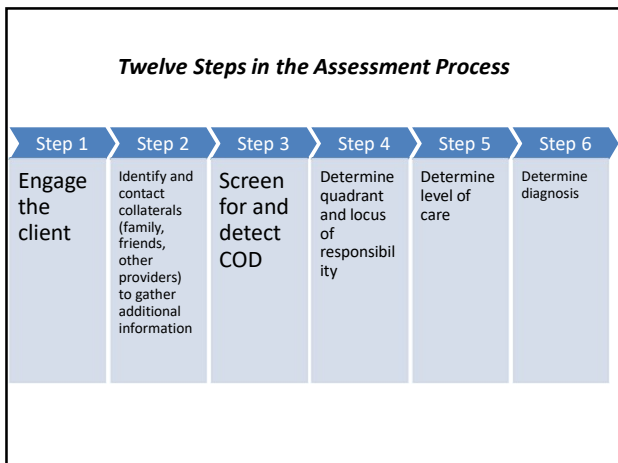
12

Biopsychosocial Sources of Information in the Assessment of COD's		
Topic Area	SUD Areas of Assessment	Mental Health Disorder Areas of Assessment
Psychological	<ul style="list-style-type: none"> • Intoxicated Behavior • Functional Impairment • Responses to SUD assessments • Document substance misuse history • History of Trauma 	<ul style="list-style-type: none"> • Mental Health Status Exam Results • Responses to mental health disorder/symptom screenings • History or Current dx of and tx f MI • Stress and situational factors • Self Image and Personality • History of Trauma

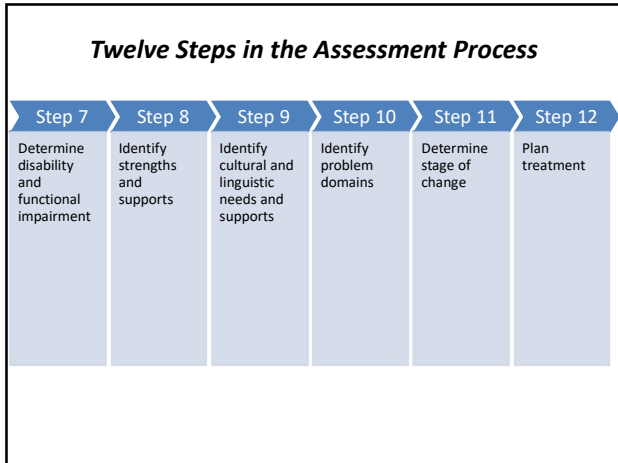
13

Biopsychosocial Sources of Information in the Assessment of COD's		
Topic Area	SUD Areas of Assessment	Mental Health Disorder Areas of Assessment
Social	<ul style="list-style-type: none"> • Collateral Information from others • Social interactions • Family Hx of SUD • Supports • Housing, education and job hx • Military hx • Ethnic and Cultural Info • Legal hx 	<ul style="list-style-type: none"> • Collateral Information from others • Social interactions • Family Hx of MH • Supports • Housing, education and job hx • Military hx • Ethnic and Cultural Info • Legal hx

14



15



16

Twelve Steps in the Assessment Process

▼

Step 1: Engage the client

- Universal Access (“No Wrong Door”)
- Empathic Detachment
- Person-Centered Assessment
- Cultural Sensitivity
- Trauma Informed Services

17

Twelve Steps in the Assessment Process

▼

- **Step 2: Identify and contact collaterals (family, friends, other providers) to gather additional information**
 - Follow CFR 42 Part 2 and get permission from the client
 - Info is valuable to working with Co-Occurring clients to verify their report and gather anything they may not be able to recall

18

Twelve Steps in the Assessment Process

Step 3: Screen for and detect COD

- SUD Providers screen all new clients for co-occurring Mental Health Disorders
- MH Providers screen all new clients for substance misuse

19

Screening Tools

- Mental Health Screening Form III
- Revised Health Screening Survey (RHSS)
- 2 Michigan Alcohol Screening Test (MAST)
- 3 CAGE
- 4 MAST, CAGE
- 5 History of Trauma Scale, MAST, CAGE
- 6 MAST, Drug Abuse Screening Test (DAST)
- 7 MAST, Problem Oriented Screening Instrument for Teenagers (POSIT)
- 8 MAST, DAST
- 9 MAST, DSMIIIR
- 10 POSIT, DSMIIIR
- 11 POSIT
- 12 POSIT
- 13 MAST, POSIT, CAGE, RHSS, Alcohol Use Disorders Identification Test (AUDIT), Addiction Severity Index (ASI)

20

Risk of Harm:

- **This dimension of the assessment considers a person’s potential to cause significant harm to self or others.**
- **While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases it can also be caused by:**
 - misinterpretations of reality
 - inability to care adequately for oneself
 - altered states of consciousness due to use of intoxicating substances.

21

Risk of Harm:

For the purpose of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself.

22

Risk of Harm:

In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as:

- past history of dangerous behaviors
- ability to contract for safety
- availability of means.

When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.

23

Minimal risk of harm:

- No indication of suicidal or homicidal thoughts or impulses, no history of suicidal or homicidal ideation, and no indication of significant distress.
- Clear ability to care for self now and in the past.

24

Low risk of harm:

- No current suicidal or homicidal ideation, plan, intentions or serious distress, but may have had transient or passive thoughts recently or in the past.
- Substance use without significant episodes of potentially harmful behaviors.
- Periods in the past of self-neglect without current evidence of such behavior.

25

Moderate risk of harm: (Part 1)

- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent significant change from baseline.

26

Moderate risk of harm: (Part 2)

- Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
- Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

27

Serious risk of harm (Part 1):

- Serious risk of harm: Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.

28

Serious risk of harm (Part 2):

- Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
- Clear compromise of ability to care adequately for oneself or to be aware adequately of environment.

29

Extreme risk of harm: (Part 1)

Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior without expressed ambivalence or significant barriers to doing so; or with a history of serious past attempts which are not of a chronic, impulsive, or consistent nature; or in presence of command hallucinations or delusions which threaten to override usual impulse control.

Source: AACP 2000a.

30

Extreme risk of harm: (Part 1)

- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- Extreme compromise of ability to care for oneself or inability to adequately monitor the environment with evidence of deterioration in physical condition or injury related to these deficits.

Source: AACP 2000a.

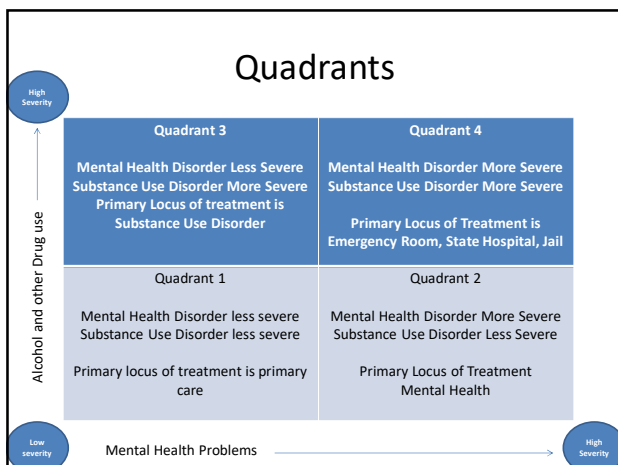
31

Twelve Steps in the Assessment Process

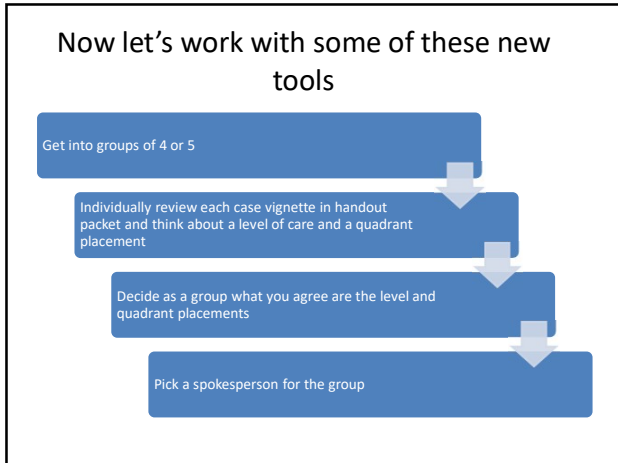
Step 4: Determine quadrant and locus of responsibility

32

Quadrants



33



34

Twelve Steps in the Assessment Process

Step 5: Determine level of care

– Which Placement Criteria: ASAM or LOCUS

- LOCUS is known to be a superior tool for Co-Occurring Placement

35

LOCUS

- LOCUS is simpler to use than ASAM PPC2R.
- It has a point system for each dimension that permits aggregate scoring to suggest level of service intensity.
- LOCUS also permits level of care assessment for individuals with mental disorders or substance use disorders only, as well as for those with COD. Some pilot studies of LOCUS have supported its validity and reliability.
- However, compared to ASAM PC2R, LOCUS is much less sensitive to the needs of individuals with substance use disorders.

36

LOCUS

- The LOCUS Adult Version (Sowers, 2016) can be used as a systemwide level of care assessment instrument for either mental health settings only, or for both mental health and substance abuse treatment settings.

37

LOCUS

- Like the ASAM, LOCUS uses multiple dimensions of assessment:
 - Risk of Harm
 - Functionality
 - Comorbidity (Medical, Addictive, Psychiatric)
 - Recovery Support and Stress
 - Treatment and recovery history
 - Engagement and recovery status

38

ASAM

- The ASAM PPC3R (ASAM 2013) evaluates level of care requirements for individuals with COD. Dimension 3 encompasses “Emotional, Behavioral or Cognitive Conditions and Complications.”

39

ASAM

- ▼ Five areas of risk must be considered related to this dimension
 - Suicide potential and level of lethality
 - Interference with addiction recovery efforts (“The degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and conversely, the degree to which a patient is able to focus on addiction recovery”)
 - Social functioning
 - Ability for self-care
 - Course of illness (a prediction of the patient’s likely response to treatment)

40

ASAM

Consideration of these dimensions permits the client to be placed in a particular level on a continuum of services ranging from intensive case management for individuals with serious mental disorders who are not motivated to change (Level I.5) to psychiatric inpatient care (Level IV).

41

- ▼ In addition, there is the capacity to distinguish, at each level of care, individuals with lower severity of mental symptoms or impairments that require standard or Dual Diagnosis Capable programming at that level of care,

compared to: individuals with moderately severe symptoms or impairments that require Dual Diagnosis Enhanced programming.

42

ASAM

The ASAM PPC have:

- undergone limited validity testing in previous version
- are used to guide addiction treatment matching in more than half the States
- are influential in almost all of the rest.

43

Twelve Steps in the Assessment Process

Step 6: Determine Diagnosis

44

The Importance of Client History

- diagnosis is established more by history than by current symptoms presentation
 - First step is to determine whether there is a prior diagnosis
 - if unable to obtain from client ask collaterals
 - Addictions counselors may not be able to diagnose, however they can and should document prior diagnosis.

45

Create a Chronology of Mental Health and SUD Symptoms

- Make sure to connect symptoms to periods that are helpful for the diagnostic process
 - before onset of substance use disorder
 - during periods of abstinence or very limited use
 - after onset of Sud and persisting for more than 30 days.

46

Create a Chronology of Mental Health and SUD Symptoms

- If a standardized tool such as the MINI Plus is not available, you can use the following questions:
 - Did this symptom or episode occur during a period when you were abstinent for at least 30 days?
 - Can you recall a time when you were not using? Did these symptoms occur during that?

47

Drug Effects That Can Mimic Mental Disorders

	Intoxication	Acute Withdrawal	Protracted Withdrawal
Alcohol	Euphoria Mood Lability Disinhibition Slurred Speech	Agitation Anxiety Tremors Insomnia Hallucinations Delirium	Mood instability Hostility Fatigue Low Sexual Interest Sleep Disturbance
Stimulants	Euphoria Impulsivity Grandiosity Paranoia	Depression Fatigue Agitation Sleep Disturbances	Anhedonia Lethargy Dysphoria Anxiety
Hallucinogens	Sensory Dissociation Visual Hallucinations Panic	Anxiety Delirium	Depression Flashbacks

Miller, Forcehimes & Zweben, 2019

48

Drugs Effects That Can Mimic Mental Disorders

	Intoxication	Acute Withdrawal	Protracted Withdrawal
Cannabis	Euphoria Agitation Lethargy Grandiosity (High Doses) Perceptual Distortions	Irritability Depression Anxiety	Irritability Depression Anxiety
Inhalants	Euphoria Slurred Speech Psychomotor retardation	Insomnia Agitation Anxiety	Anxiety Depression Irritability
Sedatives	Euphoria Slurred speech Disinhibition Mood Lability	Mood instability Depression Anxiety Insomnia Hyper activity	Anxiety Depression Perceptual distortions Sleep Disturbances
Opioids	Euphoria Indifference Apathy	Agitation Irritability Anxiety Depression Anhedonia Insomnia Delirium	Anxiety Depression Sleep Disturbance

Miller, Forcehimes & Zweben, 2019

49

Substance Induced Mental Health Disorders

	Alcohol	Stimulants	Hallucinogens	Cannabis
Psychosis	Yes	Yes	Yes	Yes
Bipolar	Yes	Yes	Yes	Yes
Depression	Yes	Yes	Yes	Yes
Anxiety	Yes	Yes	Yes	Yes
Obsessive Compulsive	No Mention	Yes	No Mention	No mention
Sleep	Yes	Yes	Yes	Yes
Sexual	Yes	Yes	No Mention	No Mention
Neurocognitive	Yes	Yes	Yes	Yes

50

Substance Induced Mental Health Disorders

	Sedatives	Inhalants	Opioids
Psychosis	Yes	Yes	No Mention
Bipolar	Yes	Yes	No Mention
Depression	Yes	Yes	Yes
Anxiety	Yes	Yes	Yes
Obsessive Compulsive	No Mention	No Mention	No Mention
Sleep	Yes	Yes	Yes
Sexual	Yes	Yes	Yes
Neurocognitive	Yes	Yes	No Mention

51

Substance Induced Mental Health Disorders

- If these disorders are substance induced you will see symptoms diminish within the first weeks or days of cessation of use. If symptoms last longer than one month the disorder is independent of drug use and requires clinical attention. (DSM 5, 2013)
- All literature states that Co-Occurring Disorders must be treated simultaneously. In other words if depression is present treat it, and if it goes away in a few weeks discontinue that specific treatment.

52

Twelve Steps in the Assessment Process

Step 7: Determine disability and functional impairment

- Are they capable of living independently?
- Are they capable of supporting themselves financially?
- Can they engage in reasonable social relationships?
- What is the client's level of cognitive functioning?

53

Twelve Steps in the Assessment Process

Step 8: Identify strengths and supports

- Talents and interests
- Educational interest
- High levels of motivation to change
- Existing supportive relationships
- Prior successes in treatment
- Identification of current successes

54

▼ **Twelve Steps in the Assessment Process**

Step 9: Identify cultural and linguistic needs and supports

- Problems with literacy
- Not fitting into treatment culture
- Cultural and linguistic service barriers

55

▼ **Twelve Steps in the Assessment Process**

Step 10: Identify problem domains

- Medical
- Legal
- Vocational
- Family
- Social

56

▼ **Twelve Steps in the Assessment Process**

Step 11: Determine stage of change :

- It is key to assess stage of change for both substance use disorder and mental health disorder
- Then, tailor interventions based on stage of change for each disorder

57

Twelve Steps in the Assessment Process

Step 12: Plan treatment

- Integrated treatment planning involves helping the client to make the best possible treatment choices for each disorder
- At the same time, the counselor needs to help the client adjust the recommended treatment strategies for each disorder as needed in order to take into account problems related to the other disorder

58

Assessment Considerations

Engagement:

- What does the client want?
- What is the treatment contract?
- What are the immediate needs?
- What are the DSM-5 diagnoses?
- Multidimensional severity/level of functioning profile:
- Identify which assessment dimensions are most severe to determine treatment priorities.
- Choose a specific priority for each medium/severe dimension.
- What specific services are needed to address these priorities?
- What "dose" or intensity of services is needed?
- Where can these services be provided in the least intensive, but safe, level of care or site of care?
- How will outcomes be measured?
- What is the progress of the treatment plan and placement decision?

Source: Adapted from Mee-Lee 1998

59

Treatment

- For treatment to be effective, mental illness and substance related disorders must be treated simultaneously. Treatment can include individual therapy, group therapy, self help groups, and psychiatric medications. There are both outpatient and residential treatment facilities that treat co -occurring disorders. The "every door is the right door" strategy provides treatment access and outcomes for more people with co-occurring disorders.

TIP 42, 2014

60

A Sample of Evidence Based Practices For Co-Occurring Disorder Treatment

- Assertive Community Treatment
- Intensive Case Management
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy
- Moral Reconation Therapy
- Multi-systemic Family Therapy
- Adolescent Community Reinforcement Approach

SAMHSA, 2014

61

Video Segment:

- *A Less Than Helpful Consultation*
 - Physician asking a patient to stop smoking and drinking

62

Essential Attitudes and Values for Clinicians Who Work With Clients Who Have COD

- Desire and willingness to work with people who have COD
- Appreciation of the complexity of COD
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the limitations of one's own personal knowledge and expertise
- Recognition of the value of client input into treatment goals and receptivity to client feedback
- Patience, perseverance, and therapeutic optimism
- Ability to employ diverse theories, concepts, models, and methods
- Flexibility of approach
- Cultural competence
- Belief that all individuals have strengths and are capable of growth and development (added by consensus panel)
- Recognition of the rights of clients with COD, including the right and need to understand assessment results and the treatment plan

SAMHSA, 2014

63

MI in a Nutshell

SPIRIT
Partnership
Acceptance
Compassion
Evocation

FOUR PROCESSES
Engaging
Focusing
Evoking
Planning

CHANGE TALK
Desire
Ability
Reason
Need
Commitment
Activation
Taking Steps

CORE SKILLS
Open-ended questions
Affirmations
Reflections
Summaries
Elicit – Provide – Elicit

64

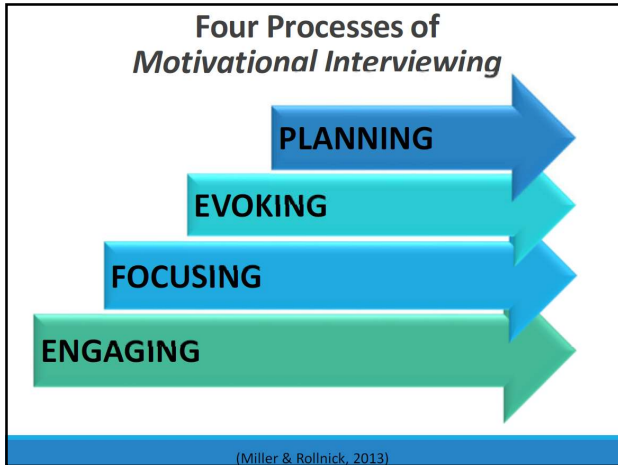
Video Segment:
 ↻ *Motivational Interviewing: Helping People Change*, DVD Set, 2013
 • Interview 1: “The Confirmed Smoker: Engaging & Evoking”

65

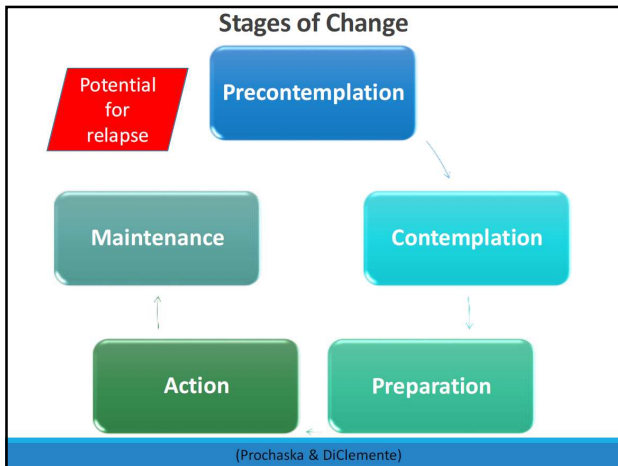
In several evidence-based practices that combine CBT with Motivational Interviewing, there is a focus on engagement; that is, understanding the many facets of the person’s situation, and their motivation for change.

Why might this be an important place to start?

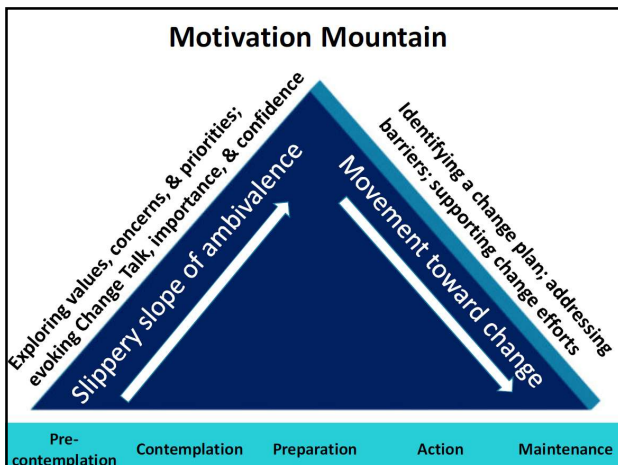
66



67



68



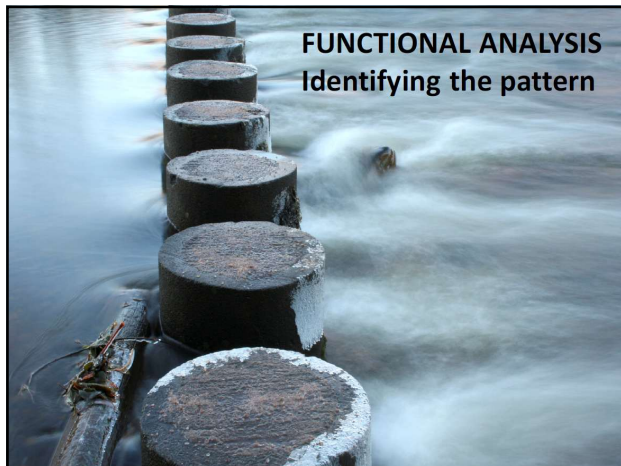
69

Some engagement questions

- What do you hope to get out of treatment?
- Tell me about your previous experience in counseling.
- What concerns you most right now?
- How would you like to change your substance use? Mood? Relationships?
- Importance, Confidence, Readiness Rulers: Scaling questions (See handout)

What are your engagement questions?

70



71

Tips for getting the most out of the FA

- Use a large sheet of paper with plenty of space.
- Have the client do the writing, when possible.
- Use your best MI skills (e.g., reflections, open-ended questions) to clarify understanding.
- Facilitate the FA columns out of order:
 1. Substance-Using Behavior
 2. External Triggers
 3. Positive Consequences
 4. Negative Consequences
 5. Internal Triggers



72

Tips for getting the most out of the FA, cont.

- Often, the Internal Triggers column is the most difficult for individuals. Use what you learned in the Positive Consequences column to prompt people beyond basic answers of boredom and socialization.
- Use the Feelings Wheel.
- Take your time.
- Summarize at the end and ask an evocative question:
 - What jumps out at you when you look at this?
 - What do you notice about your pattern of use?
 - What did you learn about your use?

73

Skills practice: Functional Analysis

Get into groups of 3.

Roles: Client, Counselor, Observers

Practice facilitating the FA.

You have 20 minutes.

Take your time.

74

What strategies worked best in getting the most out of the Functional Analysis?

75



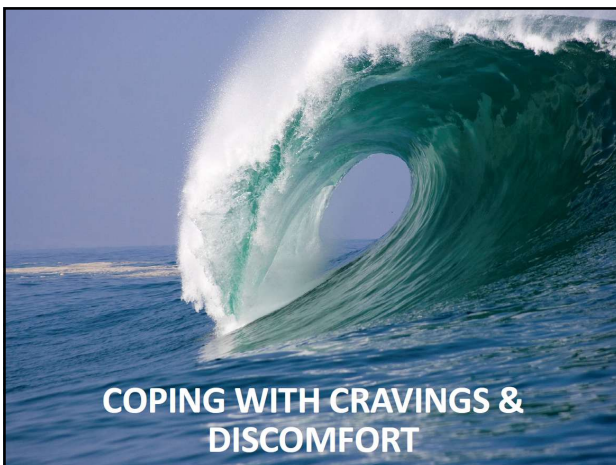
HIGH RISK SITUATIONS
 After the Functional Analysis has been completed, the individual can begin to watch for *High Risk Situations* that occur in their daily lives:

- Recognize
- Avoid
- Cope
- Plan

76

Processing High Risk Situations	Processing High Risk Situations
<p>No use occurred: Individual effectively avoided or coped with triggers; the plan worked; person may feel successful, proud, hopeful</p> <p>Counselor strategies:</p> <ul style="list-style-type: none"> • Affirm the specific skill or action chosen by the individual <ul style="list-style-type: none"> ◦ “You had a craving to smoke, and you went for a walk. You let it pass.” • Relate success to overall goals <ul style="list-style-type: none"> ◦ “You are making progress toward earning trust back.” • Elicit how the skill might be used in other HR situations 	<p>Use occurred: Individual was overwhelmed or surprised by triggers; coping skills didn’t work; person didn’t know what to do; disappointment, discouragement</p> <p>Counselor strategies:</p> <ul style="list-style-type: none"> • Facilitate understanding: <ul style="list-style-type: none"> ◦ “What about the situation made it most tempting to use?” ◦ “What were the pros/cons of using?” ◦ “What skills might have helped?” ◦ “How might this situation be avoided in the future?”

77



COPING WITH CRAVINGS & DISCOMFORT

78

Tools for Coping with Cravings & Discomfort

- Session 6 from SAMHSA's (2014) "Integrated Change Therapy, pp. 108 - 113
 - Urge Surfing on p. 110
 - Learning New Coping Strategies on pp. 112-113
 - Potential homework: Daily Record of Urges to use on p. 111



79

Would the thoughts below increase or decrease a person's craving to use?

- "I'll just have one drink."
- "I can get through this without smoking."
- "I *have to* get high today."
- "I can't imagine living without pills."
- "I've been sober for almost two weeks. My partner is starting to trust me again."

What are other examples?

80

CBT for COD Session Structure utilizing the "Law of Thirds"

First Third	Second Third	Third Third
<ul style="list-style-type: none"> • Agenda-setting • Review of homework • Past week substance use • Review past week High Risk Situations 	<ul style="list-style-type: none"> • Provide rationale for skill to be learned • Practice skill using role plays and relevant examples from the individual's life 	<ul style="list-style-type: none"> • Summarize session content • Anticipate upcoming High Risk Situations • Agree on how the skill will be practiced in real-life situations for homework

81

Advice to the Counselor: Managing Countertransference

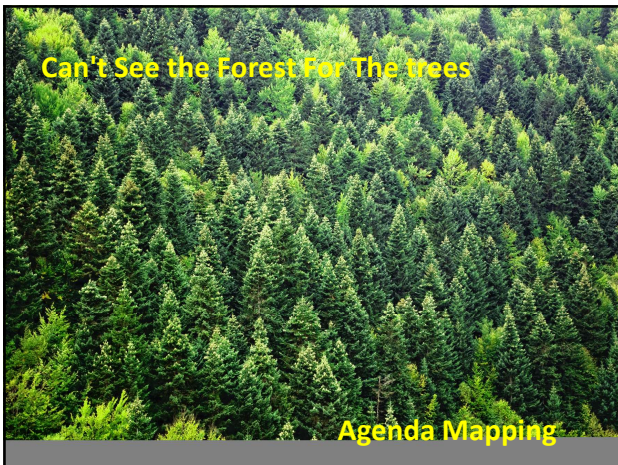
- The consensus panel recommends the following approach for managing countertransference with clients who have COD:
- The clinician should be aware of strong personal reactions and biases toward the client.
- The clinician should obtain further supervision where countertransference is suspected and may be interfering with counseling.
- Clinicians should have formal and periodic clinical supervision to discuss countertransference issues with their supervisors and the opportunity to discuss these issues at clinical team meetings.

82

Advice to the Counselor: Monitoring Psychiatric Symptoms

- The consensus panel recommends the following approaches for monitoring psychiatric symptoms with clients with COD:
- Obtain a mental status examination to evaluate the client's overall mental health and danger profile. Ask questions about the client's symptoms and use of medication and look for signs of the mental disorder regularly.
- Keep track of changes in symptoms.
- Ask the client directly and regularly about the extent of his or her depression and any associated suicidal thoughts.

83



84

Top of the Mountain

- When we live life true to our values it is like being at the top of your mountain
- Most people seeking our services have gotten off route
- It is helpful to know where the top is when we are determining the best route



85

Values Card Sort Exercise

Instructions:

- Get into groups of two: Counselor and Client
- Using Values Card Deck
 - Counselor: Have the client sort the cards into three piles (Very Important, Important and not important)
 - Counselor: Once the client is finished have them go through the Very Important pile and list their three to five most core values
 - Counselor: Elicit from the client the reasons they chose the five Values
- Once you are done, switch roles
- Clients: remember your core values

86

Top of The Mountain Exercise

Instructions

- Find a different partner
 - Get out a Top of the Mountain worksheet
 - Use one of the Core Values identified in the last exercise and place it at the top of the mountain
 - Counselor: Use MI skills to help client develop a list ways to get to the value (Climbing Routes)
 - Counselor: List barriers which stand in the way of getting on the routes (Valley)

87



88
