Treatment and the “Primary Diagnosis”:

What if we can’t figure it out?

A 7 Step Approach

When an Individual has both Substance Use and Mental Health Issues, it is often impossible to determine which diagnosis is primary.

PARADIGM SHIFT:
TREAT BOTH AT THE SAME TIME Through the Stages of Change

HOW DO WE APPROACH THIS IN TREATMENT?

1. Integrated Care Construct
2. Relationship
3. 6 Guiding Principles for COD
4. Screening and Assessment
5. Staging
6. Processes of Change
7. Interventions and Documentation

STEP 1

Integrated Care as the Core Construct within Treating Individuals with COD

American Psychiatric Association

- The American Psychiatric Association (APA) advocates for integrated treatment approaches for individuals with co-occurring mental health and substance use disorders, emphasizing the importance of addressing both conditions simultaneously for better outcomes.
- Co-occurring mental health and substance use disorders are extremely common, and these often complicate and worsen the treatment prognosis of either condition alone.
- People with co-occurring disorders, are best served through integrated treatment, and (clinicians) have a vital role in assessing and treating both disorders, leading to better outcomes.

(APA Official Actions, Position statement on substance use disorders, Approved by the Board of Trustees, July, 2019, Approved by the Assembly, 2019).

STEP 2

Maximizing the Relationship for Individuals with COD

Driver of Positive Treatment Outcome: Therapeutic Alliance

- A PositiveTherapeutic Alliance Helps Clients to:
  - Improve symptom management
  - Improve overall Functioning
  - Improve Treatment engagement
  - Improve Treatment satisfaction
  - Improve Quality of life

https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf (142-143)

A Strong Therapeutic Alliance for Individuals with Severe Mental Illness (SMI) Results In:

- Reduction in symptoms
- Fewer hospitalizations
- Greater antispsychotic medication adherence
- Improved self esteem
- Treatment retention
- Self-efficacy
- More days of abstinence

https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf (142-143)

When in Doubt?

Always Start with the Relationship.

STEP 3

When Treating Individuals with COD Always Abide by the 6 Guiding Principles

6 Guiding Principles for Individuals with COD (outcomes of diagnoses vs. diagnoses themselves)

1. *Use a Recovery Perspective-* A long term perspective.
2. *Adopt a multi-problem viewpoint*-Identify (a) immediate and

(b) longer- term needs such as housing versus work, etc.

3. *Develop a phased approach to treatment*-Utilize the Stages of Change to help ensure **appropriate interventions are attached to the stages**

https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf (14-15

6 Guiding Principles for COD Care (cont.)

4. *Address specific real life problems early in treatment:* There is growing recognition that personal/social problems can be drivers of COD which has prompted approaches that address specific life problems early in treatment (loneliness, work, bereavement, relationships, children, etc.)

5. *Plan for the individual's cognitive/functional impairments*-Individuals with COD may have trouble comprehending information/completing tasks where there needs to be shorter/focused sessions

6. *Use support systems to extend treatment* effectiveness-Provider awareness and willingness to integrate into treatment are key)

https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf (14-15)

STEP 4

Screening and Assessment for Individuals with COD

IDDT Fidelity Index-Screening

- Conduct POC Urine Drug Screen (UDS)/Breathalyzer
- All new and existing clients are screened for substance use (both drug(s) and alcohol)/and mental health using a standardized protocol/instrument (e.g., CAGE, Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD/ PHQ-9, GAD-7, etc.).
- Every newly admitted client is screened for COD within 24 -72 hours
- The screening is included in the individual's record.
- The screening process includes when and who administers the screen and what steps to follow for a positive screen regarding drugs and alcohol.

Screening Basics

1. Screening is a simple process of determining whether more indepth assessment is needed, often consisting of asking the client basic “yes” or “no” questions.
2. Nearly any clinician can screen. Generally, no special training is required.
3. All SUD treatment clients and mental health treatment clients should be screened for CODs at least annually.

https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf

Screening Basics (cont.)

4. Screening is also needed when clients report or exhibit symptoms suggesting another disorder may be present.
5. Screening can happen anywhere that services are offered.
6. Screening is a necessary first step to ensure that clients receive the right diagnosis and treatment.

https://library.samhsa.gov/sites/default/files/pep20-02-01-004.pdf

Screening-In Summary

1. Make sure to review MH and SUD screening measures – important to do both
2. Assessment should include both areas of focus, and all diagnoses should be made (might be multiple MH and multiple SUD dx)
3. All are primary-The focus may differ on any given day

STEP 5

Staging for Individuals with COD

Client Staging

- Individuals are in various stages of readiness to address one or both of their challenges which should inform the type of treatment approaches utilized.
- The expectation is that newly admitted individuals are staged for both challenges by the treatment team prior to development of the first comprehensive treatment plan, within 5 days of admission.
- All individuals should be re-staged as needed and appropriate. The results of the staging process should determine the selection of treatment goals and interventions.

Chronology of Both Disorders

- MH and SUD History should be accurately reflected in the Medical Record
- Treatment Plans-Plans routinely address both disorders equivalently and in specific detail.
- Assess and Monitor Interactive Course of Both Disorders-Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both substance use and mental health disorders.

Discharge and Moving Forward

- Discharge Planning-Both disorders are seen as primary, with confirmed plans for follow-up.
- Focus on ongoing recovery for both disorders

Stages of Change: A Quick Review

Precontemplation Defined

- Not considering change within 6 months
- Interventions: Help people to “get concerned” and/or “seriously consider change”
- Precontemplation is what people are “not doing” (not engaging in the processes of change)
- Treatment may be prompted through external bodies

Contemplation Defined

- Considering change over next 6 months
- “Ambivalent”-of two minds-Beginning to engage the cognitive process of change
- Consideration of change
- Shift in the decisional balance

Preparation Defined

- Planning on change within one month
- “Micro” successes-no structured change plan

Action Interventions

- 3-6 months
- Behavior must be extinguished
- Confidence in new skills vs. temptation of “old” behaviors
- New patterns of behavior
- Less crisis driven-more sustainable

Maintenance Defined

- Greater than 6 months
- New behavior becomes the “norm”
- Integration into daily lifestyle
- Harder NOT to keep doing what you are doing

Relapse What is it?

- “Relapse happens”
- Can return to an earlier stage but this has to be determined

STEP 6

Utilizing the Transtheoretical Model for Individuals with COD

Why do we need a model?

Need a universal language

Need a universal way to assess

Need a universal way to understand and *document* interventions

Need a universal way to assess *and document* for medical necessity

Transtheoretical Model of Behavior Change (TTM)

- Stages of Change-Central concept (Precon/Cont)
- Processes of Change-Interventions
- Markers of Change-Measuring client change
- Change occurs over time
- Cognitive to behavioral
- Process vs. Event in time

• Behavior is dynamic: Not “all or nothing”

Processes of Change

- The processes necessary to move through different stages of change
- They ultimately represent the types of change necessary to ultimately effect long standing behavior change
- Clinician's job is to establish emotion/interest on the part of the individual as simply going through the motions or action will not last
- 10 Processes of Change we focus on 8 (not self or social liberation)

Processes of Change-Cognitive/Experiential Processes (Precontemplation/Contemplation)

- Consciousness-Raising-Increasing awareness about the causes, consequences and ways to remediate a problem behavior.
- Self-Reevaluation-An assessment of one's self image with or without a target behavior.
- Dramatic Relief-Positive/negative emotions that help to motivate taking action around a specific behavior.
- Environmental Reevaluation-Assessment of how the presence or absence of a behavior affects one's environment

https://hvresearch.org/wp-content/uploads/2023/04/Trans-Model_Stages-of-Change_FINAL-_New-Template.pdf

Processes of Change-Behavioral Processes (Preparation/Action)

- Stimulus Control-Removing triggers for unhealthy habits and adding prompts for healthy options
- Counter Conditioning-Learning healthier behaviors that can substitute for problem behaviors
- Reinforcement Management-Creating rewards for engaging in a desired behavior and eliminating any rewards received from engaging in the unwanted behavior
- Helping Relationships-Enlisting the support of others specifically for eliminating an old behavior or adopting a new one

https://hvresearch.org/wp-content/uploads/2023/04/Trans-Model_Stages-of-Change_FINAL-_New-Template.pdf

How do we Mark Change over Time?

Markers of Change

- Pros and Cons from the Decisional Balance Scale,
- Self-efficacy vs. Temptation

STEP 7

Operationalizing the Stages Into Practice for Individuals with COD: Interventions and Documentation

Interventions

- Staff will use stimulus control with John focused on helping him to avoid situations which trigger physical outbursts in the home.
- Staff will utilize self re-evaluation with John and help him to develop cognitive dissonance with his current behaviors and their impact upon his desire to be a “healthy role model” for his son.

Precontemplation

- **Individual Therapy:** Met with John today. The focus was on his staying in the residential and not needing to be discharged which could result in his becoming homeless. He is currently in Precontemplation. We utilized environmental re-evaluation focused on how his behaviors impact those around him, specifically how coming home late and intoxicated trigger others in the residential to use and result in volatile interactions which led to at least two calls to the police. He considered this an "overreaction" but was able to see through a decisional balance that the consequence of the behavior outweighed the pro of using specific to the risk of becoming homeless. He cycles between precontemplation and contemplation with his depression as we also conducted a decisional balance related to taking his medication which he agrees to take but at the same time continues to drink heavily minimizing the depressive effects of the alcohol and the serious impact it has on his mood. Overall, John's temptation to use substances continues to outweigh his desire to follow the rules of the residential leaving him at risk for discharge. The plan is to continue focusing on the impact John has on his environment through environmental re-evaluation and pros and cons with an emphasis on potential homelessness.

Contemplation

- **Contemplation**
- **Individual Therapy:** Met with John today. He is in Contemplation. Evidenced a greater level of ambivalence around his cocaine use and in taking medication for his depression. Last week he was able to conduct a decisional balance the day after relapsing on cocaine and state "I shouldn't have done it because I don't want to get thrown out of my house" but was also able to state "For a few minutes I felt like I had some friends." He also conducted a decisional balance related to his depression stating "I am thinking about taking the medication now. On the one hand I think it could help me, but on the other, there are days I am not sure if it is really worth it." John found this helpful. His temptation to use cocaine has lessened a little bit as his mood continues to wax and wane in intensity. We will continue to focus on decisional balancing and moving towards preparation for both substance use and treatment for his depression.

Action

Individual Therapy: Met with John today. Focused on his verbal declaration regarding abstinence intent to go to 12 step meetings. John is now in Action. He is focused on stimulus control and counter-conditioning. Today, we focused on continuing to use stimulus control as a mechanism to avoid passing bars on the way home from work with a plan to learn how to manage his anxiety and start using counterconditioning over time. We worked together on deep breathing and visualizing being able to drive down streets that were high anxiety for him. We also discussed his improved mood which he attributed to staying away from cocaine, but he acknowledged feeling lonely which is also a trigger. We role played how to stand up and ask for a sponsor at 12 step meetings and also how to manage his anxiety at meetings and at the same time make a commitment through making the coffee. The plan is for John to continue using stimulus control with a goal towards learning to utilize counterconditioning and increasing his social support to decrease his isolation and loneliness through 12 step meetings.

Relapse

Individual Therapy: Met with John today. He briefly relapsed to old behavior patterns, but cycled back to preparation as a stage of recovery. He went out after work with his friends and did not come back to the residential until 6:00PM, a three hour period of time. He was subsequently told that if this were to occur again he would be discharged from the facility. John was angry about this and stated "I should be able to be with my friends". We reviewed the rules of the house and conducted a decisional balance. John became teary and stated "I don't want to end up on the street again' (emotion/affect)". We focused on stimulus control and on independently conducting decisional balances. John agreed to do so and agreed to go to a 12 step meeting tomorrow and call his sponsor. He also agreed to set an appointment with his therapist, although he is still cycling between contemplation and preparation regarding therapy.

Summary

- 1. Establish a trusting, safe relationship
- 2. Screen for both mental health and substance use
- 3. Ensure safety through UDS/Breathalyzer
- 4. Utilize TTM model with emphasis on staging and processes of change
- 5. Treat both mental health and substance use as primary

QUESTIONS?