

Integrated Treatment: A Recipe for Success

June 7, 2011

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THE ARGUMENT FOR INTEGRATED TREATMENT



Co-occurring disorders typically refers to a combination of: 1) substance use disorder (SUD); and 2) mental disorders, i.e., any mental or emotional condition or psychiatric diagnosis including as eating, anxiety, mood, traumatic stress, bipolar and depressive disorders, schizophrenia, psychoses, other serious psychological distress.

Due to the enormous human and economic toll caused by co-occurring disorders, treatment providers and funders have sought better means to assess individuals to recommend the most appropriate treatments.

[Castaneda, Sussman, Westreich, et al. 1996; Corrao, Bagnardi, Zambon, et al. 2004]

Facts About Co-occurring Disorders

- At least 10 million people in the U.S. have a co-occurring disorder (SAMHSA).
- National co-morbidity survey found that up to 65.5% of those with a substance use disorder had at least one mental disorder and 51% of those with a mental disorder had at least one substance use disorder.
- Employees with co-occurring disorders experience a much greater work loss than those with all nonfatal injuries or illnesses - 25 days away from work compared with 6 in 2001. [NIOSH *Anxiety, Stress, and Neurotic Disorders in the Workforce*]

Prevalence of Co-occurring Disorders

- 28 % of people with schizophrenia have co-occurring substance use disorder
- 51% of people with bipolar disorder have a co-occurring substance use disorder
- 72% of people with mood disorders have a co-occurring substance use disorder
- Only 19% of people with co-occurring SMI and addiction disorders received treatment for both disorders - 29% receive no treatment at all

More Facts

- Typically have multiple co-occurring disorders and problems and have higher rates of physical illness, death, unemployment, homelessness, and CJ involvement.
- Many substance abuse and mental health programs use criteria that exclude people with co-occurring issues.
- Clients with a co-occurring disorder should be the “rule not the exception”.

More...

People with co-occurring conditions comprise the majority of the 10 percent of people using over 70 percent of the nations healthcare resources



Employers Addressing Substance Use Disorders Save By Addressing Co-Occurring Mental and Substance Use Disorders

Failure to deliver effective care to people with mental health and drug or alcohol problems results in significant costs to the nation's economy, including considerable costs to employers that result from employee absenteeism, poor job performance, disability and on-the-job accidents. But employers can take action to mitigate these problems.

How Co-Occurring Disorders Cost Employers

Untreated mental and substance use disorders contribute to:

□ *Increased healthcare costs*

- One study found that people with co-occurring substance use disorders and depression incurred healthcare costs that were about \$5,300 higher than those without the disorders.
- Co-occurring disorders can complicate existing health conditions and increase the risk for developing other serious medical problems such as cardiac and pulmonary diseases.
- People whose co-occurring disorders go untreated often access medical care at the acute stage and require high-cost services such as inpatient and emergency room care.


□ *Decreased work productivity:*

- Depression, the most common mental disorder, costs employers \$44 billion a year in lost productivity (including worker absenteeism and reduced job performance).
- Alcohol problems alone cost employers nearly \$134 billion in lost productivity in 1998, mostly due to absenteeism and poor work performance.

□ *Risk management concerns*

- Both mental and substance use disorders represent significant risk management issues, because they are associated with increased injuries on the job and increased disability claims.

Mental Disorders most frequently seen in EAP Settings

- 
- Generalized Anxiety Disorder
 - Panic Disorder
 - Social Phobias
 - Obsessive-Compulsive Disorder
 - Dysthymia
 - Depression

To complicate things further...

- More likely to be refused admission
- Prematurely discharged from one treatment system
- Seek treatment for other condition first
- Incompatible philosophies about treatment
- Lose clients between two systems



Co-occurring disorders result in worse outcomes

- Relapse of mental illness
- Treatment problems and hospitalization
- Violence, victimization, and suicidal behavior
- Homelessness and incarceration
- Medical problems, HIV & Hepatitis risk behaviors and infection
- Family problems
- Increase service use and cost

What doesn't work?

- Sequential and parallel systems of care--alienates them from treatment and have poorer outcomes
- Untrained or unsupported professionals
- The way we have most systems of care set up now do not work effectively for our clients

Dueling Diagnostics



- ❑ Alcohol and Drug treatment is often confrontational
- ❑ Mental Health –opposite end of spectrum
- ❑ Often contradictory methods
- ❑ Funding streams separate
- ❑ Views of cause and effect

Why Hasn't Traditional Treatment Been Effective?

- “Expert” approach
- “Expert” vs. Client Readiness
- If it's not working – the (“non-expert”) is,(fill in the blank)

Non-compliant?

Treatment resistant?

Manipulative?

Personality Disorder?

When was the last time you felt misunderstood? Like no one was really listening? Or couldn't see you for who you were?

Differences between substance abuse and mental health treatment and recovery concepts:

The phenomenon of craving is not generally experienced in mental health recovery.

The term enabling has different meanings in mental health recovery than in substance dependency recovery.

A “relapse” in substance use can result in expulsion from treatment while a “relapse” with mental health symptoms generally results in increased services.

Despite advances in science and research there is still a great deal of “moralizing” around behaviors associated with substance use.

Similarities between substance dependence and mental health treatment and recovery concepts:

Ultimate responsibility for ensuring recovery rests with the individual.

The process of recovery for co-occurring disorders requires HOPE.

Recovery is defined as a process not an event.

Recovery requires diligence and daily involvement.

Recovery involves growing beyond the level of maturation achieved at the time of the onset of the disorder.

What does work?



- INTEGRATED TREATMENT

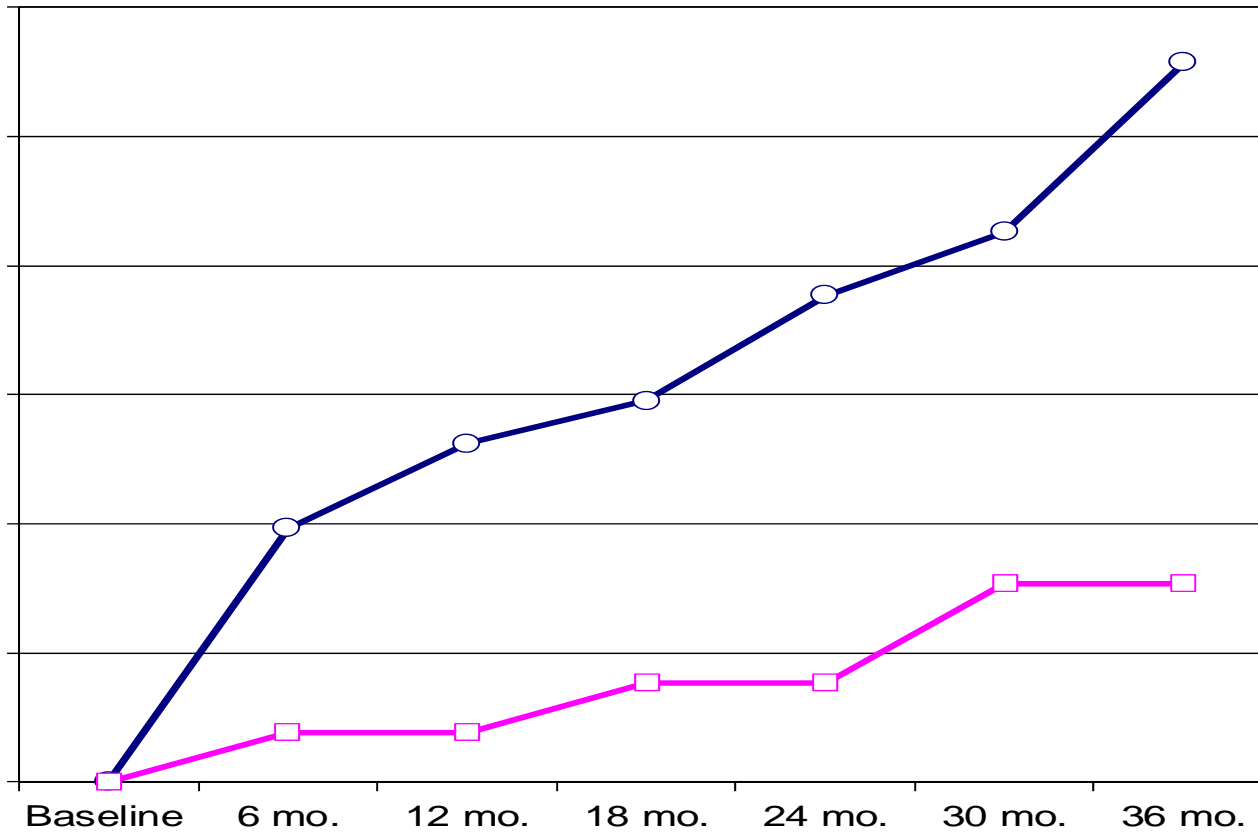
Why integrated treatment for co-occurring disorders?

- 10 studies show integrated treatment is more effective than traditional separate treatment
- Ongoing research provides data confirming that EBT in an integrated setting yields better outcomes.
 - (Drake et al, Schiz Bull 1998 and Drake et al, Psych Services 2001 for summaries).
 - Foundations Recovery Network, Research Department

Fidelity to IDDT principles improves abstinence

McHugo et al, 1999

Figure 1. Percent of Participants in Stable Remission for High-Fidelity ACT Programs (E; n=61) vs. Low-Fidelity ACT Programs (G; n=26).



used Practices

Research Outcomes

Three year study at La Paloma:

- 70-80% improvements in abstinence
- 60% reduction in severity of psychiatric symptoms
- 80-90% reduction in use of inpatient and emergency services for mental health
- 50% reduction in medical healthcare
- Patients reported it being their “first time to understand” the relationship between co-morbidities

Integrated Treatment provides a powerful message of empathy, hope and respect.

Hope is the cornerstone of motivation, resilience and determination. It is the medication for the fear “will I ever be normal again”.

Patients must be engaged in a positive and supportive way rather than being experienced as misfits, often acquiring negative labels that ultimately interfere with clinicians’ ability to engage them in positive treatment relationships.

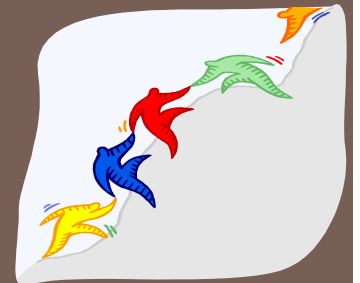
Patients must gain insight into what recovery can be and the impact it will have on their life.

Services and treatment goals are consumer-driven

Unconditional respect and compassion for consumers is essential

Integrated treatment specialists are responsible for engaging consumers and supporting their recovery

Kenneth Minkoff, MD



Empathy

Hope

Respect



Provides the foundation for what's possible in recovery from co-occurring disorders.

Colors
Like
These



Effective treatment for dual disorders is based on the core value of shared decision making, and it incorporates the following core components:

- Integration of services (represents the organizational dimension of treatment)
- Comprehensiveness (addresses the scope of interventions/services)
- Assertiveness (addresses how clients are engaged in treatment – effective treatment programs for people with co-occurring disorders do not wait for often reluctant clients to seek treatment/engage in treatment – precontemplation)
- The reduction of negative consequences (represents the philosophical dimension of integrated treatment – given the damaging impact of dual disorders on the lives of patients, the first and foremost goal of clinicians is to reduce the harmful effects – without judgment or imposition of personal values.)

Core Components Continued...

- A long-term perspective (time unlimited services)
- Availability of multiple psychotherapeutic modalities (as many formats as may be needed – and several usually are – Individual, Group, Family Therapy, Self-help, medication interventions, psychosocial interventions.)
- Motivation based treatment (orients interventions to the clients' desire to change their behaviors.)
- Patient centered

Integration of Services

- Integrated assessment is critical. Assess for both disorders and the associated interactions.
- Same clinician or team of clinicians provides treatment for mental illness and substance use disorders at the same time.
- The treatment team assumes the responsibility of integrating the treatments so that the interventions are selected, modified, combined and tailored for each individual.

Comprehensiveness

- Individuals with co-occurring disorders typically have a wide range of needs – work related issues, finding meaningful activity, improving family and social relationships, developing capacity for leisure and recreation without the use of alcohol/drugs, developing skills for managing mental health symptoms.
- Requires comprehensive assessment spanning the range of affected areas.

Comprehensiveness continued...

- Seven types of services need to be considered to determine the comprehensiveness of a treatment program:
 - Residential Services
 - Case Management
 - Supported Workplace/Employment System
 - Family Education/Therapy
 - Social Skills Training
 - Training in illness management
 - Pharmacological Treatment

ASSERTIVENESS

Alcoholics Anonymous is a program of “promotion rather than attraction”.

Treatment requires a great deal of promotion!

- Recognizes that EAPs and clinicians must make every effort possible to actively engage reluctant clients in the process of treatment and recovery.
- Outreach, Intervention, Persuasion
- Potential workplace issues can be effectively “asserted” to assist an individual in getting needed help.

Reduction of Negative Consequences

- The essence of focusing on reducing the harmful effects of substance use is to protect clients from the most dire consequences of their substance use, while developing a good working alliance with them that can ultimately help them perceive the negative effects of substance use and the impact on mental health issues.
- Can lead to debate among clinicians regarding whether such efforts protect clients from experiencing natural consequences.

Long-term Perspective

- Studies indicate that integrated treatment results in gradual improvement of outcomes over time.
- Long-term support through extended/ongoing treatment services, self-help, EAP, church, and family lead to life-long recovery.
- Major life changes result over months and years.

Multiple Psychotherapeutic Modalities

Respect Complexity and Develop Resiliency

- Individual Therapy
- Integrated Group Therapy
- Psycho-education Groups
- Stage-Wise Treatment Groups
- Family Therapy/Group
- Social Skills Training
- Self-Help Groups

Standard Interventions for Co-occurring Disorders

- Use leverage to promote treatment
- Match treatment demands with what is possible
- Set clear treatment goals and expectations early for clients mandated to treatment.
- Provide information for self-diagnosis
- Identify and discuss the positive benefits of substance use and psychiatric symptoms
- Connect alcohol and drug use and behaviors resulting from psychiatric symptoms with negative life consequences
- Require clients to be abstinent during treatment sessions
- Promote medication compliance
- Promote skills needed to achieve treatment goals.
- Use group treatment as much as possible
- Promote self-help involvement



Families play a very important positive role in the treatment process when they are supportive.

Research substantiates this intuitive thought.

Atkinson, Tolson and Turner, 1993

Hendrickson, Stith, and Schmal 1995

It is vital that we make every effort to engage families in the treatment process.



The Impact of Co-occurring Disorders on Families

- The extent of the impact depends on several factors:
- Severity of the disorders
- Length of time exposed to the disorders
- Behaviors of the individual with co-occurring disorders
- Relationship between the individual with the co-occurring disorders and family members
- Family member's perceptions and feelings about the situation



Co-occurring disorders can impact any area of family functioning:

- ❑ Mood and atmosphere in the home
- ❑ Roles assumed by family members
- ❑ Rules by which the family operates
- ❑ Relationships and communication among members
- ❑ Cohesion
- ❑ Ability to confront and solve problems
- ❑ Families may feel tired, burned out or hopeless.
- ❑ The multi-dimensional impact of co-occurring disorders on families
 - ❑ Mental
 - ❑ Physical
 - ❑ Emotional
 - ❑ Social
 - ❑ Spiritual

Common Reactions/Strategies of Families:

- Protective Strategies
- Logical Interventions
- Grief
- Aggressive, Passive, Passive-Aggressive, Frozen Feelings
- Use of a Mood Altering Drug
- Control
- Enable
- Cut-Off
- Intervention

Common Concerns of Family Members

- ❑ Mistrust of professionals and treatment systems
- ❑ Tired of being labeled resistant, dysfunctional or codependent
- ❑ Feelings of guilt or responsibility for causing the disorder
- ❑ Fear of safety for the family or the individual with the co-occurring disorder
- ❑ Worries that other family members may develop co-occurring disorders as well
- ❑ The other family members' need for participation in treatment and support groups
- ❑ Managing the emotional and financial burden of paying for hospitalization or treatment
- ❑ Anxiety about treatment effectiveness and long term outcome
- ❑ Fear of relapse of mental disorder or substance use disorder and uncertainty about how to deal with it
- ❑ Handling suicidal threats or behavior
- ❑ Coping with persistent symptoms of the disorders
- ❑ Impact of the illness on any children who may be involved-what to tell them about the situation and how to help them deal with their feelings and reactions
- ❑ Setting behavioral limits with the individual with the co-occurring disorder
- ❑ Changes in family patterns and lifestyle to support the individual with the co-occurring disorder



- ❖ FAMILIES EXHIBIT TREMENDOUS RESOURCEFULNESS IN DEALING WITH THEIR TROUBLED RELATIVES. IN MANY CASES, THESE FAMILIES HAVE LEARNED HOW TO SURVIVE AND COPE WELL IN AN EXTREMELY DIFFICULT SITUATION.

ASSESS FOR STRENGTHS INSTEAD OF FOCUSING ON DEFICITS

Motivation Based Treatment

What is Motivational Interviewing?



Motivational Interviewing (MI) is a client-centered, directive approach to enhance intrinsic motivation for behavior change by working with and resolving ambivalence (Miller & Rollnick, 2002; Rollnick & Miller, 1995).

This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources.



Motivational Interviewing

“Intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for a person to explore the possibly painful present in relation to what is wanted and valued.” (Miller and Rollnick, 1991)

The first task of therapy is to discover the locus of the client’s unbearable pain”
(Edwin Schneidman, 1954)

The Spirit of Motivational Interviewing

Collaboration vs Coercion

Evocation vs Education

Autonomy vs Authority

Respectful Listening

Roll with Resistance

Fundamental

Accurate Empathy

Resistance is a stage of change

Acceptance NOT Approval

In some instances – a very real challenge

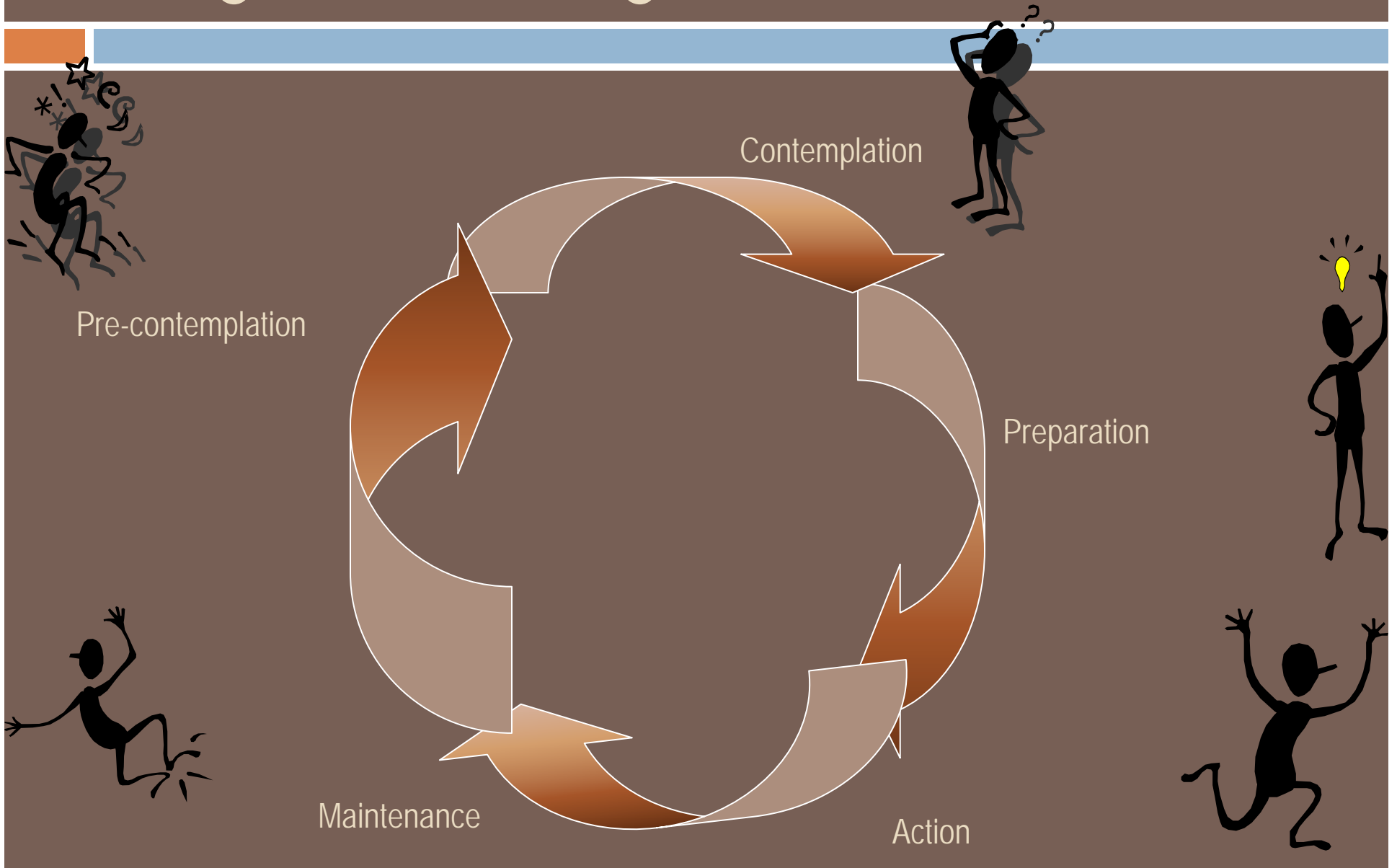


Evidence for Staff/Patient Relationships

- Strong, positive relationships between patient and staff are essential to positive treatment outcomes.
 - “The more effective therapists were those that had consistently higher working alliances scores across all patients.” Baldwin, Wampold, and Imel (2007)
 - “In fact, meta-analytic studies indicate ‘a little over half of the beneficial effects of psychotherapy...are linked to the quality of the alliance.’ (Horvath, 2001, p. 366)
 - “A post hoc analysis of the Project MATCH data found that...the therapeutic relationship was a significant predictor of treatment participation, drinking behavior during treatment, and drinking at 12-month follow up.” (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997).



Stages of Change



Motivation Based Treatment

85% of the people that present for treatment are in a pre-contemplation stage of change - Significant implications on how treatment process will occur.

Stages of Treatment/Stages of Change

Engagement/Pre-contemplation

Persuasion/Contemplation and Preparation

Active Treatment/Action

Relapse Prevention/Maintenance



DiClemente & Prochaska, 1998

Pre-contemplation – The Stage of Avoidance

Assertive outreach, practical help (housing, entitlements, other), and an introduction to individual, family, group, and self-help treatment formats

Contemplation – The Discovery of the Discrepancy

Education, goal setting, and building awareness of problem through motivational counseling

Preparation – Strategies for Change

Asking the questions to engage strategies

Action – The Stage of Experimenting

Counseling and treatment based on cognitive-behavioral techniques, skills training, and support from families and self-help groups

Maintenance – The Stage of Recovery

Continued counseling and treatment based on relapse prevention techniques, skill building, and ongoing support to promote recovery

Relapse – Stage Disruption

Patient Centered Care

- We must always be focused on providing what the client/patient wants and needs.
- Carefully manage our own desires/goals for the patient.
- Replace judgment with acceptance.
- Give and receive feedback for continued engagement and alliance.



We treat people and not behaviors:

It is essential to find out who your client is and what they need.

Where do you hurt? How can I help you?

A thorough review of all aspects of their life is essential – the key may be hiding among imposters.

Social, environmental, vocational/occupational, psychological/psychiatric, spiritual, cultural, medical, legal.

Take the time to find out what has this person asking for help.



Evidence for “Patient-Centered”

- Successful treatment focuses on an individual’s specific needs and concerns versus a model, philosophy, tradition, or manual
 - ▣ High levels of adherence to specific technical procedures interfere with the development of a good relationship (Henry, Strupp et al., 1993), and with positive outcomes (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).
 - ▣ “Over the last 15 years, professional discourse and practice has evolved with a gradual but steady movement away from program-driven treatment toward ‘individualized, assessment-driven treatment.’” Mee-Lee (2001)

“Absolutely anything you want to say about alcoholics is true about some of them and not true about all of them.”

Thomas McLellan

Providing a collaborative environment

Studies show patients view health care professionals as condescending and paternalistic, more preoccupied with their own tasks than with the patient's concerns.

This is particularly true of patients with co-occurring disorders, who already feel disenfranchised, shameful and misunderstood.

- Demonstrated sense of continuity, teamwork and connectedness across departments, allowing patients to place their trust in the institution's overall competence.
- Making patients cooperating partners; empowering patients to be informed and make decisions and judgments across all phases of the treatment, rather than forcing them to act like helpless inmates.
- Respecting the patients' personhood by treating them as adult participants in an experience in which, after all, they have the most at stake.

Evidence for Patient Engagement

Patient engagement early in treatment is critical to the patient's overall success.

- In one study of more than 2,000 therapists and thousands of clients found that treatments in which no improvement occurred by the third visit did not, on average, result in improvement over the entire course of therapy. Brown, Dreis, & Nace (1999)

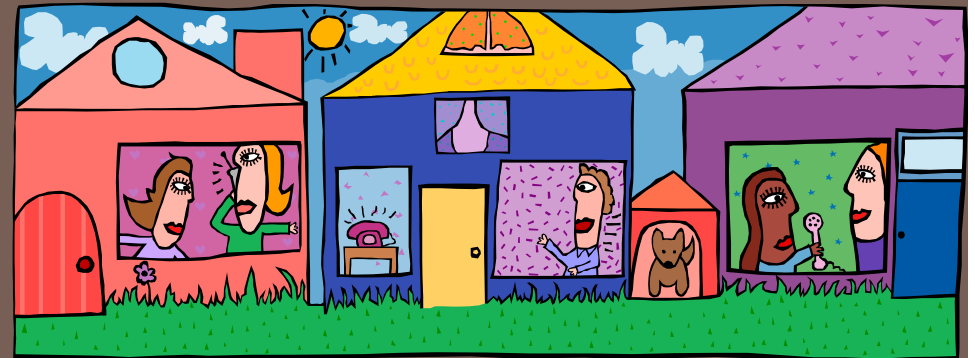


Review of Treatment and Recovery Model

- Client/patient driven
- Unconditional respect and compassion
- Clinician responsible for helping client with motivation for treatment
- Focus on client goals and function, not on adherence to treatment
- Client choice and shared decision making are important

More factors for recovery

- Social support interventions
 - ▣ (groups, self help, family)
- Long term perspective
- Rehabilitation of skills
 - ▣ (coping, social, leisure, work)
- Cultural sensitivity and competence
- Program fidelity



Other key factors in recovery from co-occurring disorders

- ❑ Stable housing
- ❑ Sober support network/family
- ❑ Regular meaningful work/activity
- ❑ Trusting clinical relationship



Alverson et al, Com MHJ, 2000

Abstinence leads to improvements in other outcomes

Drake et al, 1998

- ❑ Reduce institutionalization
- ❑ Reduce symptoms, suicide
- ❑ Reduce violence, victimization, legal problems
- ❑ Better physical health
- ❑ Improve function, work
- ❑ Improve relationships and family



Strategies for EAP

A key challenge in treating those with co-occurring disorders is ensuring EA professionals are cross-trained in mental health and addiction screening, assessment, and are abreast of current research on effective treatment approaches with this population. In this approach, services appear seamless and coordinated to the individual who receives the care.

Enhance EA efforts to identify and assist those employees with co-occurring conditions has the potential to demonstrate increased value and better client outcomes.

Enhance EAP Worksite Approach

Pressure points for an EAP might include:

- Increase screening for an SUD/MD and COD
- Increase worksite awareness efforts
- Provide web-based information and referrals
- Increase level of supervisory training
- Expand support for workers in recovery
- More frequent, structured follow-up and/or compliance monitoring

Maximizing EA Effectiveness

- Earlier screening for identification of substance abuse
- More comprehensive assessments for appropriate treatment referrals
- Use of MI for optimum intervention and maximum client compliance
- Closer EAP case management and increased follow-up to assure greater adherence to treatment plans
- Greater use of performance measures and outcome reports to support continued expansion of services

Strategies for clinicians and supervisors

- Outcome based supervision
- Knowledge base
- New skills
 - ▣ Assessment
 - ▣ Motivational treatment
 - ▣ Substance abuse counseling
- Specialty training
- Secondary strategies

Strategies for program leadership

- Consensus and vision
- Specific leader
- Train all clinicians
- Comprehensive integration
- Records
- Outcomes
- Quality assurance

Assessing for a Substance Use Problem

- Addiction Severity Index (ASI) – McLellan et al
- The CAGE Questionnaire – Mayfield, McCleod and Hall
- Chemical Use, Abuse, and Dependence Scale (CUAD) – McGovern and Morrison
- Clinical Rating Scales – Mueser
- Michigan Alcoholism Screening Test (MAST)– Selzer
- Dartmouth Assessment of Lifestyle Inventory (DALI) – Rosenberg – developed specifically for individuals with a major mental disorder
- Diagnostic and Statistical Manual (DSM)

Differentiating Substance Induced Disorders from Co-Occurring Axis I Disorders

4 questions:

Did the psychiatric symptoms predate the onset of the substance use?

Kessler found that the vast majority of individuals with mood disorders and co-occurring substance use disorders report that the symptoms of their mood disorder predated their substance use by, on average, four years. Many clients can be poor historians – better to obtain information from family members.

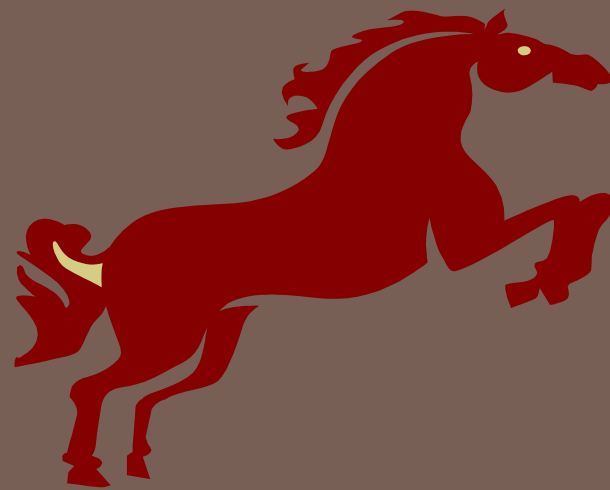
Is there a history of similar mental disorders in the client's biological family?

Is the onset of symptoms within the normal age range?

Does a significant change occur in the psychiatric symptoms after two or more weeks of abstinence?

Seabiscuit

Becoming the Horse He Was Meant to Be



Resource Documents:

American Association of Community Psychiatrists. Principles for the Care and Treatment of Persons with Co-Occurring Psychiatric and Substance Disorders.

www.comm.psych.pitt.edu/finds/dualdx.html

Robert Kenneth White & Deborah George Wright (Editors). *Addiction Intervention: Strategies to Motivate Treatment-Seeking Behavior*. Haworth Press. Binghamton, NY 13904-1580. 1998. ISBN: 0789004348 Mid-America Addiction Technology Transfer Center. *Psychotherapeutic Medications: What every counselor should know*. Kansas City, Missouri, 2000. 816-482-1100. www.mattc.org , atc@mattc.org

NIAAA. *Assessing Alcohol Problems, A Guide for Clinicians and Researchers*. 2nd Edition. 2003. NIH Publication#03-3745

Online Resources:

Substance Use Screening & Assessment Instruments Database – University of Washington, Alcohol and Drug Abuse Institute. This database is intended to help clinicians and researchers find instruments used for screening and assessment of substance use and substance use disorders. <http://lib.adai.washington.edu/instrumentsearch.htm>

Free online screening for alcohol use disorders www.alcoholscreening.org

Free online screening for mood and anxiety disorders www.mentalhealthscreening.org

Integrated Treatment for Dual Disorders: A Guide to Effective Practice, Mueser,
Noordsy, Drake, Fox 2003

Treating Co-Occurring Disorders: A Handbook for Mental Health and Substance Abuse Professionals, Hendrickson, Schmal, Ekleberry, 2004

“Addressing Co-occurring Disorders in the EAP Setting”
ValueOptions’ Health and Performance Solutions University,
Bernie McCann, M.S., CEAP, 2006

“Addressing Co Morbidity In The EAP Setting”, Bernie McCann, M.S. CEAP, 2007

Key Web Resources:

ICMH Iowa Consortium for Mental Health
SAMHSA

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IDDT Toolkit

COCE – Co-Occurring Center of Excellence, Ken Minkoff