Introduction to Co-Occurring Disorders Part II:
Skill Building for Integrated Co-Occurring Disorders Services

David Mee-Lee, M.D.
Davis, CA
(530) 753-4300; Mobile: (916) 715-5856
davidmeelee@gmail.com davidmeelee.com
tipsntopics.com instituteforwellness.com

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A. Needs Assessment

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

B. Terminology

- Co-Occurring Mental and Substance-Related Disorders

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

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

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


C. Selected Questions

Select and Circle the Best Answer:

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

2. Reasons for diagnostic confusion in addiction problems and psychiatric disorders are:
   a) Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity).
   b) Prolonged alcohol/drug use can cause short or long-term psychiatric illness.
   c) Alcohol/drug use can escalate in episodes of psychiatric illness.
   d) Addiction illness sometimes co-occurs with mental illness as an independent disorder.
   e) All of the above.
Indicate True or False:

3. A mental health evaluation should not be done until the client is 30 days sober.  
   ( ) ( )

4. If a client is depressed assume Major Depressive Disorder until proved otherwise.  
   ( ) ( )

* (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” pages 79-84)

D. Different Theoretical Perspectives: Different Treatment Methodologies

1. Integrated Treatment versus Parallel or Sequential Treatment
   • hybrid programs - staffing difficulties; numbers of patients and variability, but one-stop treatment
   • parallel programs - use of existing programs and staff, but more difficult to case manage

2. Care versus Confrontation
   • mental health - care, support, understanding, passivity
   • addiction - accountability, behavior change

3. Abstinence-oriented versus Abstinence-mandated
   1. treatment as a process, not an event
   2. respective roles in both approaches

4. Deinstitutionalization versus Recovery and Rehabilitation
   • role of “least restrictive” setting
   • role for individualized treatment with continuum of care

E. Integration Plan for a New Department of Behavioral Health Services

Final Draft Presented to the Board of Supervisors Santa Clara County, January 28, 2014

The Plan adopts a hybrid model of integration based on elements of two behavioral health integration frameworks: the CCISC (Comprehensive Continuous Integrated System of Care) and the EBT (Evidence-Based Treatment) Kit, developed by SAMHSA (Substance Abuse Mental Health Services Administration). The primary approach of both frameworks emphasizes the need to incorporate best practices and evidence-based practices. The CCISC has been implemented in a number of states and its overarching philosophy is endorsed by SAMHSA. The values underlying the CCISC model represent the key principles of integrated treatment.

First Principle - Co-occurring conditions and issues are an expectation, not an exception.
Key Implications
   • Initial assessment includes sufficient data to diagnose and assess both mental and substance use disorders
   •

Second Principle – Clients must receive treatment that emphasizes empathy, hope, integration, and a strength-based approach.
Key Implications
   • The client’s goals for treatment are the central focus that drives the treatment plan.
   • Interfacing with consumers should be in the spirit of hope and expectancy for change
   • Access to treatment is convenient, open and readily available.
   • Opportunity to return to treatment is readily accessible.
   • Staff and systems are skilled to identify client needs and strengths, skills and resources
Third Principle – Treatment for co-occurring disorders must be tailored to the needs of the population.

Key Implications
- Appropriate and continuous supports go beyond acute medical needs and extend to community and family supports. (flexible funding programs) (case management)
- Holistic multidimensional assessment is available to guide matching of services to need.

Fourth Principle – Treatment of both mental illness and substance use disorders should be concurrent.

Key Implications
- Staffing and services should reflect equal emphasis on both disorders in accord with the prevalence of co-occurring disorders in the populations served.
- Treatments are balanced to effectively address both mental health issues and substance use or addiction issues in a client-centered manner.
- Identify gaps in the system in order to determine where resources are needed.

Fifth Principle – Recovery involves moving through stages of change.

Key Implications
- Staff are skilled at assessing stages of change; engaging and attracting clients into treatment and recovery; and facilitating a self-change process.
- Staff competencies in motivational interviewing and strength-based services.
- Services exist to facilitate clients through stages of change. A broader range of “discovery” services is required to balance existing “recovery” services.

Sixth Principle – Progress occurs in an environment in which a client is adequately supported and rewarded for skill-based learning for each condition.

Key Implications
- Content and length of stay reflects the needs of the individual and their response to treatment.
- Helping clients identify what skills they have achieved in managing their illness during successful periods of recovery.
- Staff should remain strengths based and solution focused.

Seventh Principle – Recovery plans and interventions must be individualized.

Key Implications
- Services are abstinence-oriented but not abstinence-mandated.
- Staff should be skilled in assessing and working with all levels/stages of change.
- A broad continuum of care exists to allow matching of the intensity of services to client’s current level of functioning.
- Episodes of care are seen within the context of on-going continuous services.
F. **Person-Centered Assessment and Treatment Services**

1. **Biopsychosocial Perspective of Addiction and Mental Disorders**

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


   The common language of the six assessment dimensions can be used to determine multidimensional assessment of obstacles and needs to help the client get what they want.

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

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

   Motivate - dual diagnosis clients can have denial, resistance and passivity about their addiction and mental health problems; deal with resistance at a pace that keeps the patient engaged in treatment; family and healthcare workers may also need “motivating” to deal with both addiction and psychiatric issues equally. (Dimension 4)

   Manage - because dual diagnosis clients easily present to both addiction and mental health programs, treatment is more case management across the addiction and mental health treatment systems, social welfare, legal, and family systems and significant others, than individual therapy; case management especially important for high risk, multiproblem and chronic relapsing clients; take a total systems approach; to improve outcomes, alternative services may be necessary e.g. educational or vocational services, child care and parenting training, financial counseling, coping with feelings and dual relapse groups, daily living skills, tutoring or mentoring services, transportation. (Dimensions 1 - 6)
Medication - for a diagnosed co-morbid psychiatric disorder, but only after sufficient assessment strategies exclude addiction mimicking; also for detoxification if necessary; educate clients about their medication and interaction with alcohol/drugs; prepare them on how to deal with conflicts about medication at AA/NA meetings; anti-addiction medication: naltrexone (Vivitrol), acamprosate (Campral); disulfiram (Antabuse); methadone; buprenorphine; opioid antagonists. (Dimensions 1, 2, 3, 5)

Meetings - mainstream into AA and NA as much as possible, but prepare clients on how to not alienate themselves e.g. too readily discussing medication and mental health issues unless with an understanding member or group; help clients deal with their “dual identity”; help identify appropriate meetings in the area and locate or develop special support groups for those unable to be “mainstreamed”. (Dimensions 3, 4, 5, 6)

Monitor - to ensure continuity of care, be alert to missed appointments; hospitalizations and professionals unfamiliar with dual diagnosis and the treatment goals e.g. drug-free diagnostic trial; promote accountability for an ongoing treatment plan, rather than fragmented response to crises; recognize treatment as a process, not an event. (Dimensions 1 - 6)

G. Co-Occurring Integration Implementation and a Changing Environment

1. Changing the program mission and vision – organizational culture

(a) The Culture Iceberg Exercise – Unwritten Rules/Norms and Beliefs/Assumptions
* (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” pages 152-155)

(b) Gather team members to re-visit the Mission, Vision and Values of the health care system involved in the upcoming or active change process
* (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” pages 17-22)

Addiction counselors may not be interested in working with those “crazy” psychiatric patients; and mental health clinicians may not be interested to in working with “those people - those out of control alcoholics and addicts”. In fact that is part of the reason they chose the agency and field of work in the first place. Now they are suddenly expected to work with people with both problems (not that they weren’t actually working with them anyway). The juices for working with co-occurring disorders don’t automatically flow with administration’s declaration of a new direction.

A good place to start in any system’s change that requires team members to challenge their attitudes, perspectives and comfort zone of work competence is to meet together to understand the context for and collaborate in fashioning the new Mission. This provides the opportunity for all to take responsibility for re-committing to their job; or for deciding that they are not interested in, or committed to the new Mission.

A discussion of Values allows the team to develop principles before policies, procedures and personalities provoke the inevitable disagreements over what to do if a client shows up to treatment having used alcohol or some other drug on the way. Or what to do when a client refuses to take medication; or when a client wants to stop methamphetamine or heroin, but keep drinking alcohol or smoking marijuana? Discussing and naming the Values before the actual situation arises provides the anchor to guide the practice when things get tossed around.

a) For example, suppose one Value was: Relapse in addiction and mental health are both addressed as crises in a person’s treatment requiring evaluation of the crisis and revision of the service plan. Suspension or discharge from treatment and zero tolerance of relapse will not apply to either a person’s substance use or mental health crisis.

b) Discussion of all the issues in developing such a Value statement engages all team members in fruitful attitudinal and clinical practice implications
2. **Develop specific implications for each Value that arises out of the discussion of the new Mission and Vision**

Just about every agency and company has a Mission Statement that very few team members can even recall, let alone articulate and speak to the real implications of the Mission.

- See if you can repeat right now your agency’s Mission Statement without looking it up.
- Or you have always thought of it as being so generically lofty, “motherhood and apple pie” and so broad as to be of little practical use in the dilemmas and pressures of daily life on the job.

One task that can help counteract this common phenomenon is to move beyond the Mission, Vision and Values to a comprehensive exploration and listing of all the implications for each Value. To continue with the example Value above that “Relapse in addiction and mental health are both addressed as crises in a person’s treatment requiring evaluation of the crisis and revision of the service plan. Suspension or discharge from treatment and zero tolerance of relapse will not apply to either a person’s substance use or mental health crisis.” * (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” page 18)

What would be the implications of such a Value? The list could include:

1. If a crisis of substance use, suicidal, violent or self-mutilation behavior, psychosis, mood instability etc. should occur, all clients will receive timely assessment to address any immediate needs; and to revise the treatment plan to improve the client’s progress and outcome
2. If a client’s relapse triggers reactions in other clients, this provides the opportunity to assist both the relapsing client, as well as helping other clients learn from their reactions to the relapse and crisis.
3. No client will be excluded from treatment due to the recurrence of symptoms of their addiction or mental illness. However, if a client deliberately undermines treatment by enticing others to use substances or by violating boundaries with violence or impulsive behavior, discharge is appropriate for the client who cannot be engaged in accountable treatment.

* (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” page 20)

H. **Clinician Competencies for Being Co-Occurring Capable**

* (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” pages 2-3)


1. **TWELVE STEPS FOR CLINICIANS DEVELOPING CO-OCCURRING DISORDER COMPETENCY**

These steps are based on the Principles of CCISC, and can be practiced by any clinician within the scope of his or her existing job or caseload.

1. WELCOMING: Welcome individuals who have co-occurring disorders, thank them for coming, and let them know you are glad to get to know them as they are.
2. HOPE: Ask every one about their goals for a happy life, and inspire a belief that you will work with them to help them to achieve that vision.
3. INTEGRATED: Screen for problems in multiple life domains (mh, sa, trauma, court, etc.) in the course of conversation, and practice using one tool.
4. EMPATHY: Ask clients to describe in detail their experience with the issues in the “other” domain, and empathize fully with what it feels like.
5. **STRENGTHS**: Ask clients to identify a period of recent success in relation to their problem, and describe in detail how they were successful, and what they were experiencing: e.g., mental health issues during a period of sobriety, what were they and how were they managed.

6. **QUADRANT**: Review each case in the case load, and determine: are they COD (yes, no, maybe). What quadrant are they in? (mild SUD vs. severe SUD; SPMI vs less serious mental health issues).

7. **INTEGRATED PRIMARY PROBLEM SPECIFIC TREATMENT**. For any client, list each problem, and list a specific day at a time set of recommendations to help that person succeed. Discuss with the client how they attempt to follow each set of recommendation on any given day. Include recommendations in other areas, like medical issues, probation, etc.

8. **STAGE OF CHANGE**: For each identified problem that may affect the person’s goals for happiness, identify stage of change. Write down a stage matched goal for each problem in the client’s own words. Practice establishing empathy with clients in earlier stages of change.

9. **SKILLS AND SUPPORTS**: For any identified problem during a period of success, identify in detail with the client the specific skills that the client used to be successful, including skills asking for help or using supports.

10. **SKILL-BASED LEARNING**: Use one manual for teaching co-occurring skills, and practice one exercise with a client that is connected to their life. For example, work with the client in an addiction setting on managing mental health symptoms on any day; or work with a mental health client on refusing drugs from a friend.

11. **POSITIVE REWARDS**: Identify small steps of progress for any problem in any client, and provide strong positive reward for those small steps, as a “round of applause for one day of sobriety”

12. **RECOVERY SUPPORT**: Identify a place where the client can receive recovery support for each problem, whether from peers, family, or others, and discuss in detail how the client can improve asking for help.

2. **Identifying gaps in competencies; and what are already effective skills**


   **Examples of recommended scope of practice activities:**
   1. Convey a welcoming, empathic attitude, supporting a philosophy of dual recovery

   2. Screen for co-morbidity, including trauma history.

   3. Assess for acute mental health/withdrawal risk, and know how to get the person to safety.

   4. Obtain assessment of the co morbid condition, either one already been done, or, if needed, a new one.

   5. Be aware of- and understand -the diagnosis and treatment plan for each problem (at least as well as the client understands them).

   6. Support treatment adherence, including medication compliance, 12 Step attendance, etc.
7. Identify stage of change for each problem.

8. Provide individual and group interventions for education and motivational enhancement, to help clients move through stages of change.

9. Provide specific skills training to reduce substance use and/or manage mental health symptoms or mental illness (e.g., help clients learn how to say no to a dealer; help clients to take medication exactly as prescribed)

10. Help client manage feelings and mental health symptoms without using substances.

11. Help client advocate with other providers regarding mental health treatment needs.

12. Help client advocate with other providers regarding addiction treatment needs.

13. Collaborate with other providers so that client receives an integrated message.

14. Educate client about the appropriateness of taking psychiatric medications and participating in mental health treatment while attending 12 Step recovery programs and participating in other addiction treatment support systems, and vice versa.

15. Modify (simplify) skills training for any problem to accommodate a client’s cognitive or emotional learning impairment or disability, regardless of cause.

16. Promote dual recovery meeting attendance, when appropriate for the client, and such meetings are available.

1. **Improving COD Services**

1. **Integrated Dual Disorders Treatment Fidelity Scale**
(http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring)

Integrated Dual Diagnosis Treatment is for people who have co-occurring disorders, mental illness and addiction. This treatment approach helps people recover by offering both mental health and substance use services at the same time and in one setting.

This approach includes:

* Individualized treatment, based on a person's current stage of recovery
* Education about the illness
* Case management
* Help with housing
* Money management
* Relationships and social support
* Counseling designed especially for people with co-occurring disorders
In 2002, the Substance Abuse Mental Health Services Administration (SAMHSA) identified the use of co-occurring disorder treatment principles, or Integrated Dual Disorder Treatment (IDDT) for the mental health service setting, for persons with serious and persistent mental illness and significant substance use problems. An IDDT implementation toolkit was developed and made available to treatment providers and states to assist in the implementation of IDDT.

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

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

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

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

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

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

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

4. **Crosswalk between IDDT, DDCAT and DDCMHT**

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

<table>
<thead>
<tr>
<th>DDCAT and DDCMHT Domains</th>
<th>IDDT Fidelity Scale Items</th>
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| **Program Structure:** focuses on general organizational factors which foster or inhibit the development of Co-Occurring Disorder (COD) treatment e.g., mission statement; certification & licensure; coordination and collaboration with substance related services; financial incentives | 4. **Time-Unlimited Services**  
  - Addiction treatment counseling  
  - Residential services  
  - Supported employment  
  - Family psychoeducation  
  - Illness management  
  - ACT or ICM |
**Program Milieu:** focuses on the culture of program and whether the staff and physical environment of the program are receptive and welcoming to persons with COD.  
*E.g.*, routine expectation of and welcome to treatment for both disorders; literature and patient educational materials

**Clinical Process: Assessment:** examines whether specific clinical activities achieve specific benchmarks for COD assessment.  
*E.g.*, routine screening for substance related symptoms and assessment for positive screening results; substance use and mental health diagnoses made and documented; substance use and mental health history reflected in medical record; service-matching based on substance related symptom acuity: low, moderate, high; service matching based on severity of the persistence of disability: low, moderate, high; stage-wise treatment initial

**Clinical Process: Treatment:** examines whether specific clinical activities achieve specific benchmarks for COD treatment.  
*E.g.*, treatment plan; assess and monitor interactive courses of both disorders; procedures for substance related emergencies and crisis management; stage-wise treatment ongoing; policies and procedures for medication evaluation, management, monitoring, and compliance; specialized interventions with substance related content; education about substance related disorder and its treatment, and interaction with mental health disorders and its treatment; family education and support; specialized interventions to facilitate use of (COD) self-help group; peer recovery supports for patients

### 6. Motivational Interventions:
Clinicians who treat IDDT clients use strategies such as:

- (a) Express empathy
- (b) Develop discrepancy between goals and continued use  
- (c) Avoid argumentation  
- (d) Roll with resistance (*Recognize discord*, Motivational Interviewing, 2013 edition)  
- (e) Instill self-efficacy and hope

### 2. Stage-Wise Interventions: Treatment consistent with each client’s stage of recovery (engagement, motivation, action, relapse prevention)

13. Secondary Interventions for Addiction Treatment Non-Responders:  
Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as:

- Clozapine, naltrexone, disulfiram  
- Long-term residential care  
- Trauma treatment  
- Intensive family intervention  
- Intensive monitoring

### 3. Access for IDDT Clients to Comprehensive DD Services

- Residential services  
- Supported employment  
- Family psychoeducation  
- Illness management  
- ACT or ICM

### 6. Motivational Interventions:
Clinicians who treat IDDT clients use strategies such as:

- (a) Express empathy  
- (b) Develop discrepancy between goals and continued use  
- (c) Avoid argumentation  
- (d) Roll with resistance (*Recognize discord*, Motivational Interviewing, 2013 edition)  
- (e) Instill self-efficacy and hope

### 7. Addiction Counseling:
Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse counseling that include:

- Teaching how to manage cues to use and consequences to use  
- Teaching relapse prevention strategies  
- Drug and alcohol refusal skills training  
- Problem-solving skills training to avoid high-risk situations
### 8. Group DD Treatment:
DD clients are offered group treatment specifically designed to address both mental health and addiction problems.

### 9. Family Psychoeducation on DD:
Clinicians provide family members (or significant others):
- Education about DD
- Coping skills training
- Collaboration with the treatment team
- Support

### 10. Participation in Alcohol & Drug Self-Help Groups:
Clients in the action stage or relapse prevention stage attend self-help programs in the community.

### 11. Pharmacological Treatment:
Prescribers for IDDT clients:
- Prescribe psychiatric medications despite active substance use
- Work closely with team/client
- Focus on increasing adherence
- Avoid benzodiazepines and other addictive substances
- Use clozapine, naltrexone, disulfiram

### Continuity of Care: Examinations
- The long-term treatment issues and external supportive care issues commonly associated with persons who have COD.
- Co-occurring disorder addressed in discharge planning process; capacity to maintain treatment continuity; focus on ongoing recovery issues for both disorders; facilitation of self-help support groups for COD is documented; sufficient supply and compliance plan for medications is documented.

### 4. Time-Unlimited Services
- Addiction treatment counseling
- Residential services
- Supported employment
- Family psychoeducation
- Illness management
- ACT or ICM

### 5. Outreach:
Program demonstrates consistently well-thought-out strategies and uses outreach to community whenever appropriate:
- Housing assistance
- Medical care
- Crisis management
- Legal aid

### 12. Interventions to Promote Health:
Examples include:
- Teaching how to avoid infectious diseases
- Helping clients avoid high-risk situations and victimization
- Securing safe housing
- Encouraging clients to pursue work
**Staffing:** examines staffing patterns and operations that support COD assessment and treatment e.g., psychiatrist or other physician; on site staff with addiction treatment licensure; access to supervision or consultation for substance related disorders; supervision, case management or utilization review procedures emphasize and support COD treatment; peer/alumni supports are available with COD

**Training:** appropriateness of training and supports that facilitate the capacity of staff to treat persons with COD. e.g., basic training in prevalence, common signs and symptoms, screening and assessment for substance related symptoms and disorders; staff is cross-trained in mental health and substance use disorders, including pharmacotherapies.

1. **Multidisciplinary Team:** Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team

1b. **Integrated Addiction Treatment Specialist:** Addiction treatment specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT

10. **Participation in Alcohol & Drug Self-Help Groups:** Clients in the action stage or relapse prevention stage attend self-help programs in the community

1a. **Multidisciplinary Team:** Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team

1b. **Integrated Addiction Treatment Specialist:** Addiction treatment specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT

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

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

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**J. Counseling Techniques**

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

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

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

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

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

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

2. Be careful about reinforcing suicidal behavior

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

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

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

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

K. **Communication and Conflict Resolution** * (“Tips and Topics: Opening the Toolbox for Transforming Services and Systems” pages 144-147)

1. **Normalize conflict in the team.** If there aren’t disagreements, someone is wimping out and not advocating for their beliefs.

It is highly unlikely that you can assemble a team of mental health and addiction treatment professionals, some of whom are in their own personal recovery, without there being conflict over when and what and if to use medication. Or on how to deal with an inmate’s stage of change where they are more at Action to get out of prison earlier; and are at Contemplation about being abstinent. Or on the role of confrontation especially with COD inmates. The problem isn’t the fact of disagreements or conflict. The problem is if you don’t have a functioning conflict resolution policy. Practice disagreeing without being disagreeable:

> “Doctor, would you be willing to share with me your evaluation and history data you got, so I can understand the information I got from the client? I am concerned that the psychotropic medication you have prescribed plays into what the client has learnt to say the make it sound like a mental health problem, just to get medication. I want to be sure I am clear on our work together with this client.”

- Check if you have a conflict resolution policy
- Do you know where it is and what it says?
- Do all team members know how to use the policy?

**Conflict Resolution Policy and Procedure**

**Policy Rationale:**
Disagreements, differences of opinion, varying clinical perspectives on assessment and treatment, and interpersonal conflicts are inevitable among interdisciplinary team members. Because of different life experiences, training, theoretical orientations and familiarity with recovery, personnel can be expected to encounter clinical, administrative and team-functioning conflicts. If conflicts are not evident from time to time, it is likely that one or more members of the team is not speaking up assertively for what they believe in. They may not be advocating for their perspective, to the possible detriment of the people served, and also the health of the team.

Given all this, disagreements and conflict are normal. The following procedures will ensure safe and effective care for the people served, and promote healthy team functioning. Faithful adherence to these procedures is a performance expectation of all staff.

**Procedure:**

1. Each team member has the right and obligation to ask for clarification and discussion about any behavior, decision or treatment intervention that could compromise high quality care.

2. If the question arises as a result of an individual team member’s behavior, decision or treatment intervention, then the discussion should occur at the lowest level possible, directly face-to-face.

3. If resolution is not achieved, either person has the right and obligation to seek consultation from a team member who is next higher in the organizational structure. However this is openly suggested and discussed together before calling in such a person. Sometimes such discussion finally resolves the conflict; while at other times, seeking such consultation will be necessary.

4. If resolution is not achieved even with this consultation and three-way discussion, each person has the right and obligation to seek consultation from a team member who is now next higher in the organizational structure. This again is openly discussed together before calling in such a person. This process of consultation moving up the organizational structure continues until the conflict is resolved, even to the point of a calling in a consultant outside of the organization, if necessary.

5. If there is a question or conflict about administrative, clinical, or other issues that affect the whole team or agency, then it is the person’s right and obligation to bring the concern to group supervision or an equivalent team meeting.
6. The group supervision or team meeting addresses the concern in a timely fashion so as to maintain the healthy functioning of the team for the good of the people served. If the issue is unresolved, any team member has the right and obligation to openly suggest consultation from a person who is next higher in the organizational structure. As before, this process of consultation moving up the organizational structure continues until the conflict is resolved, even to the point of a calling in a consultant outside of the organization if necessary.

7. A team member may require supervision to assist in resolving conflicts at the lowest level possible. However, supervision is not a substitute for open discussion of the conflict between or amongst team members. Follow-through on these conflict resolution policies is a performance expectation, and will be included in areas monitored in employee evaluations.

L. **Gathering Data on Policy and Payment Barriers** *(The ASAM Criteria 2013, p 126)*

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or inadequate meeting of a client’s needs can be a data point that sets the foundation for strategic planning and change

- Finding efficient ways to gather data as it happens in daily care of clients can help provide hope and direction for change:

<table>
<thead>
<tr>
<th>PLACEMENT SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Care/Service Indicated</strong> - Insert the most appropriate level of care/service that can provide the service intensity needed to address the client’s current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter</td>
</tr>
<tr>
<td><strong>Level of Care/Service Received</strong> - If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service</td>
</tr>
<tr>
<td><strong>Anticipated Outcome If Service Cannot Be Provided</strong> – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):</td>
</tr>
</tbody>
</table>

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Case Presentation Format
(The ASAM Criteria 2013, pp 119 -126)

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

I. Identifying Client Background Data

   Name
   Age
   Ethnicity and Gender
   Marital Status
   Employment Status
   Referral Source
   Date Entered Treatment
   Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
   Current Level of Service (if this case presentation is a treatment plan review)
   DSM Diagnoses
   Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. Current Placement Dimension Rating  (See Dimensions below 1 - 6)
    1.
    2.
    3.
    4.
    5.
    6.

   (Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

This last section we will talk about together:

III. What problem(s) with High and Medium severity rating are of greatest concern at this time?
     Specificity of the problem
     Specificity of the strategies/interventions
     Efficiency of the intervention (Least intensive, but safe, level of service)
**Jeff**

**Age:** 15  
**Occupation:** Student

**Chief Complaint:** Wants assessment in order to "keep peace" with his parents.

**History:**

* Fifteen-year-old high school student who presents for assessment at the insistence of his parents. Jeff's advisor has expressed concern that patient's deterioration in academic performance may be related to drug use. In the past, he's gotten mostly A's. However, during the last year he has been getting B's and C's and one D. It has also been noted that he has missed some classes.

* Jeff's parents became very concerned and searched his room where they found drug paraphernalia. Jeff admits that he has been smoking marijuana.

* First marijuana exposure was at age 13. His use has progressed during the last year as he thinks that it improves his artistic talents (he wants to be an artist).

* Marijuana also helps when he feels nervous. He says that he is simply not as interested in his other classes and has skipped some classes, but he does believe that he could probably improve his grades by reducing marijuana use.

* He also recognizes that has run out of money and borrowed from friends before and that might be related to his marijuana use.

* He relates smoking one to two joints, two to five times per week. He also drinks a few beers on weekends, but once ended up in the emergency room acutely intoxicated with “alcoholic poisoning”, which scared him. He has experimented with other drugs, methamphetamine, Ecstasy and inhalants, but no IV use and says he doesn’t use regularly.

**Past Medical History:**

* He had a head injury when he was 10 years old after falling from a tree he was climbing and was hospitalized overnight for observation. No significant other health problems and no medications.

* History of brief psychiatric treatment a year ago as an outpatient for five sessions with a psychiatrist. He was feeling depressed and suicidal after a fight with father. He was not consistent with appointments and dropped out of treatment.

**Family History:**

* Jeff lives with his parents and younger sister. His mother does not drink alcohol or use drugs. His father drinks one to three drinks nightly. An uncle has alcohol use disorder. There are frequent family arguments, but no family violence. The client feels that his family does not understand him and is unfairly pressuring him.

**Social History:**

* Jeff is in high school and is interested in art. He does not have a job.

* He is not involved in a relationship. Some of his friends use drugs and some do not.
Review of Systems and Physical and Mental Status Examination:

* Review of systems is unremarkable – no significant symptoms

* Jeff is in no acute physical distress. BP 94/60; Pulse 100 and regular. Temperature is normal. Brethalyzer is 0. Skin color and tone normal. Respirations and chest movements normal. Heart sounds normal; no arrhythmias. Abdomen was soft and bowl sounds normal. Gait and central nervous system grossly intact.

* Client is alert and oriented. He appears somewhat anxious and depressed but is cooperating and not expressing any suicidal ideation. No evidence of psychosis or homicidal impulses. Speech is normal. Intelligence above average. No signs of organicity.

* He is willing to consider treatment recommendations, but he's not willing to commit to abstinence. He wants to stay in school.

Severity Profile:  
(High, Medium, Low)  
Dimension:  
Severity:  
1  2  3  4  5  6

Services Needed:

Site of Care:

Kim

Kim is a 29-year-old, single mother, unemployed woman who was referred because of depression with suicidal and homicidal ideation, but no specific plan or means to follow through. The client appeared depressed and had made verbal threats towards the Child Protective Services office as well as suicidal threats and feelings, if she did not get her children back.

Two months earlier, her two sons, who are two and a half and eight, were put in a foster home because she supposedly left them unattended. She says that her boyfriend of fourteen years actually pushed her down some steps and she fell and was unconscious for four days. She had taken two hits of crystal methamphetamine and says that as a result of the "dirty" urine test, her children were taken away from her and she is very angry and depressed about this. Her boyfriend who is now in jail for parole violation is apparently being charged with attempted murder because of the incident.

Kim has been depressed over wanting to get her children back and angry at "the system" because she feels she has been wronged. She says that she has not used any drugs other than one day two month’s ago, for nearly three years and was very active in Alcoholics Anonymous having a sponsor and being involved up until eight months ago. Kim has drifted away from Alcoholics Anonymous and feels that this may have caused her relapse in two months earlier. She wants to get her life together but also has been feeling angry about the difficulty of getting public assistance and has been making verbal threats of wanting to "blow people's brains out" and also feelings of wanting to give up and "that she is cracking up".

Kim says she is not currently using alcohol or other drugs although she recognizes past significant problems with cocaine and marijuana. She has had a previous psychiatric hospitalization four years ago, when she had cut her wrists and needed a couple of sutures after an argument with her boyfriend.

Kim is not having trouble with sleep; and has had an increased appetite with a slight increase in weight but her energy and libido have been decreased and she has had suicidal feelings. She has been having some trouble with constipation, poor hearing in her left ear and occasional headaches perhaps related to the fall two months ago. Her menstrual periods have been normal and she smokes a pack of cigarettes every two days. She does want help, however, mainly though to get her children back.
C.W.

February 18

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

Stephen

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

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

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

1. Where would you place him for treatment – level of care and COC or COE?

Wanda on Welfare

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

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

She is the child of an alcohol-addicted father whom she alternately idolized and feared and who was seductive but not openly sexual with her as she was growing up. He father was killed in barroom brawl when she was 30 years old. Her mother 67 years old, lives alone and is still doesn’t agree about Wanda’s father’s alcoholism. She is the younger of two female children and her older sister is a teetotaler and a pillar of her church. They have not had contact in about three years.
A year ago she again began attending AA and claims she enjoys it. She attends weekly. She now drinks about once a week without apparent problem. She no longer smokes pot. She does feel hypocritical attending AA and still drinking but she neither wants to stop drinking nor discontinue her AA attendance because she has a few women friends there. They do not know about her current drinking. She had considered finding another counselor because of her dissatisfaction with her life but never translates this into action. She does not believe that she has a drinking problem. She is not sure what she wants, other than what she has.

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

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

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

**Cathy**

**Age:** 27  
**Occupation:** Waitress

**Chief Complaint:** “I’m a junkie”

**History:**

- Twenty-seven year old, single, female waitress with long history of using multiple substances presenting because of withdrawal symptoms, accompanied by her parents.

- Started marijuana at age 15 with weekend alcohol and other drug use until college.

- In college, used marijuana heavily almost daily and LSD once a month.

- A year ago, began a methamphetamine binge, which terminated three months later with a methamphetamine-induced psychosis. After a seven-day psychiatric hospitalization, she did well for two months.

- Began marijuana again and also heroin. She spends $40-$50/day which she finances by waitressing. Some occasional cocaine use. No legal problems.

- Around age 18, she was diagnosed with a panic disorder and began on Klonopin and has been maintained on 3 - 4 mg./day ever since. This diagnosis was made approximately one year after the birth of a child resulting from a rape. Incident was kept secret from parents until she was close to labor.

- Has tried to quit using twice recently in the last month, but was too physically ill. Came for help because a drug-using friend is also trying to quit and called her parents to tell them of their daughter’s drug use.
* No previous addiction treatment, but did attend four Narcotics Anonymous meetings with NA friend but felt she wasn’t as bad as everyone there.

* Complaints of muscle aches, irritability, anxiety, tremulousness, tearfulness, abdominal cramps and nausea. Also heavy menstrual bleeding and feeling tired and weak.

* Last use of heroin morning of evaluation.

**Past Medical History:**

* Two heroin overdoses resulting in respiratory arrest, but one of her shooting buddies was a registered nurse who administered CPR.

* History of heavy menstrual bleeding and pelvic inflammatory disease.

**Family History:**

* Both grandfathers suffered from alcohol use disorder.
* Father somewhat distant, but is the disciplinarian.
* Mother “enabling”.
* No other psychiatric illness in family.
* Only child.

**Social History:**

* Single; never married and has boyfriend who drinks addictively and two good friends in NA.
* Lives with parents, who supplement her income and give free room and board.
* Has not seen child since giving him up for adoption at age 17.
* Waitress.
* Family not religious. No religious affiliation.

**Review of Systems and Physical and Mental Status Examination:**

* Symptoms of abdominal cramps, nausea and diffuse muscle aches.

* Pale and still some menstrual bleeding.

* Anxiety, tremulousness and irritability, but not suicidal nor homicidal, and is cooperative, wanting to feel better and please her parents. Would like to get “clean and sober” to perhaps see her child, or at least get married and have another baby. But also doesn’t know if she can stop using or whether she would attend NA.

* Physical and mental status exam: BP 110/70; Pulse 90; Respiration 18. Mild discomfort; IV track marks in right antecubital fossa; increased bowel sounds; some dilatation of pupils.

* Laboratory data: CBC, Chem 20, HIV negative; not pregnant.

**Diagnoses:**

Opioid Use Disorder; Methamphetamine Use Disorder; Cannabis Use Disorder. Panic Disorder Without Agoraphobia.
Diagnostic and Management Issues

**Data:** Client arrived 45 minutes late into a 50-minute session. Client was highly agitated; angry, yelling, and threatening to throw things in this writer's office. Client was agitated, aggressive and unwilling to lower her voice despite being asked multiple times. The client adamantly denied being asked to show up at 9:00 am for her appointment and informed this writer and the client’s daughter, Banasa (also attending) that she would not participate in family counseling if it meant arriving at the clinic at 9:00 am every Wednesday.

When the client was asked why she would not show up, she reasserted that her time for services began at 10:00 am and no one would make her come any earlier. Further, the client stated that no one told her she needed to be here at 9:00 am. She was confronted with information that was not consistent with her recall. The client denied being told to be here at 9:00 am. (Banasa, reported that her sister, Octavia, made a phone call last night reminding her about the meeting. Her mother received a similar phone call.)

The client continued to raise her voice; despite being asked not to yell. She threatened this writer by asking if he prefers her (the client) to throw things in the office instead of yelling. The client was instructed to lower her voice and directed not to throw anything in the office. The client did not throw anything. This writer attempted to remind the client why there was family therapy and that Ms. Java (care coordinator) mandated treatment. She stated that she did not care what was mandated. She would not show up and participate; “I am 42 years-old and no one will tell me what to do.”

The client was informed that her time was up and next week at 9:00 would be her next appointment. The client left. Five minutes later the client was given an appointment slip with the date and time of her next appointment; next Wednesday at 9:00 am.

**Assessment:** Thought process was disturbed, thought content perseverated on the belief that she would not be told or controlled into showing up every week at 9:00 for family therapy. Mood was dysphoric, affect was angry, aggressive, hostile and belligerent.

The client does not possess adequate impulse control skills to be in family therapy. She has a history of assaulting her daughter, Banasa and given the client's impulse control deficiencies there is a moderate potential that the client would become assaultive in session given the correct stimulus. The client needs intensive individual sessions focused on management of her impulse control deficiencies, her anger and rage, her inability to see the numerous resources wanting to help her but unable to because she lacks the willingness or ability at this time to cooperate.

The client's UA was negative for drug use which leads to the conclusion that the client has co-occurring mental health disorder impeding her ability to interact successfully with her own family members and her current participation in group therapy. The question about this client being able to care for her own six year old son is obvious; at this time, given her deficiencies, this client does not possess the ability to care for a child.

This client needs to return next week to family session so that this material may be communicated to her as a clinical goal of allowing the client to experience the weight of the consequences of her behaviors. The client has used for quite sometime her anger, rage, yelling and threats of violence (and actual violence) as a means to manage the relationships in her life. Next week will be this client's last family session until she develops better skills to manage her impulse control deficient, anger and rage.

**Plan:** 1. Individual sessions weekly or bi-weekly are necessary for this client. 2. Continue UA weekly and random. 3. Client needs a more intensive level of care to include parenting classes, impulse control groups, anger management groups as well.
LITERATURE REFERENCES AND RESOURCES


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RESOURCES FROM SAMHSA

1. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) presented “A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders”. It provides a summary of practices for preventing substance use disorders among individuals who have mental illness and also a summary of evidence-based practices for treating co-occurring disorders. Resource: www.samhsa.gov/reports/congress2002/foreword.htm
2. A 2003 publication, “Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders” is also available on the SAMHSA website or though the SAMHSA National Mental Health Information Center at (800) 789-2647. SAMHSA Publication No. 3782, SAMHSA

Also Available: “Quick Guide for Clinicians Based on TIP 41, Substance Abuse Treatment: Group Therapy” (NCADI No. QGCT41)


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