Illinois Institute for Addiction Recovery • An Affiliate of UnityPoint Health

PARADIGM

Vol. 22 No. 3

The Importance of SAMHSA'S Trauma-Informed Approach

Collaboration Among Families and Professionals for Recovery from Co-Occurring Disorders

Building Recovery Oriented Systems of Care

Twelve Steps to Co-Occurring Competency

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To Our Readers

According to a 2014 survey by the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 43.6 million (18.1%) Americans ages 18 and up had a mental/emotional disorder and 20.2 million adults (8.4%) had a substance use disorder during the past year. Of these, 7.9 million people had a mental/emotional disorder and a substance use disorder, also known as a co-occurring disorder. (Center for Behavioral Health Statistics and Quality, 2015)

What does it mean to have a co-occurring disorder? What is considered best practice in treatment and ongoing management of co-occurring disorders? How can providers ensure they are using evidence-based practices in the treatment of such disorders? What is the best delivery system for the treatment and management of co-occurring disorders?

This issue of *Paradigm* looks at co-occurring disorders from several different perspectives as our contributors share their collective knowledge and experience relating to treatment and management of co-occurring disorders.

In "Building Recovery Oriented Systems of Care," authors DiClemente and Knoblach explain Recovery Oriented Systems of Care (ROSC), its importance to management of co-occurring disorders and how organizations can move towards this important delivery model.

The concept of Comprehensive Continuous Integrated Systems of Care (CCISC) is explored by Kenneth Minkoff, MD in "Twelve Steps to Co-Occurring Competency," including the six evidence-based principles associated with the model care.

In "Collaboration Among Families and Professionals for Recovery from Co-Occurring Disorders" Judith Laudau and Christy Ruehman discuss the importance of collaboration between and among professionals and family systems in the treatment of co-occurring disorders, including an overview of the ARISE Comprehensive Care with Intervention.

Finally, we have included an excerpt from "Integrated Treatment for Co-Occurring Disorders" from SAMHSA's Evidence-Based Practice KIT Series. This article discusses seven practice principles integral to building effective programs in the treatment of co-occurring disorders.

At UnityPoint Health–Illinois Institute for Addiction Recovery, we are committed to providing comprehensive treatment for individuals struggling with co-occurring disorders in our communities. We invite you to contact us for more information about our programs and services.

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Reference:

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

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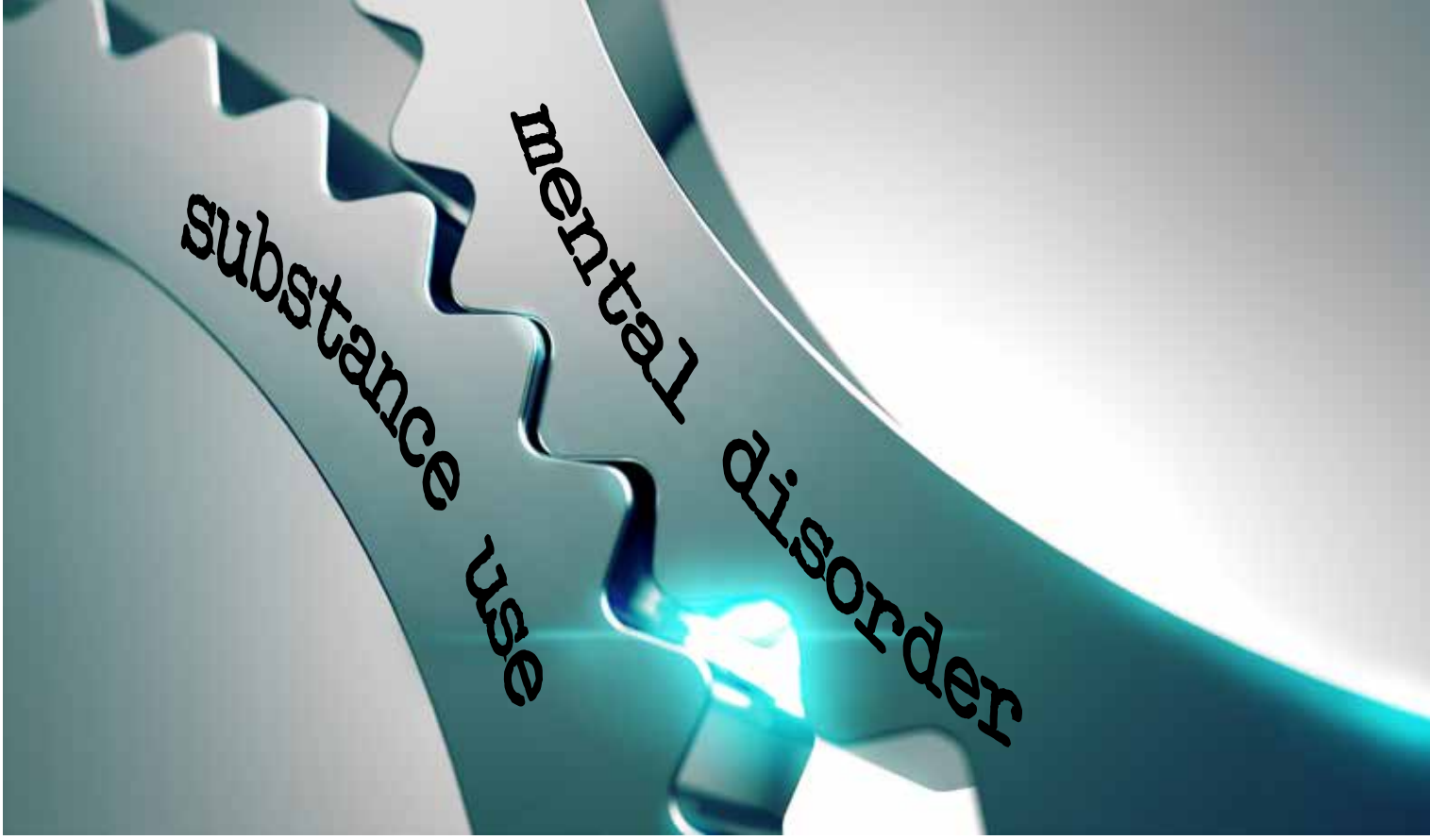

The Importance of Integrating SAMHSA's Trauma-Informed Approach into the Treatment of Substance Use and Co-Occurring Disorders

Jennifer Mathis, PhD, LPC

The importance of integrating a trauma-informed approach to treatment for mental/emotional disorders and substance use disorders is showcased through the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2014 guide which includes key assumptions and principles. The SAMHSA study and others, including the Adverse Childhood Experiences study (Department of Health and Human Services, 1998), have identified the widespread impact of trauma, and the subsequent correlation of increased risk of mental health and substance use issues. SAMHSA's concept of a trauma-informed approach is the over arching lens with which counselors and therapists view their clients. This lens realizes the widespread impact of trauma and understands potential paths for recovery, recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, responds by fully integrating knowledge about trauma into policies, procedures, and practices; and most importantly seeks to actively resist re-traumatization. This means that the organization as a whole will work to ensure that clients are met from a client centered approach, and that each member of the organization is committed to following SAMHSA's key assumptions and principles.

What is Trauma?

Trauma is a broad term that is used to describe a person's exposure to stressful and/or negative events. These events get categorized in the brain and body (nervous system) in such a way that fosters a recreating of the original experience. These are patterned responses, and for many it is difficult to break this cycle without professional help. The Diagnostic and

Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) explains this re-living/pattern as Post Traumatic Stress Disorder (PTSD) or Complex PTSD. Trauma "occurs as a result of violence, neglect, loss, disaster, war, and other emotionally harmful experiences."

"Many people who experience a traumatic event will go on with their lives without lasting negative effects; others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune system responses and subsequent health risk behaviors. Unaddressed trauma results in increased mental/emotional disorders and substance use disorders as well as chronic physical issues" (SAMHSA, 2014).

Single event trauma and repeated exposure trauma can have the same impact on an individual, because when a trauma occurs the brain and body do not grade the severity of the trauma. All traumas are traumas. This means that what is often referred to in the professional arena as Big T and Little T trauma are both traumatic. We use Big T to describe single incident events and Little T to describe repeated exposure or complex trauma. Single incident trauma can sometimes be easier to identify and process in treatment whereas repeated, complex traumas can be more difficult to identify and reprocess. Often complex trauma comes from attachment deficiencies and/or growing up in stressful and chaotic home environments as reported in the ACEs study. When a child grows up in a stressful or chaotic environment the nervous system can become over-engaged. The dopamine and opioid receptors become stunted due to rapid repeated engagement of the sympathic nervous system (flight/flight/freeze). Insufficient release of dopamine and opioids can create vulnerabilities towards substance use and mental health issues, thus negatively impacting one's ability to deal with stressful events in the future.

Why a Trauma-Informed Approach Matters

In an attempt to cope with their stressful and chaotic environment children will develop ways to escape and will attempt to find the comfort they desire. Children may seek comfort, belonging and acceptance by acting out with peers or getting sick in an attempt to have their needs met. Because children are not empowered to control their environment they will try to escape the stress through the use of avoidant behaviors: escape through video games, television, or creating alternate realities via their imagination. Dissociation is a common co-occurring phenomenon of substance use and PTSD. Avoidant/escape behaviors become a child's way of trying to control an uncontrollable environment, and these behaviors continue to grow and will follow them into adulthood, often exhibited as self-defeating behaviors which are in reality maladaptive coping strategies created by a linked response to trauma. These strategies show up later in life as substance use, mental and physical health issues.

Due to the linked response that takes place in the brain and body during traumatic events, maladaptive patterns can form. These maladaptive patterns stem from a lack of safety and choice. They are often habitual and automatic reactions to what is currently happening, but are linked to past events. We refer to this process as being triggered. When we are triggered a lack of safety and control is engaged and the triggering situation is interpreted from a defensive stance. Because this interpretation is linked to an unpleasant feeling and self-limiting belief system the engagement of avoidant/escape behaviors happens in an effort to protect the self from uncomfortable feelings and belief systems. This could be referred to as the 'InSanity Cycle' and can be challenging to break out of without professional help. The maladaptive patterns are an attempt to cope with the stressors of life, but these attempts become a double-edge sword, creating more stress that cues more avoidant/escaping behaviors.

In order to escape the cycle, a reset of the nervous system must take place through resourcing, distress tolerance, emotional regulation and self-compassion. These processes are the basis of The Mathis Model© which promotes engaging clients in therapeutic activities that reinforce resourcing and stabilization to support the rewiring process and avoiding the InSanity Cycle. Rewiring is accomplished by unlinking from the old and creating new empowering linked feeling states and belief systems. For rewiring to occur, the three pillars of The Mathis Model must be present: compassion, understanding and curiosity.

Compassion must be present in order to move away from criticism and judgment and into a place of understanding how these links and patterns get created. Curiosity occurs when events are reinterpreted from a

new perspective rather than the old linked response. Once the three pillars are in place then rewiring can occur, and the shift from the external/fear based InSanity Cycle can move towards an internal focus that is responsive rather than reactive. This internal focus is described as In-Lightened L.I.F.E. (Live. Intentional. Free. Empowered.). When coming from an In-Lightened L.I.F.E. the trigger, issue, event, and/or stressor no longer holds the same meaning it once did; the self-limiting linked feeling state and belief are severed which allows for more adaptive links to take root, thus reducing or replacing avoidant and escaping behaviors with behaviors that are in alignment with one's core self and are empowering rather than self-limiting.

It is important that an integrated, client centered, trauma-informed approach be in place when working with co-occurring substance use and mental health issues in order to provide the clients an opportunity to heal from these deeply ingrained fear based patterns. Exploring painful memories and learning how to process difficult feelings and emotions in new ways can be overwhelming for clients. Avoidance and escape behaviors have become the primary coping strategy. The use of re-traumatizing language is rampant in the industry. It's not uncommon to hear staff referring to clients as "resistant" or "unmotivated" or speculating that a client isn't ready and is going to relapse. Using this type of language only perpetuates the feelings of shame associated with trauma. Choosing a trauma-informed approach and training staff to focus on understanding and compassion is needed. Understanding the widespread impact that trauma has, and incorporating that understanding as a way to approach clients, rather than exuding judgment, will be more effective. This will help instill more feelings of safety and acceptance into the client's treatment experience. The 2014 Trauma and Justice Strategic Initiative (SAMHSA, 2014) suggests that creating therapeutic environments that promote safety, trustworthiness, transparency, collaboration, mutuality and provide clients with empowerment through the use of choice and voice are the preferred way to work with clients.

Moving towards a trauma-informed approach means incorporating trauma-informed care into treatment programming. Creating programming focused on resourcing and regulation will be imperative to create safe environments for clients with co-occurring disorders to begin the healing process. A solid treatment program will have components of SAMHSA's key assumptions and principles along with a variety of trauma-informed interventions. Important components of treatment include

- targeting the areas of the brain responsible for creating these trauma links and focusing on regulation of the nervous system;
- teaching applicable skills that promote rewiring of old maladaptive links; and;
- integrating adaptive empowering links that are important components of treatment. Such interventions include mindfulness, breath work, meditation, yoga, eyemovement desensitization and reprocessing (EMDR), brainspotting, cognitive-behavioral therapy (CBT), rational emotive behavior therapy (REBT), acceptance and commitment therapy (ACT), and sandplay. Peer support such as the 12-step community, smart recovery, celebrate recovery, refuge recovery, or any other safe supportive environment can also be effective interventions.

A solid multi-level treatment program that includes inpatient and outpatient services can provide adequate time for the resourcing and stabilization phase to take root. Once a client is stable and able to resource they can begin processing trauma so true integration can take place and new more adaptive links can form.

Dr. Jennifer Mathis is the clinical director at Calvary Healing Center in Phoenix and creator of The Mathis Model© and In-Lightened L.I.F.E.™ an integrated program designed to identify and rewire the habitual patterned scripts characterized by self-sabotaging behavior. Dr. Mathis is a certified yoga instructor, master addictions counselor with co-occurring disorders, nationally certified counselor, licensed professional counselor and approved supervisor for the state of Arizona. She is also independently licensed in California and Hawaii, a certified EMDR therapist and consultant, a sandtray specialist, and certified brainspotting therapist. Her clinical experience includes specializations in co-occurring disorders, addictions, and trauma. She uses an integrative, client-focused approach to address a variety of behavioral health and substance use concerns in adults and adolescents. She may be contacted at inlightenedjourneys@gmail.com.

References:

U.S. Department of Health and Human Services, Center for Disease Control and Prevention (1998). *Relationship of Adverse Child Abuse and Household Dysfunction to Many Leading Causes of Death in Adults.* Retrieved from https://www.cdc.gov/violenceprevention/acestudy/about.html

Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, (2014).

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Collaboration
Among Families and Professionals for Recovery from Co-Occurring Disorders

Collaboration is especially important when an individual with co-occurring disorders is experiencing transition. We are constantly in transition, and scientific advances make transitions more rapid. People are vulnerable during normal life cycle transitions, and even more vulnerable during trauma, resulting in increased rates of stress, depression, suicide, addiction, and first breaks or relapse of a mental/emotional disorder. Collaboration among providers can help ease the transition for the client and keep continued recovery within reach. Regardless of genetic factors, onset of addiction is almost always connected to major loss, trauma, abuse, and mass disaster. This increases rates of onset and relapse of both mental health problems and addiction.

The term *co-occurring disorders (COD)* replaces the term *dual diagnosis* when referring to an individual who has a co-existing mental/emotional disorder and a substance use disorder. While commonly used to refer to the combination of substance use disorder and a mental/emotional disorder, the term also refers to other combinations of disorders (such as mental health and physical health challenges). A client can be described as having co-occurring disorders when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from another disorder.

To recover, both disorders require concurrent treatment. Working collaboratively is critical, as approximately 50% of individuals with severe mental/emotional disorder are affected by substance use disorder, and 37% of alcohol users and 53% of drug users have at least one serious mental health challenge.

Effective Multidisciplinary Collaboration

Specialization in the healthcare field results in fragmentation of treatment, but collaborative partnership can overcome this. Brunette and Mueser's (2006) study of people with schizophrenia and substance use disorder—an example of co-occurring disorders—showed 60% of those receiving integrated treatment, and 20% of those receiving separate treatment, achieved substance use remission. The collaborative treatment team should include not only the professional providers but also the family, a key influence on an individual's healing journey. Families are the primary source of health-related beliefs and behaviors. The stress of transitions can manifest in physical symptoms, which serve adaptive functions and are maintained by family patterns. Families are also a valuable resource and source of support for illness management, providing a more accurate picture of the individual's symptoms and compliance than the individual alone. If families are excluded, they unintentionally become a liability rather than a resource. Long-term biopsychosocial, cultural, and spiritual health is achieved by trusting the individual and family's intrinsic capacity for healing. Goals are achieved by accessing everyone's inherent resilience, strength, and competence.

Importance of Connectedness to Family

Families influence outcomes. Contrary to popular belief, people with addiction, regardless of age, are in close contact with their families of origin (Stanton, 2015). A significant percentage of addicted individuals have daily phone contact with their parents compared to non-addicts: heroin addicts (64%), polydrug addicts (51%), and non-addicts (9%) (Perzel & Lamon, 1979).

➥

Strong connection to family and culture is associated with reduced risk-taking. A study of women's sexual risk-taking showed increased contact with extended family and knowledge of family stories correlated with reduced sexual risk-taking (Landau, Cole, Tuttle, Clements, & Stanton, 2000). A study by Tuttle, Landau, Stanton, King and Frodi (2004) showed a similar pattern with troubled adolescent girls where both measures held independently and together. The stories were analyzed for themes of resilience vs vulnerability. The least risk-taking correlated with themes of resilience, next lowest risk-taking with themes of vulnerability, and the most risk-taking with knowing no stories. The stories' content was often identical—what varied was the families' perception of their challenges.

Family involvement is critical for treatment entry, completion, and long-term recovery. Evidence shows family and couples treatment is most effective and has longer-lasting results than individual treatment alone (Stanton, 2015).

Enhancing Positive Connectedness

Healthcare professionals can enhance positive connectedness by drawing on the family's inherent resilience, rather than labeling behavior and communication patterns as dysfunctional. Negative labeling increases vulnerability and risk-taking, instead of increasing self-esteem, competence, and self-efficacy (Landau et al., 2000). Similarly, educating communities about a positive perspective and resilience provides a context for prevention and early recognition to reduce the opportunity for epidemics.

Healing, Recovery, and Role of Healthcare Providers

Early discussion of pain management strategies with clients and their families opens the door to collaboration focused on healing and recovery. With the epidemic of opioid abuse, pain medications essential in the physician's toolbox should be scrutinized by providers who could provide medical and alternative methods for pain reduction (e.g., yoga, meditation, Pilates), thereby reducing the dose or eliminating the medication, if appropriate.

Poviders can also facilitate collaboration between their clients and primary care providers. The focus should be on the client, not the specialty. Regular communication with family and referring professionals is key. Providers can also recommend family participation in adjunctive therapies, including family psycho-education, multifamily groups, cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), equine, family, and couples' therapy.

Resilience Supports Survival, Then Recovery

A 30-year study exploring the history of 35 families struggling with addiction who could trace their ancestors back five to seven generations showed a common pattern in the intergenerational life cycle of families and addiction (Landau & Garrett, 2008). The study found this intergenerational adaptation gets perpetuated down generations. Individuals and families who experience serious trauma (e.g., warriors and first responders) keep secrets to protect one another, effectively isolating themselves when they most need to be close. If someone enters recovery before grieving is done, the addicted individual relapses, subconsciously triggering reconnection as the family once again focuses on the problems. After three to five generations, trauma is forgotten, the passage of time naturally resolves grief, and people enter recovery. Families who survived serious trauma used addiction to deal with pain, rather than committing suicide. Landau realized therapeutic intervention can happen in any generation, instead of waiting for natural grief resolution (TEDx Talks, 2013).

In this way, addiction is "Resilience in Action." This family pattern holds true across time, countries, and cultures. Garrett and Landau (2007) call this "Family Motivation to Change or Heal." It operates within a family experiencing major loss, guiding them first toward maintaining survival, and then toward healing when the threat is removed.

First responders often have an early opportunity to demonstrate collaboration with the family and promote healing and recovery by observing safety precautions; providing education about opiates, alcohol, marijuana, and other substances; and being certified in cardiopulmonary resuscitation (CPR) and administering naloxone. Debriefing with a colleague or therapist and working on a team helps ensure first responders are taking care of themselves too.

All providers should support collaborative healing and recovery, starting with understanding the stages of normal development and the family cycle. They can collaborate with families by meeting with young people in their homes and performing positive interviewing. They can support diversity and tolerance by recognizing

cultural and learning styles and challenges, and avoiding negative language. Providers should develop a robust referral network and know when to refer and delegate. A community of providers committed to recovery serves as a safety net for the individual and family facing relapse or failure to recover.

ARISE® Comprehensive Care with Intervention is one resource that respectfully and lovingly introduces the family and addicted person to a life of healing and recovery for all before they hit rock bottom. It is characterized by a series of collaborative family meetings focused on long-term recovery. A network of national and international interventionists and recovery specialists are aligned to meet the specific needs and budget of the client and family. Personalized case management guides the group during times of transition, with coaching in or out of the home, companionship, and monitoring. Safe Passage transportation is provided between home and treatment venues. The program is a federally designated evidence-based best practice model based on Transitional Family Therapy (TFT) that considers current status, intergenerational family history, and the larger context across time.

Fernandes, Begley, and Marlatt (2006) identified several elements that make ARISE successful, including the focus on individual and family recovery, and individuals being invited and motivated to participate in treatment. The collaboration with professionals in a joint "Family Board of Directors" and reliance on the family's inherent strength, motivation, and resilience, also contribute.

Multiple studies support the effectiveness of ARISE. A National Institute on Addiction (NIDA) study (Landau et al., 2004), replicated in several "real world" settings, demonstrated 50% treatment engagement within one week; 76% within two weeks; and 83% within three weeks. At an informal, 6-month follow-up, 96% entered treatment. The more members of the support system involved, the better the outcome. A Brandeis retrospective survey found 62% clean and sober at one year, and both individuals and families spoke highly of the process.

Conclusion

Regardless of diagnosis, families are the core unit of healing and change, and are intrinsically healthy and competent with the capacity to heal. Symptomatic behavior in family members has its origins in protection and resilience. Families are in constant transition and repeat incomplete life cycle transitions unless they explore intergenerational influences and understand their context and "here-and-now" events. This allows them to make informed choices about the present and change the future for themselves and future generations. By collaborating with professionals, individuals, families, and members of their support systems, we can foster lasting change and healing.

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References:

Brunette, M.F., & Mueser, K.T. (2006). Psychosocial interventions for the long-term management of patients with severe mental illness and co-occurring substance use disorder. *Journal of Clinical Psychology, 67*(7), 10-17.

Fernandez, A., Begley, E.A., & Marlatt, G.A. (2006). Family and peer interventions for adults: Past approaches and future directions. *Psychology of Addictive Behaviors, 20*(2), 207-213. doi: 10.1037/0893-164X.20.2.207

Garrett, J., & Landau, J. (2007). Family Motivation to Change: A major factor in engaging alcoholics in treatment. *Alcoholism Treatment Quarterly, 25*(1-2), 65-83. doi: 10.1300/J020v25n01_05

Landau, J., Cole, R., Tuttle, J., Clements, C.D. & Stanton, M.D. (2000). Family connectedness and women's sexual risk behaviors: Implications for the prevention/intervention of STD/HIV infection. *Family Process, 39*(4), 461-475.

Landau, J., & Garrett, J. (2008). Invitational intervention: The ARISE model for engaging reluctant alcohol and other drug abusers in treatment. *Alcoholism Treatment Quarterly, 26*(1-2), 147-168. doi: 10.1300/J020v26n01_08

Landau, J.L. (2018). Transitional Family Therapy. In: J. Lebow, A. Chambers, & D. Breunlin, (Eds.). *Encyclopedia of Couple and Family Therapy*. Cham, Switzerland: Springer.

Landau, J., Stanton, M.D., Brinkman-Sull, D., Ikle, D., McCormick, D., Garrett, J., Wamboldt, F. (2004). Outcomes with the ARISE approach to engaging reluctant drug- and alcohol-dependent individuals in treatment. *American Journal of Drug & Alcohol Abuse, 30*(4) 711-748.

Perzel, J. F., & Lamon, S. (1979). *Enmeshment within families of polydrug abusers*. Paper presented at National Drug Abuse Conference, New Orleans, August, 1979.

Stanton, M.D. (2015). Family therapy. In M. Galanter, H.D. Kleber, & K.T. Brady (Eds.). *Textbook of Substance Abuse Treatment* (5th ed., Chap. 31, pp. 479-495). Washington, DC: APA Publishing.

TEDx Talks. (2013, January 25). *Family Stories, Secrets and Survival: Dr. Judith Landau at TEDxVailWomen* [Video file]. Retrieved from http://www.youtube.com/watch?v=_F3Yyl6e_ZQ

Tuttle, J., Landau, J., Stanton, M.D., King, K., & Frodi, A. (2004). Intergenerational family relations and sexual risk behavior in young women. *The American Journal of Maternal Child Nursing, 29*(1), 56-61.

Building Your Program

Integrated Treatment for Co-Occurring Disorders

What is Integrated Treatment for Co-Occurring Disorders?

Integrated Treatment for Co-Occurring Disorders differs from traditional approaches in several ways. First, services are organized in an integrated fashion. For example, assessments screen for both mental illness and substance use.

Practitioners in the Integrated Treatment program (called *integrated treatment specialists*) develop integrated treatment plans and treat both serious mental illnesses and substance use disorders so that consumers do not get lost, excluded, or confused going back and forth between different mental health and substance abuse programs.

Consumers receive one consistent, integrated message about substance use and mental health treatment. Second, clinical treatment is integrated. Integrated treatment specialists have knowledge of both substance use disorders and serious mental illnesses and understand the complexity of interactions between disorders. They are trained in skills that have been found to be effective in treating consumers with co-occurring disorders.

Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Therefore, within specialty mental health and substance use clinical settings, it is the norm rather than the exception to see consumers with co-occurring disorders. Lacking recognition of the high prevalence of co-occurring disorders, agencies that develop specialty teams to treat small groups of consumers with co-occurring disorders, consequently, leave many consumers undiagnosed and untreated.

In the Integrated Treatment model, however, one or more integrated treatment specialists participate in each multidisciplinary treatment team in the agency. They cross-train other treatment team members to disseminate information and skills about treating consumers with co-occurring disorders. Working in multidisciplinary treatment teams also ensures that treatment addresses consumers' goals related to both substance use and serious mental illness.

The goal of this evidence-based practice is to support consumers in their recovery process. Recovery is not simply abstaining from substance use, controlling symptoms, or complying with mental health treatment. Instead, *recovery* means that consumers are learning to move beyond illness so that they can pursue a personally meaningful life. Integrated treatment specialists support and empower consumers to define and achieve their individual goals.

Integrated Treatment programs are based on a core set of practice principles that form the foundation of the program (see below). A mid-level manager (called a *program leader*) with both administrative and clinical skills and authority oversees the Integrated Treatment program. The program leader supervises integrated treatment specialists and develops policies and procedures to ensure that these practice principles and other core components of the evidence-based model guide the way treatment and services are provided.

The Practice Principles

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.

Principle 1. Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders

Co-occurring disorders are common. Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Yet most consumers with co-occurring disorders receive treatment from different agencies or for their mental illness or substance use disorder *only*—if they receive treatment of any kind. This kind of fragmented treatment often leads to poor outcomes. Consumers with co-occurring disorders have a better chance of recovering from both disorders when they receive mental health and substance abuse treatment in an integrated fashion from the same practitioner (an integrated treatment specialist).

Principle 2. Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses

To effectively assess and treat co-occurring disorders, integrated treatment specialists should be trained in psychopathology, assessment, and treatment strategies for both mental illnesses and substance use disorders. Mental health practitioners, therefore, should increase their knowledge about substance use disorders including the following:

- Substances that are abused by consumers;
- How these substances affect people with co-occurring disorders; and
- The short- and long-term effects of abuse and dependence.

Integrated treatment specialists should understand both mental health terminology and the language used for substance use disorders. They should understand the differences in levels of substance use and abuse and be able to provide integrated services to treat co-occurring disorders.

Principle 3. Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages

Consumers recovering from substance use disorders and serious mental illnesses go through stages, each of which marks readiness for a specific treatment. Integrated treatment specialists must assess consumers' stage of treatment and tailor services accordingly.

The Four Stages of Treatment

- Engagement
- Persuasion
- Active treatment and
- Relapse prevention

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Principle 4. Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage

Motivational interventions are key to integrated treatment for co-occurring disorders. These interventions help consumers identify personal recovery goals. Typically, consumers reduce or abstain from using substances of abuse as they become motivated to reach their goals. These interventions often stimulate consumers to make a number of changes in their lives.

Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment. When providing the interventions, integrated treatment specialists use specific listening and counseling skills to help consumers who are demoralized or who are not ready to pursue abstinence.

Principle 5. Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages

Consumers may have difficulty managing unpleasant emotions and symptoms that lead to substance use disorders. Integrated treatment specialists with skills in cognitive-behavioral counseling can help consumers stop automatic patterns of thought that lead them to abusing substances. For example, one way to help consumers change their substance use behavior is to help them identify thoughts or feelings that trigger the urge to use and then help them change these thoughts and feelings. Learning to manage negative thoughts and emotions can dramatically help consumers to stay away from substances.

Principle 6. Multiple formats for services are available, including individual, group, self-help, and family

Consumers benefit most when multiple formats are available to them at appropriate stages of treatment. For example, consumers in the persuasion stage may benefit from motivational interventions that are provided individually. Including family or other supporters in treatment is recommended because they can be a strong source of support for consumers who often have a restricted, non-substance-using social network. Also, families who receive information are better able to effectively support their relative.

Group treatment can help consumers feel less alone. Whether groups are led by professionals or peers, group treatment allows consumers to develop a peer network. Consumers with similar experiences offer support, empathy, and opportunities to socialize with nonusers, which is especially useful in the relapse prevention stage.

Principle 7. Medication services are integrated and coordinated with psychosocial services

Physicians, nurses, or other approved providers who prescribe medications should be trained to treat co-occurring disorders effectively. Medication prescribers should participate in multidisciplinary treatment team meetings. They should work closely with consumers, integrated treatment specialists, and other treatment team members to ensure that treatment for both mental illnesses and substance use disorders is provided in an integrated fashion.

Psychiatric medication should be prescribed despite active substance use. Medication prescribers should avoid prescribing potentially addictive medications to consumers with co-occurring disorders and, when appropriate, they should offer medications that may help reduce addictive behavior.

Many people who take numerous medications at various times throughout their day have difficulties following medication regimes. Providing medication services can help consumers by enhancing their motivation and offering strategies for remembering medication regimes.

How do we know that it's effective?

Researchers began to document the prevalence of co-occurring disorders in the early 1980s. As noted earlier, studies found that up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Also, studies showed that compared to consumers without co-occurring disorders, consumers with co-occurring disorders relapsed more frequently and were more likely to be—

- Hospitalized;
- Violent;
- Incarcerated;
- Homeless; and

- Infected with HIV, hepatitis, and other diseases (Drake et al., 2001).

Studies also showed that consumers who received care in systems in which mental health and substance abuse treatment were separate were often excluded from services in one system and told to return when the other problem was under control. Those who received services in nonintegrated systems of care also had difficulty making sense of disparate messages about treatment and recovery. Consequently, the evidence demonstrated that consumers with co-occurring disorders in nonintegrated systems of care have poor outcomes (Drake et al., 2001).

Since the mid 1990s, eight studies support the effectiveness of Integrated Treatment for Co-Occurring Disorders. While the type and array of interventions in these programs vary, they include the critical components outlined in the Integrated Treatment Fidelity Scale. This scale's measures help agencies assess whether their Integrated Treatment program provides services in a manner that adheres to the evidence-based model. In contrast with nonintegrated treatment, integrated treatment is associated with the following positive outcomes:

- Reduced substance use;
- Improvement in psychiatric symptoms and functioning;
- Decreased hospitalization;
- Increased housing stability;
- Fewer arrests; and
- Improved quality of life (Drake et al., 2001).

In short, consumers with co-occurring disorders fare better when provided Integrated Treatment for Co-Occurring Disorders. For more information about the effectiveness of this evidence-based model, see *The Evidence* in this KIT.

Who benefits most?

Studies show that Integrated Treatment for Co-Occurring Disorders is effective for consumers with a wide range of backgrounds. Although consumers with co-occurring disorders tend to be younger, studies include a wide range of ages, with most consumers between ages 18 and 55 (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Godley, Hoewing-Roberson, & Godley, 1994; Jerrell & Ridgely, 1995).

Similarly, all these studies included both males and females, with males making up the majority of participants, which is consistent with the higher prevalence of substance abuse in men than women (Mueser, Yarnold, & Bellack, 1992; Mueser et al., 2000). Special issues have been identified related to the unique needs of women with co-occurring disorders (Brunette & Drake, 1998; Brunette & Drake, 1997; Gearon & Bellack, 1999), but no evidence suggests that women with co-occurring disorders benefit less from integrated treatment.

Race and ethnicity have varied across the different studies, with most studies including a majority of Caucasian consumers but also including some African American consumers (Carmichael et al., 1998; Drake et al., 1998a; Godley et al., 1994; Jerrell & Ridgely, 1995). One study included only African American consumers and reported very positive results (Drake et al., 1997).

Research studies have also included significant numbers of consumers with housing instability and homelessness (Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Meisler, Blankertz, Santos, & McKay, 1997). The evidence from these studies shows that this model is effective at improving both co-occurring disorders and housing outcomes. Presumably, the outreach component is critical to successful outcomes in work with this challenging population.

Where should Integrated Treatment for Co-Occurring Disorders be provided?

Integrated Treatment for Co-Occurring Disorders has been successfully implemented in a variety of settings and geographic locations. The majority of the studies have been conducted on an outpatient basis, with positive results (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Godley et al., 1994; Jerrell & Ridgely, 1995).

Less research has examined the effectiveness of this model provided in inpatient, residential, or intensive day treatment programs. Most of the studies examining short-term, residential, or intensive day treatment (3 to 6 months) programs suffer from high dropout rates (Blankertz & Cnaan, 1994; Burnam et al., 1995; Penn & Brooks, 1999; Rahav et al., 1995).

BUILDING

RECOVERY ORIENTED SYSTEMS OF CARE

The essential ingredients of this type of system of care include treating patients differently and reorienting our care delivery system.

Carlo C. DiClemente, PhD, ABPP and Daniel Knoblach, MA

Recovery from substance use and mental/emotional disorders is not a single event. It is a personal journey through a series of complicated, interacting life stressors and health conditions during a time of personal learning and discovery. Abstinence or being adequately medicated is not the ultimate goal but only part of a much larger process of personal recovery involving interpersonal functioning, health, well-being, and quality of life. The Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition of recovery from mental/emotional disorders and substance use disorders is "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012).

The contemporary understanding of recovery reaches well beyond diagnostic symptoms and has become more complex, addressing a constellation of overlapping mental and physical health conditions as well as social and spiritual considerations. Recovery is understood in a broader context with terms like *health* and *wellness* replacing *in remission*, *symptom free*, and *abstinent*. Recovery also means inviting individuals in recovery to outline change plans that optimize their own definition of personal well-being. Providers are being asked to broaden and diversify their understanding of the multifaceted nature of recovery to best treat and help their patients in recovery reach their full potential.

Recovery Oriented Systems of Care

Since the problems during recovery are complex and multifaceted, short-term fixes, isolated or sequential treatments, and siloed services are completely inadequate to address the complicated needs of these patients on their recovery journey. What is needed has been called a recovery oriented system of care (ROSC). The essential ingredients of this type of system of care include treating patients differently and reorienting our care delivery system. Patients become collaborators whose motivations and perspectives are valued, rather than passive recipients of care. The focus becomes centered on the whole person and not just the specific presenting problems. Providers are being asked to shift from provider-driven to patient-centered care.

To accomplish this shift, healthcare professionals must provide integrative care and consumer-oriented services, moving from building specific treatment programs to creating systems of care that are comprehensive, patient-centered, integrated, and collaborative (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). What can be done to create these systems of care? Hoge and colleagues outlined a set of core competencies that would be needed to create a system of integrated behavioral health and primary care. Some of the key competencies of integrated care are elaborated below.

Shifting from a specialist model to a coordinated care model requires an understanding of the larger context of the patient and the care system. Patients striving to enter or remain in recovery from mental/emotional disorders and substance use disorders often have multiple problems. When interacting with the healthcare system they often need services from a multidisciplinary set of providers. They can enter the healthcare system from many different portals. Providers offering healthcare for mental health, substance use disorders, infectious disease, medical emergencies, and primary or family care see these patients on a daily or weekly basis. However, these patients and the complex nature of their problems are often not assessed, recognized, or treated in most of these systems because the focus is on the primary problem of interest to that particular healthcare setting. If behavioral health problems are recognized, often these patients are referred to other caregivers with little or no sharing of information, coordination of services, or follow-up and continued care. Coordination of healthcare is difficult to achieve even when the needed resources are within the same system, let alone if needed care must be delivered by someone outside the system.

Transforming current healthcare systems to integrated health systems capable of becoming recovery-oriented systems of care requires changes in our systems and services. Substance use and mental health consumers often present with high rates of comorbidity. One critical component for providing integrated and coordinated care is comprehensive screening of patients as they enter and navigate their way through each of the provider systems. Screening needs to address the variety of problems faced by these patients. Emergency care that addresses an acute medical crisis but ignores the alcohol use disorder that caused it fails to provide the holistic screening perspective needed to create a recovery oriented system of care. The treatment of diabetes by primary care without coordination with the medication assisted treatment for substance use or the psychiatrist treating the bipolar depression creates parallel, not integrated care. The mental health provider who does not address nicotine addiction or obesity also is not providing integrated, comprehensive, and responsive care. Recovery oriented systems of care must find a way to provide comprehensive screening and assessment, effective communication among providers, and coordinated services (DiClemente et al, 2016).

Consumer-Centered Care

There is a saying that if you have seen one alcoholic individual, you have seen one alcoholic. The idea is that although we often have a mental image of these types of people, the reality is that each one is unique and not like any other by virtue of history, presentation, complicating context of their life, motivation, ethnicity, race, and a host of other variables. Recovery for these individuals follows a common but unique path involving progression, regression, slips, relapses, and often success. There are common themes and similar problems, like trauma, domestic violence, and dual diagnosis, but the combination is unique to each mental health and substance use patient. The uniqueness means that we cannot simply offer standard care for a condition, and there are several important implications of this truth.

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First, treating individuals as consumers who have some ideas about what they want and need, and what services may be most helpful to them, is critical. It is true that patients do not always know all their needs and are not always motivated to pursue some of the recovery objectives. However, they are the experts on their lives, they own the motivation that is critical to successful treatment and recovery, and they have networks that can be supportive of or detrimental to recovery. They need to be consulted and engaged in treatments and these services must fit into and enhance their recovery efforts (DiClemente et al., 2016). For example, the pregnant substance abusing woman needs a host of services that require the coordination of multiple agencies and providers to care for her and her newborn. However, these women are commonly given sequential and segregated services from obstetricians, hospital nurses, neonatal intensive care providers, pediatricians, social services, judicial systems, and specialty providers. Often there are social and support services for these women and children that are either not recognized or underutilized to manage the woman's trauma, the child's developmental delay, or the family's needs. Integrated care is critical to the successful recovery of these women and their families.

Second, patients are not passive recipients of our services. They are active consumers with choices to be made about recovery. Recovery involves a process that encompasses change across many different behaviors over time. Taking medications or abstaining from a substance can be viewed as the critical outcome or as simply a part of the recovery process of revitalizing the health and well-being of the individual. The patient must be a collaborator who has control of the motivational aspects of change. Their goals, concerns and behaviors are central to recovery. Their decisional considerations will influence whether they will make the changes needed to maximize well-being. In the working definition of recovery, this reality is summed up in the statement "Recovery is based on respect." Respect is best demonstrated by listening rather than talking, exploring patient motivation and perspectives, honoring cultural concerns, and responding in a manner that demonstrates that the patient has been heard.

Third, integrated care is only possible with communication and coordination among healthcare providers and patients. Providers, patient records, and staff must be available to coordinate care among providers, patients, and families so that all can make informed decisions about needs, types, and strategies of care. Comprehensive care plans must drive administration and sequencing of care. Many times, patients in recovery are like pinballs bouncing from one service to another with both provider and patient being unable to see the bigger picture. Families and support systems must be engaged to provide the scaffolding that is necessary to move through the recovery process. Integrated care is coordinated care. Our systems and information technology must be empowered to support and improve integrated care.

The implications of a recovery oriented system of care for behavioral health, primary care and specialty providers are important and can seem daunting. A system is composed of multiple, integrated parts that work together to achieve a goal. However, as we see happening in technical, government, and family systems, problems occur frequently and can make these systems dysfunctional. In order for the healthcare system to truly support recovery, all providers and staff and the programs we build have to be an integral part of the solution and not the problem.

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References:

DiClemente, C.C. (2018). *Addiction and Change: How Addictions Develop and Addicted People Recover.* (Second Edition) New York: Guilford Press.

DiClemente, C.C., Norwood, A.E., Gregory, W.H., Travaglini, L., Graydon, M., & Corno, C. (2016) Client centered, collaborative, and comprehensive care: The royal road to recovery. *Journal of Addictions Nursing, 27*(2), 94-100.

Hoge, M.A., Morris, J.A., Laraia, M., Pomerantz, A., & Farley, T. (2014). *Core Competencies for Integrated Behavior Health and Primary Care.* Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions.

Substance Abuse and Mental Health Services Administration, (2012). *SAMHSA's Working Definition of Recovery.* Retrieved 26 June 2018 from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.VmrytUorLcs.

12 TWELVE STEPS TO CO-OCCURRING COMPETENCY

Kenneth Minkoff, MD

Many who provide service to individuals and families with co-occurring mental health and substance use conditions want to develop their skills and feel more successful. This applies to front line clinicians, supervisors, program leaders or agency managers, regardless of experience or licensure.

I have been working on and writing about developing integrated services and systems for people with co-occurring conditions for almost 35 years and over that time, have learned much about how to make it really simple for people at all levels to be successful improving their own work, the work of their programs, and the work of their agencies. In fact, with consistent effort to apply simple best practice approaches, all services can be re-designed to welcome the needs, inspire the hopes, and provide integrated services to individuals and families with co-occurring conditions and other complex needs.

Welcoming and Prioritizing People with Co-occurring Conditions

The term "co-occurring conditions" can be applied to any person, of any age, with any combination of any mental health issue (including trauma) and any substance use disorder or addictive issue (including gambling, or even nicotine dependence), whether or not they have already been diagnosed. We can also refer to co-occurring families (a concept particularly relevant in children's services) as families with a child with one kind of condition (e.g., serious emotional disturbance) and a family member or caregiver with another kind of condition (e.g. substance use disorder) so that the family system needs an integrated approach.

People and families with co-occurring conditions are present in every type of service setting. As a group, they tend not to have only mental health and substance use conditions, but also have health and cognitive challenges, as well as challenges with housing, legal issues, parenting, disability, and more. In short, these individuals and families are characterized by complexity, and are likely to struggle with multiple challenges on a daily basis. Further, there is ample data that people with co-occurring conditions have poorer outcomes and higher costs in every conceivable domain including a higher likelihood of premature death. For all of these reasons, in every setting, individuals and families with co-occurring conditions should be welcomed as a priority population.

Second, not only are these people doing poorly, but there are many of them. That is, the prevalence of co-morbidity is so great in every setting (and more so in settings associated with higher costs and poorer

outcomes) that "co-occurring is an expectation, not an exception" (SAMHSA Report to Congress, 2002). While this is well known, it is striking the degree to which our entire system of care is frequently organized as if this isn't true. Therefore, in order for us to be successful in helping those with complexity who are in greatest need, we need to go beyond creating a few special "co-occurring programs" or "co-occurring clinicians" to developing capacity to help people with complexity throughout the system.

Building Co-occurring Competency in the Entire System

Over the course of the past several decades, we have learned about how system leaders and practitioners can work collaboratively to create a system that is designed on every level to be about the needs and hopes of the people and families with complex needs who are routinely coming through the door. The system must be built with the expectation that people with co-occurring issues are an expectation in every agency, in every program, and in the caseload of each individual service provider. How do we do this? Over 20 years ago, I began to develop a model for system design that became known as the Comprehensive Continuous Integrated System of Care (CCISC) (Minkoff, 1991; Barreira, Espey, Fishbein, Moran, & Flannery, 2000).

The ultimate goal of CCISC is to help develop a system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types (mental health, substance use, medical, cognitive, housing, legal, parenting, etc.). A well-developed system with those traits will help these clients and families with complex needs to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

CCISC has been widely utilized in the U.S. and Canada to implement a system of care that is designed to meet the needs of individuals with co-occurring mental health and substance use conditions, as well as other complex health and human service needs (Minkoff & Cline, 2004; 2005).

The basic tenets of the CCISC model are as follows:

Every system process (e.g. crisis response) and every system program is designed to be a "co-occurring program." That is, every program is designed to be recovery/resiliency oriented, trauma-informed, and co-occurring (or complexity) capable.

Every person providing help is designed and supported, within their job and level of training, to be a "co-occurring (or complexity) competent" helper. That is, every single staff person, regardless of level of licensure, has a specific set of instructions within their program to know how to be helpful to the people with co-occurring needs.

There are six evidence-based principles and associated interventions that are the foundations of the model. These principles were identified by reviewing the literature on successful programs and interventions, then looking inside those diverse programs to identify the common elements that could be applied in any program, by any team of staff, to be better providing services to the people with co-occurring conditions that are already present. The key to success is simplicity. The more complex the client, and the more complex the system, the more important it is that there are simple instructions that provide guidance for providing services that promote success. The six principles are:

1. **Welcoming.** Co-occurring disorders are an expectation. This includes emphasizing proactively welcoming individuals with co-occurring conditions exactly as they are (basic customer service), including when they present with active symptoms that may make us feel uncomfortable.

2. **Empathic, hopeful, integrated, strength-based partnership.** Individuals with complex conditions are welcomed into relationships, with individuals and/or teams, that help them identify their issues and work with them in small steps over time to address all those issues to achieve a happy, hopeful, and meaningful life. This involves purposely inspiring hope by helping clients articulate their goals for a happy life throughout the process, position ourselves to help them figure out how to address all their issues together, and build everything on a strength-based foundation. We identify the strengths people are already using to address and build on those strengths to help them make further progress.

3. **All people with co-occurring disorders are not the same.** Each client's needs are based *not* on just having two diagnoses, but on the specific experience

of that person with each of his or her disorders, as well as the other relevant issues in his or her life. All programs are co-occurring, but different programs have different tasks based on their mission, and the types of co-occurring clients they tend to see. Further, mental health conditions vary from severe, persistent and disabling, to mild or moderate in severity, to painful feelings and traumatic experiences that are undiagnosed. Similarly, substance use issues range from simple misuse (without a substance use disorder diagnosis, but perhaps adversely affecting a mental/emotional disorder) to a full range of substance use disorders from mild to severe. Individuals can have these conditions in all types of combinations.

4. **When multiple disorders or issues co-exist, each one is considered primary, and integrated best practice intervention for each issue is needed.** Each individual needs the best next step for each of his or her disorders or issues at the same time. If this seems overwhelming, the challenge is to make the steps small enough so that the person can succeed.

5. **For each issue, individuals move through stages of change, and interventions and outcomes must be stage-matched for each disorder or issue**. This is based on the stage matching literature (Mueser, Noordsy, Drake, & Fox, 2003). If someone asks, "What stage of change is a client in?" the correct answer is always: "For which issue?" Staging is issue specific. Using stage matching for each issue allows more effective matching of integrated interventions (e.g. motivational engagement for individuals in earlier stages of change) to the person.

6. **Active change involves adequately supported, adequately rewarded, skill-based learning for each issue.** Whatever recommendation (including medication for either mental/emotional disorder, addiction, or both) the key to success is helping each client learn the skills needed to succeed for each issue. Skill based learning involves practice, rehearsal, and repetition in small steps, with big rounds of applause (positive contingent learning) for each bit of progress. Skills for any issue (including legal, housing, parenting, etc., as well as illness management) involve self-management skills and asking-for-help skills, including help from peers, professionals, family members, and natural supports. Skill manuals (Roberts, Shaner & Eckman, 1999) are available and demonstrate how to help clients learn skills in simple and practical ways.

Twelve Steps of Complexity Competence Will Guide Staff

Although the principles and interventions are simple, they may be difficult to apply routinely. Many who work in this field have learned approaches to care that are not aligned with the principles, or they work in settings in which the principles are confounded on a regular basis. There may be unwelcoming rules and policies, and the assessments and service plans are focused on deficits with just a sprinkling of strengths, or interventions are more parallel than integrated by all staff. Or the interventions are not individualized adequately and have steps that are too big, stage matching is not routine, and there is more focus on compliance and consequences than on learning and reward.

However difficult it may be, service providers can all make progress right away in areas they control. Consider one small step that you can take consistently in your own work, in your own program, in your own agency…whatever your reach. You can ask for help to engage in a formal process using appropriate co-occurring capability improvement tools to make progress in your agency or program. Further, as an individual practitioner working to make progress in this area the Twelve Steps of Complexity Competency for Adult Staff (Minkoff & Cline, 2017) may be helpful.

1. Welcome individuals and families with complex issues into an empathic relationship.

2. Identify individual and family vision for a happy, hopeful, meaningful life.

3. Screen for all co-occurring issues (including mental health, substance use, health, trauma, intellectual disability/developmental disability, brain injury, domestic violence, abuse/neglect, parenting, school/work, legal, housing, and other challenges).

4. Assess for the presence of immediate safety risk in any domain, and know how to get the individual to safety.

5. Integrate the ability to gather basic assessment information relevant to each co-occurring issue into the assessment, including integrating assessment information obtained from family members and collateral providers. Understand

the distinctions between high– and low– severity mental health and substance use issues.

6. Routinely identify and communicate individual strengths (periods of success, what they are already doing right) for each issue, as part of all forums (team meetings, supervision, presentations, service planning, etc.), with or without the individual present.

7. Be aware of, and understand, the specific nature of *each* issue, and the associated recommendations for that issue, at least as well as the individual understands them.

8. Identify stage of change for each issue, for the individual served.

9. Provide stage-matched interventions as indicated, to assist the individual to move through stages of change for each issue in order to be successful in achieving his/her goals. For issues in earlier stages of change, help each individual determine the right amount of attention to that issue (e.g., What is the right amount of substance use for me? What is the right amount of medication for me?) in order to achieve his/her vision of a happy life.

10. For issues in more active stages of change, provide specific and positively rewarded skills training on how to make progress for each issue. This includes specific skills training for any issue, such as on reducing substance use (in the face of mental health challenges) and/or managing mental health symptoms or painful feelings (without using substances) and/or how to manage medical issues, legal issues, housing, etc. Modify any skills training to accommodate the person's cognitive or emotional learning impairment or disability, and provide rounds of applause for small steps of progress.

11. Collaborate effectively with other types of service providers (including other mental health or substance use services, housing, primary health, justice services, disability supports, etc.) to help the individual receive an integrated message of how to make progress.

12. Promote engagement in peer support and, when appropriate, recovery self-help meetings, for individuals struggling with one or more issues.

These are competencies that anyone can work to improve, regardless of whether they are licensed, or regardless of type of licensure. Anyone can get started by looking at the Twelve Steps, and asking: Where am I strong? Where can I improve? Pick one or two steps to improve and just start to practice those steps more consistently. Do not start with the hardest steps. Building a strong foundation of welcoming, hope, and integrated strength-based partnership with your clients will help you with stage matching and skill building down the line. And make sure you ask for help if you need it. There are many people out there who have been doing this work for years, are passionate about working with co-occurring clients, and will be delighted to answer your questions.

Dr. Kenneth Minkoff *is a board-certified addiction psychiatrist, and recognized as an expert on integrated services and systems for individuals with co-occurring serious mental/emotional disorders and substance use disorders. For the past 17 years, he has worked with his consulting partner Christie A. Cline, MD, MBA, in behavioral health systems all over the world. Their mission is to help systems organize themselves at every level, with every program, process, policy, procedure, person providing help, and every penny available, to be about the needs and hopes of the people with complex issues who need service.*

Dr. Minkoff is active in influencing policy and practice on a national and state level. He is a permanent (emeritus) Board Member of the American Association of Community Psychiatrists, Board Member for the College for Behavioral Health Leadership, and assistant professor of psychiatry at Harvard Medical School. He is also director of system integration at the Meadows MH Policy Institute, and a member of the Federal Interdepartmental SMI Coordinating Committee (ISMICC). He welcomes inquiries and may be contacted at kminkov@aol.com; www.ziapartners.com.

References:

Barreira, P., Espey, B., Fishbein, R., Moran, D., & Flannery R.B., Jr. (2000). Linking substance abuse and serious mental illness service delivery systems: Initiating a statewide collaborative. *Journal of Behavioral Health Services & Research, 27*(1), 107-13.

Cline, C.A., & Minkoff, K. (2017). *CCISC Toolkit: ILSA Supervision Workbook. A Workbook for Supervisors to Assist Staff in Developing Co-occurring Competency*. San Rafael, CA; ZiaPartners.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. *New Directions for Mental Health Services, 50*, 13-27.

Minkoff, K., & Cline, C. (2004). Changing the World: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America, 27*(4), 727-743.

Minkoff, K., & Cline, C. (2005). Developing welcoming systems for individuals with co-occurring disorders: The role of the Comprehensive Continuous Integrated System of Care Model. *Journal of Dual Diagnosis 1*(1), 65-89. doi: 10.1300/J374v01_06

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guilford Press.

Roberts, L.J., Shaner, A., & Eckman, T.A. (1999). *Overcoming Addictions: Skills Training for People with Schizophrenia*. New York: W.W. Norton

Substance Abuse and Mental Health Services Administration. *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*. November 2002.

Substance Abuse Treatment

for Persons with Co-Occurring Disorders: A Treatment Improvement Protocol (TIP) 42

Similar to this KIT, TIP 42 produced by SAMHSA's Center for Substance Abuse Treatment (CSAT) is a guide for treating co-occurring mental illnesses and substance use disorders. It is an excellent complement to the Integrated Treatment KIT.

The primary audiences for TIP 42 are substance abuse treatment practitioners with varying degrees of education and experience. Secondary audiences are other professionals who work with people who have co-occurring disorders and policymakers.

TIP 42 summarizes state-of-the-art treatment of co-occurring disorders. It has chapters on terminology, assessment, and treatment strategies and gives suggestions for policy planning. Concepts, models, and strategies outlined in TIP 42 are based on definitive research, empirical support, and agreements of a consensus panel. Successful models of treatment are portrayed and specific consensus panel recommendations are cited throughout the TIP.

For example, TIP 42 presents The Quadrants of Care, developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) as a conceptual framework that classifies consumers in four basic groups based on symptom severity:

- **Category I:** Less severe mental disorder/less severe substance disorder
- **Category II:** More severe mental disorder/less severe substance disorder
- **Category III:** Less severe mental disorder/more severe substance disorder
- **Category IV:** More severe mental disorder/more severe substance disorder

The quadrants are an aid to formulating treatment and a guide to improve;in systems integration of mental illness and substance abuse (pp. 28-30). Examples of their use are given throughout the TIP. The TIP offers these six guiding principles in treating consumers with co-occurring disorders (p.38):

1. Employ a recovery perspective.
2. Adopt a multi-problem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the consumer's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

More on TIP 42

TIP 42 is a valuable source of federal, state, and private funding opportunities (pp. 52-53). It presents a wide variety of funding resources, with advice on how they may best be used and how they can be combined to collaborate on initiatives. TIP 42 also addresses organizational and systems changes necessary for successful programming and financing change.

TIP 42 summarizes a variety of outpatient and residential settings for co-occurring disorders treatment and highlights promising models as well as provides a guide to evaluating outpatient programs (see Chapter 6). TIP 42 describes Assertive Community Treatment (ACT) and Intensive Case Management (ICM) and offers empirical evidence for each. Similarities and differences of ACT and ICM are detailed (p. 159). Advice to administrators who wish to implement these programs is presented on page 157 (ACT) and page 159 (ICM).

Similar to information found in *Training Frontline Staff* of the Integrated Treatment KIT, TIP 42 includes information about practice strategies including—

- Motivational interviewing
- Cognitive-behavioral therapy
- Contingency management
- Relapse prevention
- Self-help groups

It includes information about the specific needs of consumers who are homeless, those in the criminal justice system, and women. It also offers advice for helping these special populations.

While nicotine dependence is not discussed in the Integrated Treatment KIT, TIP 42 provides a brief history of nicotine dependence and steps for addressing tobacco use in substance use and mental illness treatment planning (see Chapter 8). Additionally, TIP 42 discusses specific mental disorders in the context of their treatment in substance abuse including—

- Personality disorders
- Bipolar
- Major depressive
- Schizophrenia
- Attention deficit hyperactivity disorder
- Post-traumatic stress disorder
- Eating disorders

TIP 42 includes a brief section on substance-induced disorders that describes how substances can mimic mental illness (see Chapter 9). These disorders are distinguished from independent co-occurring disorders because the psychiatric symptoms are a result of substance use.

For a copy of TIP 42 and supplemental guides for this TIP, see the CD-ROM for this KIT or visit www.ncadi.samhsa.gov.

References:

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S.W., Moring, J., O'Brien, R., … McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *The American Journal of Psychiatry, 158*(10,) 1706-1713.

Blankertz, L.E., & Cnaan, R.A. (1994). Assessing the impact of two residential programs for dually diagnosed homeless individuals. *Social Service Review, 68*(4), 536-560.1994

Brunette, M.F., & Drake, R.E. (1998). Gender differences in homeless persons with schizophrenia and substance abuse. *Community Mental Health Journal, 34*(6), 627-642.

Brunette, M.F., & Drake, R.E. (1997). Gender differences in patients with schizophrenia and substance abuse. *Comprehensive Psychiatry, 38*(2), 109-116.

Burnam, M.A., Morton, S.C., McGlynn, E.A., Peterson, L.P., Stecher, B.M., Hayes, C., & Vaccaro, J.V. (1995). An experimental evaluation of residential and nonresidential treatment for dually diagnosed homeless adults. *Journal of Addictive Diseases, 14*(4), 111-134.

Carmichael, D.M. Tackett-Gibson, L., O'Dell, R., Menon, R., Jayasuria, B., & Jordan, J. (1998). *Texas dual diagnosis pilot project evaluation report.* Final report submitted to the Texas Commission on Alcohol and Drug Abuse and the Texas Department of Mental Health and Mental Retardation. Public Policy Research Institute, Texas A&M University.

Drake, R.E., Essock, S.M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., … Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*(4), 469-476.

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H., Miles, K., & Ackerson, T.H. (1998a). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *The American Journal of Orthopsychiatry, 68*(2), 201-215.

Drake, R.E., Yovetich, N.A., Bebout, R.R., Harris, M., & McHugo, G.J. (1997). Integrated treatment for dually diagnosed homeless adults. *Journal of Nervous and Mental Desease, 185*(5), 298-305.

Gearon, J.S., & Bellack, A.S. (1999). Women with schizophrenia and co-occurring substance use disorders: An increased risk for violent victimization and HIV. *Community Mental Health Journal, 35*(5), 401-419.

Godley, S.H., Hoewing-Roberson, R. & Godley, M.D. (1994). *Final MISA report.* Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

Jerrell, J.M., & Ridgely, M.S. (1995). Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorders. *The Journal of Nervous and Mental Disease, 183*(9), 566-576.

Meisler, N., Blankertz, L., Santos, A.B., & McKay, C. (1997). Impact of assertive community treatment on homeless persons with co-occurring severe psychiatric and substance use disorders. *Community Mental Health Journal, 33*(2), 113-122.

Mueser, K.T., Yarnold, P.R., Rosenberg, S.D., Swett, C., Miles, K.M., & Hill, D. (2000). Substance use disorder in hospitalized severely mentally ill psychiatric patients: Prevalence, correlates, and subgroups. *Schizophrenia Bulletin, 26*(1), 179-192.

Mueser, K.T., Yarnold, P.R., & Bellack, A.S. (1992). Diagnostic and demographic correlates of substance abuse in schizophrenia and major affective disorder. *Acta Psychiatrica Scandinavica, 85*(1), 48-55.

Penn, P.E., & Brooks, A.J. (1999). *Comparing substance abuse treatments for dual diagnosis: Final report.* Tucson, AZ: La Frontera Center.

Rahav, M., Rivera, J.J., Nuttbrock, L., Ng-Mak, D., Sturz, E.L., Link, B.G., … Gross, B. (1995). Characteristics and treatment of homeless, mentally ill, chemical-abusing men. *Journal of Psychoactive Drugs, 27*(1), 93-103.

Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., … Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association, 264*(19), 2511-2518.

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

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