

Presented by:  
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**Co-Occurring  
Treatment  
Adolescents  
&  
Adults**

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**Mark Disselkoben, MSW, LCSW, LADC**

**Northwest Addiction Technology  
Transfer Center**

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**The ATTC Network**

**Ten Regional Centers**

**Four National Focus Area Centers**

- SBIRT
- Hispanic and Latino
- Native American-Alaska Native
- Frontier and Rural

**SAMHSA**  
Substance Abuse and Mental Health Services Administration  
U.S. Department of Health and Human Services

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### Evaluations

- Thank you for sharing your feedback on our programming with us!
- We use this information to improve our services and to share information with SAMHSA about our work.
- Please complete the Evaluation Form and the Thirty-Day Follow Up Consent Form.

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### Introductions

- Name
- Agency
- Community

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### Self Assessment

- o Does your organization have policies that reflect integrated co-occurring disorders (COD) treatment?
- o Have you received in-service training related to integrated care?
- o Does the assessment tool you use, adequately address co-occurring issues?
- o Does the programming at your agency provide co-occurring care?
- o How do you coordinate client care when your agency does not have the expertise to address a particular co-occurring issue?

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### Policy & Procedures Quality Management

#### Policy Development:

- o What should be included?
  - o ASAM Services Description
  - o DDC Guidance (Toolkit)
  - o Training of Staff (Building Competencies) TAP 21
  - o Clinical Supervision of Staff (21A and Tip 52)

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### Policy & Procedures

- o Program Descriptions:
  - o Using ASAM Levels of care as a guide
    - o Level 0.5 Early Intervention
    - o Level 1 Outpatient Services
    - o Level 2.1 Intensive Outpatient Services
    - o Level 2.5 Partial Hospitalization Services
    - o Level 3.1 Clinically Managed Low-Intensity Residential Services
    - o Level 3.3 Clinically Managed-Specific High Intensity Residential Services (Adult Only)

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### Policy and Procedures Continued:

- Level 3.5 Clinically Managed High-Intensity Residential Services (Adult only)
- Level 3.5 Clinical Managed Medium-Intensity Residential Services (Adolescent Criteria)
- Level 3.7 Medically Monitored Intensive Inpatient Services (Adult Criteria)
- Level 3.7 Medically Monitored High-Intensity Inpatient Services (Adolescent)

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### Policies and Procedures Continued:

- Level 4 Medically Managed Intensive Inpatient Services
- Opioid Treatment Services (OTS)
- Withdrawal Management Service Levels

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### DDCAT (Let's take a look)

- Program Structure
- Program Milieu
- Clinical Process: Assessment
- Clinical Process: Treatment
- Continuity of Care
- Staffing
- Training

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### Policies and Procedures Continued:

- Mission Statement (Is it integrated ?)
- Evidence Based Practice Guidelines
  - Integrate specifically what EBP's are being utilized (More detailed discussion later)

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### Adolescent and Adults The Differences? (TIP 32)

- Onset of problem use is getting younger
- Development deficits (brain)
- Increase of traffic accidents for youth
- Delinquency
- Sexually risky behavior (onset of technology)
- Psychiatric considerations

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### Adolescent and Adults The Differences? Continued

- Progression of use
- Projecting consequences
- Value differences
- Peer dynamics

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### Screening:

- What is your definition of screening?
- Screening Basics
  - Screening is a formal process of testing to determine whether a client does or does not warrant further attention at the current time in regard to a particular disorder and, in this context, the possibility of a co-occurring substance use or mental disorder.

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### Screening Continued:

- The screening process for COD seeks to answer a "yes" or "no" question:
  - Does the substance abuse (or mental health) client being screened show signs of a possible mental health (or substance abuse) problem?
- Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be, but determines whether or not further assessment is warranted

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### Screening Tools

- CAGE (Mayfield et al. 1974), the Michigan Alcoholism Screen Test (MAST) (Selzer 1971)
- Drug Abuse Screening Test (DAST) (Skinner 1982)
- Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1992)
- The SSI-SA was developed by the consensus panel on TIP 11

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### Screening Tools Continued:

- o The Modified MINI
- o Mental Health Screening Form
- o K 6 Screening Tool
- o FASD Screening Tools

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### Types of Screening Tools

- o **The Patient Health Questionnaire-9 (PHQ-9)** and the **DSM-5 Level 1 and 2 Cross-Cutting Symptom** screens are also standardized screening tools that provide a wide variety of validated screenings as well and symptom severity ratings for on-going monitoring of symptoms during treatment and recovery.

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### Children's Behavioral Health Screenings

- o **Achenbach Children's Behavioral Checklists, the Ages and Stages Questionnaire-Social Emotional, and**
- o **The CRAFT** screening for adolescent substance use.

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### 12 Steps in the Assessment Process (TIP 42)

- Engage client
- Identify and contact collaterals
- Screen for and detect COD
- Determine quadrant and locus of responsibility and ASAM level of care
- Determine level of care
- Determine diagnosis
- Determine disability and functional impairment

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### Assessment Process Continued

- Identify strengths and supports
- Identify any linguistic needs and supports
- Identify problem domains
- Determine stage of change
- Plan treatment

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### Assessment Elements

- What assessment tool(s) does your agency utilize?
- Biopsychosocialspiritual Assessment
  - Medical
  - Employment if applicable
  - Substance use
  - Legal
  - Family/social
  - Peer Influence

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### Assessment Elements Continued:

- Mental health
- Developmental History
- Spiritual/religion
- Academic
- Risk Assessment
- History of abuse and/or neglect
- Trauma
- Cultural specific questions

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### Assessment Tools:

List of tools Appendix G, Tip 42 as well as other Tools

- WHODAS 2.0 Functional Assessment Tool
- DSM 5
- Global Appraisal of Individual Needs (GAIN)
- Adult Addiction Severity Index (ASI)
- Teen Addiction Severity Index (T-ASI)
- ASAM Criteria (Substance Use Specific)
- LOCUS Criteria (Mental Health Specific)

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### DSM 5

- Differential Diagnosis
- DSM Severity
- Substance Use Disorders

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### Criterion 1-4: Impulse Control

- Individual may take the substances in larger amounts or over a longer period than was originally intended
- Individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use
- All daily activities revolve around the substance
- Craving for the substance is present

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### Criterion 5-7: Social Impairment

- Recurrent substance use may result in failure to meet major role obligations at work, school, or home
- May continue to use despite persistent or recurrent social or interpersonal problems
- Important social, occupational and recreational activities may be given up or reduced because of use

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### Criterion 8-9: Risky Use

- Recurrent substance use in situations in which it could be physical hazardous
- Continued use despite knowledge of having a persistent or recurrent physical and psychological problems

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### Criterion 10-11: Pharmacological

- Tolerance
- Withdrawal

Note: There is still separate diagnoses for Withdrawal and Intoxication similar to the DSM IV-TR

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### Severity Rating

In Relationship to Criterion Stated In Previous Slides:

- Mild: 2-3 Symptoms
- Moderate: 4-5 Symptoms
- Severe: 6 or more Symptoms

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### Psychiatric Diagnosis Considerations with Adolescents

- Bipolar Disorders
  - Drug/Medication induced?
  - Cyclothymic disorder is given to adults who experience at least 2 years (for children, a full year) of both hypomanic and depressive periods without ever fulfilling the criteria for an episode of mania, hypomania, or major depression

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### Psychiatric Diagnosis Considerations with Adolescents

- Recognition that many individuals, particularly children and, to a lesser extent, adolescents, experience bipolar-like phenomena that do not meet the criteria for bipolar I, bipolar II, or cyclothymic disorders is reflected in the availability of the other specified bipolar and related disorder category.

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### Psychiatric Diagnosis Considerations with Adolescents

- Schizophrenia:
  - Psychotic features typically emerge between the late teens and the mid 30's: onset in adolescent is rare.
  - Peak age at onset for first psychotic episode is in the early-mid 20s for males and in the late-20s for females
  - Essential features of schizophrenia are the same in childhood, but it is more difficult to make the diagnosis.

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### Psychiatric Diagnosis Considerations with Adolescents

- In children, delusions and hallucinations may be less elaborate than in adults, and visual hallucinations are more common and should be distinguished from normal fantasy play. Disorganized speech occurs in many disorders with childhood onset (e.g., autism spectrum disorder), as does disorganized behavior (e.g. attention deficit hyperactivity disorder)

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### Psychiatric Diagnosis Considerations with Adolescents

- Attention Deficit/Hyperactivity Disorder
  - Most parents observe excessive motor activity when the child is a toddler
  - Symptoms are difficult to distinguish from normal activity prior to age 4
  - ADHD is often identified during elementary school years
  - Disorder is relatively stable through early adolescent, but some individuals have a worsened course with the development of antisocial behaviors

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### Psychiatric Diagnosis Considerations with Adolescents

- In most individuals with ADHD, symptoms of motoric hyperactivity become less obvious in adolescence and adulthood, but difficulties with restlessness, inattention, poor planning, and impulsivity persist.

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### Psychiatric Diagnosis Considerations with Adolescents

- Oppositional Defiant Disorder
  - First symptoms usually appear during the preschool years and rarely later than early adolescent.
  - Often precedes the development of a conduct disorder, but not in all cases
  - It also conveys risk for development of anxiety disorders and major depressive disorder

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### Psychiatric Diagnosis Considerations with Adolescents

- Conduct Disorder
  - Onset may occur as early as the preschool year, but the first significant symptoms usually emerge during the period from middle childhood through middle adolescent.
  - Onset is rarely after age 16
  - Disorder usually remits in adulthood
  - Early onset indicates worse prognosis
  - Risks related to conduct disorder in adulthood include, criminal behavior, substance use, mood, anxiety, PTSD, impulse control disorders for example

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### The ASAM Criteria At Assessment Updated

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### Six Dimensional Assessment

- Start on page 43
- Must be documented as part of the assessment
- Must address each assessment question per the manual

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### Dimension 1

#### Acute Intoxication and/or Withdrawal Potential

- What risk is associated with the patient's current level of acute intoxication?
- Are intoxication management services needed?
- Is there significant risk of severe withdrawal symptoms, seizures or medical complications?
- Are there current signs of withdrawal?
- Standardized withdrawal scale score?
- Vital signs?
- Does the patient have supports to assist in ambulatory withdrawal management?

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### Dimension 2

#### Biomedical Conditions and Complications

- Are there current physical illnesses, other withdrawal that need to be addressed?
- Are there chronic conditions that need stabilization or ongoing disease management?
- Is there a communicable disease present?
- Is the patient pregnant, what is her pregnancy history?

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### Dimension 3

#### Emotional, Behavioral, or Cognitive Conditions and Complications

- Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed?
- Are there chronic conditions that affect treatment such as bipolar or anxiety?
- Do any emotional, behavioral, or cognitive signs or symptoms appear to be an expected part of the addictive disorder?

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### Dimension 3: Continued

- Are they severe enough to warrant specific mental health treatment, **even if symptoms are caused by substance use?**
- Is the patient able to manage the activities of daily living?
- Can he or she cope with any emotional, behavioral or cognitive problems?

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### Dimension 3: Risk Domains

- **Dangerousness/Lethality**
- **Interference with Addiction Recovery Efforts**
- **Social Functioning**
- **Ability for Self-Care**
- **Course of Illness**

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### Dimension 4

#### Readiness to Change

- How aware is the patient of the relationship between his or her alcohol, tobacco, or other drug use or behaviors involved in the pathological pursuit of reward or relief and his or her negative life consequences?
- How ready, willing, or able does the patient feel to make changes?
- How much does the patient feel in control of his or her treatment services?

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### Dimension 5

#### Relapse Continued Use, or Continued Problem Potential

- Is the patient in immediate danger of continued severe mental health distress and/or alcohol, tobacco and/or drug use?
- Does the patient have any recognition or understanding of, or skills in coping with his or her addictive, co-occurring, or mental disorder?
- Have addiction and/or psychotropic medications assisted in recovery before?
- What are the person's skills in coping with protracted withdrawal, cravings, or impulses?

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### Dimension 5 Continued:

- How well can the patient cope with negative effects, peer pressure, and stress without recurrence of addictive thinking and behavior?
- How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment?
- How aware is the patient of relapse triggers and skills to control addiction impulses or impulses to harm self or others?

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### Dimension 6

#### Recovery Living Environment

- Do any family members, significant others, living situations, or school work situations pose a threat to the patient's safety or engagement in treatment?
- Does the individual have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful recovery?

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### Dimension 6: Continued

- Are there legal, vocational, regulatory (eg. professional licensure), social service agency, or criminal justice mandates that may enhance the **person's** motivation for engagement in treatment if **indicated**?
- Are there transportation, childcare, housing, or employment issues that need to be clarified and addressed?

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### Risk Rating System

Page 56-57

- ASAM Software Note
- High, Medium, Low
- 0-4 Point Scale, Page 57
  - 0: Low Risk
  - 1: Mild
  - 2: Moderate
  - 3: Serious
  - 4: Utmost severity

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CONTINUED SERVICE, TRANSFER AND DISCHARGE CRITERIA

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### Continued Service Criteria

Page 300

- o Making Progress
- o Not yet achieved goals articulated in the individual treatment plan
- o Capacity to resolve his or her problems
- o Actively working toward the goals articulated in the treatment plan
- o New problems have been identified that are appropriately treated at the present level of care

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### Transfer/Discharge Criteria

Page 303

- o Client has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care
- o Client has been unable to resolve the problem(s) despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated
- o Client has demonstrated a lack of capacity to resolve his or her problem(s) or has developed new problem(s) and can be treated effectively at a more intensive level of care
- o Patient has experienced an intensification of his or her problem(s) or has developed new problems(s) and can be treated only at a more intensive level of care

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### LOCUS 6 Dimensions

- I. Risk of Harm
- II. Functional Status
- III. Medical, Addictive and Psychiatric Co-Morbidity
- IV. Recovery Environment
- V. Treatment and Recovery History
- VI. Engagement and Recovery Status

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### Treatment Planning

- Integrated Treatment Plans
- Measureable Goals
- Client Objectives/Action Steps
- Clinician Intervention/Modalities

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### Integrated Treatment Plans

- Goals that address both substance use and mental health issues
- Coordination of Care
- Medication Management
- Case Management

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### Measurable Goals

- Symptom Improvement and Management
- Functioning Level (Start with DSM 5)
  - Academic
  - Criminal Justice
  - Health
  - Relationships
  - Stability in Housing
  - Abstinence

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### Client Objectives

- o What is the client going to do to work toward treatment plan goals?

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### Clinician Interventions

- o What is the clinician going to do to facilitate and encourage the client in achieving their goals?

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### Evidence Based Practices

#### NIDA 13 Principles

- o **Principle #1:**

**No single treatment is appropriate for all individuals:** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

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### Principles Continued:

o Principle #2

**Treatment needs to be readily available:**

Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

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### Principles Continued:

o Principle #3

**Effective treatment attends to multiple needs of the individual, not just his or her drug use:** To be effective, treatment must address the individual's drug use and any associated (spiritual, added) medical, psychological, social, vocational, and legal problems.

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### Principles Continued:

o Principle #4

**An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs:** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

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### Principles Continued:

o **Principle #5**

**Remaining in treatment for an adequate period of time is critical for treatment effectiveness:** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

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### Principles Continued:

o **Principle #6**

**Counseling (individual and/or group) other behavioral therapies are critical components of effective treatment for addiction:** In counseling, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

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### Principles Continued:

o **Principle #7**

**Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies:**

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### Principles Continued:

o **Principle #8**

**Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way:** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

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### Principles Continued:

o **Principle #9**

**In some cases medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use:** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

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### Principles Continued:

o **Principle #10**

**Treatment does not need to be voluntary to be effective:** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

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### Principles Continued:

o Principle #11

**Possible drug use during treatment must be monitored continuously:** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

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### Principles Continued:

o Principle 12

**Treatment programs should provide assessment for HIV/AIDS, Hepatitis B & C, Tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection:** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

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### Principles Continued:

o Principle #13

**Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment:** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

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### Guidelines for Developing Successful Therapeutic Relationships (TIP 42)

1. Develop and use a therapeutic alliance to engage the client in treatment
2. Maintain a recovery perspective
3. Manage countertransference
4. Monitor psychiatric symptoms
5. Use supportive and empathetic counseling
6. Employ culturally appropriate methods
7. Increase structure and support

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### Key Techniques for working with client who have COD (TIP 42)

- Provide motivational enhancement consistent with the client specific stage of change
- Design contingency management techniques to address specific target behaviors (PAMI)
- Use cognitive-behavioral therapeutic techniques

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### Key Techniques for working with client who have COD Continued:

- Use relapse prevention techniques
- Use repetition and skills-building to address deficits in functioning
- Facilitate client participation in mutual self-help groups

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### Evidenced Based Practice Models

- The Matrix Model
- Individual Counseling
- Motivational Enhancement Therapy
- Cognitive Behavioral Therapy
- Family Therapy Models
- 12 Step Approaches
- Medication Assisted Treatment
- Promoting Awareness of Motivation Interviewing

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### Additional Guiding Principles based research from Riggs, Crone, Flanzer & Bender

- Building a strong relationship and motivating client to attend treatment;
- Creating a treatment plan that centers on client-generated goals;
- Applying empirically supported treatments, focused on interventions specific to the client's diagnostic presentation;

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### Research continued:

- Focusing on client strengths;
- Goals and objectives focusing on change that is sustainable over the long term;
- Increasing intensity if the intended response is not achieved
- Fostering peer influence
- Psychoeducation

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### Critical Program Components Based on TIP 32 (Adolescents)

- Orientation
- Daily activities
- Peer monitoring
- Conflict resolution
- Client contracts
- Schooling
- Vocational training

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### EBP's Regardless of Age

- Family Therapy
- Cognitive Behavioral Approaches
- Motivational Interviewing

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### Family Therapy Theory

- Formal training and experience of clinician
- Proven effective with adolescent & adults in treatment
- Treating individuals as subsystems within the family system
- The family is the ultimate client
- From assessment through intervention through discharge

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### Continued

- Must assess individual as well as family unit
- Focus on changing interaction patterns
- Facilitate change in how the family relates to one another
- Encourage new healthy ways to resolve conflict/Family problem solving model/Practice at home etc.

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### Continued:

- Work with individual as well as family as a whole
- Consider extended systems, school, criminal justice etc.
- Identify underlying causes of conflict
- Appreciate values and ideas of each family member
- Differences don't have to be conflictual in nature

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### Adolescent Specific Approaches within Family Framework

- Build communication skills
- Equip parents with skills, support and resources (Parenting classes)
- Help parents regain optimism
- Help parents build self confidence
- Building a therapeutic alliance with family

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### Continued:

- Teach Parents:
  - Age appropriate monitoring
  - Relationship with children's friends
  - Negotiate reasonable curfews
  - Scheduling and positive rituals
  - Family obligations and expectations
  - Positive reinforcements
  - Consequences

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### Continued:

- Internet and cell phone contracts
- Consistent parenting
- Help build emotional attachments
- Fostering a relationship with the child in the home and out of the home

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### Cognitive Behavioral Therapy

- **What Is Cognitive Behavior Therapy?**
  - Feeling and behavior are caused by a person's thoughts, not outside stimuli like people, situations and events
  - May not be able to change circumstances, but maybe change how they think about them, equals change in how they feel and behave

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## Cognitive Behavioral Therapy

- General Approaches
  - Functional Analysis:
    - Therapist and client work together
    - Identify thoughts, feelings, circumstances related to symptomology
    - Helps client determine risks likely to lead up to relapse related substance use and mental health issues
    - Provides insight on why client symptoms increase
    - Helps identify situations in which the person has coping difficulties

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## Continued:

- Skill Training:
  - Determining how thinking is impacting coping skills
  - Goal is to get person to learn or relearn better coping skills
  - Unlearn old habits
  - Change the way they think about symptoms
  - Learn new ways to cope with situations and circumstances that lead to relapse

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## Motivational Interviewing: The History

- Bill Miller, Ph.D. and Stephen Rollnick Ph.D
- Barber Shop in Norway in 1982

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## INTRODUCTION

### Need for a Clear Definition

"Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence"

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- The spirit of motivational interviewing: Interpersonal style rather than a technique, not at all restricted to formal counseling settings:
- Differences from more confrontational approaches:

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## The Philosophy Behind Motivational Interviewing

- Client resistance typically is a behavior evoked by environmental conditions.
- The client/counselor relationship should be collaborative and friendly.
- Motivational Interviewing gives priority to resolving ambivalence.

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• The counselor does not prescribe specific methods or techniques.

• Clients are responsible for their progress.

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### Motivational Interviewing Principles

- Express Empathy
- Support Self-Efficacy
- Roll with Resistance
- Develop Discrepancy

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### Discussing Stages of Change

Pre-Contemplation Stage:

- Not thinking about making a change

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### Discussing Stages of Change

Contemplation Stage:

- Start thinking about the situation
- Not sure what to do

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### Discussing Stages of Change

Preparation State:

- People begin thinking about how they can go about making the change they desire, making plans and taking some actions

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### Discussing Stages of Change

Action Stage:

- People begin to implement the plan

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### Discussing Stages of Change

Maintenance Stage:

- Achievements are made and people attempt to sustain the change

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### Discussing Stages of Change

Relapse:

- If relapse happens, they typically return to pre-contemplation or contemplation stage
- The goal is to move through the wheel again without getting stuck

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Thank you for participating!

Questions?

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