Treating Co-occurring Mental Health Disorders in Addictions Service Programs

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Session Goal

The delivery of effective treatment services for co-occurring mental health and substance use disorders has sometimes been described as hopelessly complex and convoluted, when in reality there are naturally occurring areas of common ground that exist, and can be readily developed to equip practitioners to more successfully support those they serve. This session will focus on some readily available tools and intervention types that can be deployed in a stage-wise manner to successfully support the recovery of those with dual disorders.
Learning Objectives – Participants will be able to:

1. Learn about **3 screening tools** for mental health disorders commonly occurring in clients referred for addictions treatment;

2. Consider how the **3 cross-cutting elements of Engagement, Motivational Enhancement, and Cognitive Behavioral techniques** apply to the treatment of both mental health and addictive disorders, and

3. Effectively determine the **choice of treatment interventions** and measure progress according to the 8-level Stages of Treatment model.
3 Screening Tools for Common Co-occurring Mental Health Disorders

1. Patient Health Questionnaire (PHQ-9)
2. Posttraumatic Stress Disorder Checklist (Civilian version)
3. Borderline Symptom Checklist (BSL-23)
Patient Health Questionnaire (PHQ-9): Screening for Depression (also -7, -4)

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about oneself
7. Trouble concentrating
8. Moving or speaking noticeably slower than normal
9. Thoughts of hurting oneself, or being better off dead
Posttraumatic Stress Disorder Checklist (Civilian version)

+ 17-item screening tool for PTSD
+ High co-prevalence among substance-abusing populations
+ ACES questions important as a screening consideration in their own right, for a range of behavioral health disorders
Men and Women with ACE scores \( \geq 4 \) are more than 3 times more likely to have depression than those with an ACE score of 0.
Childhood Experiences Underlie Suicide Attempts

% Attempting Suicide

ACE Score

0
1
2
3
4+

25
ACE Scores and Rates of Anxiolytic Prescriptions

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<th>ACE Score</th>
<th>Prescription Rate (per 100 person-years)</th>
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<td>28.4</td>
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<td>5+</td>
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ACE Scores and Rates of Antidepressant Prescriptions approximately 50 years later

Prescription rate (per 100 person-years)

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<tr>
<th>ACE Score</th>
<th>Prescription Rate</th>
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ACE Scores Predict Drug Abuse

ACE Score
- 0
- 1
- 2
- 3
- 4
- >=5

Percent With Health Problem (%)

Ever had a drug problem
Ever addicted to drugs
Ever injected drugs

Ever addicted to drugs

12
Borderline Symptom Checklist (BSL-23)

- Borderline Personality Disorder features symptoms in the following 4 areas:
  - Cognitive dysregulation
  - Emotional dysregulation
  - Interpersonal ineffectiveness
  - Poor distress tolerance
Engagement, Motivational Enhancement, and Cognitive Behavioral techniques

① Evidence-based Relational Factors

② Motivational Enhancement as Pre-treatment

③ CBT Essentials
How Do People Change?

What 40 years of research has shown . . .


A. **Therapeutic factor # 1:**
   Treatment modality
   (technique, method, model of change)

B. **Therapeutic factor # 2:**
   Alliance, or relationship with an agent of change
   (therapist, doctor, case manager, sponsor, pastor, friend, family member, etc.)

C. **Therapeutic factor # 3:**
   Allegiance (hope, confidence)

D. **Extra-therapeutic client factors**
   (including willingness and readiness to change)
Evidence-based Relational Factors.

1. Alliance
2. Empathy
3. Collecting client feedback
4. Goal consensus
5. Collaboration
6. Positive regard
7. Congruence/genuineness
8. Repairing alliance ruptures
9. Managing countertransference
R1 - Alliance

- Alliance refers to the quality and strength of the collaborative relationship between client and therapist.
- The average effect size (.4-.45) of alliance across multiple studies is consistently robust, and significantly more potent than differences among treatments.
Alliance


- a.k.a. “working alliance,” or “therapeutic alliance”
- Alliance is typically measured as
  1. agreement on therapeutic goals
  2. consensus on treatment tasks, and
  3. relationship bond.
Alliance – practice implications

a) Develop a strong alliance ASAP (within first 3-5 contacts);
b) Planfully cultivate and maintain multiple alliances in multiperson interventions;
c) Recognize alliance difficulties increase as do active symptoms, stressors, etc.;
d) Foster stronger alliance via communication skills, empathy, openness, and avoiding hostile interactions;
e) Emphasize the relational bond – understanding, safety, and trust.
Empathy is the therapist’s sensitive ability and willingness to understand clients’ thoughts, feelings and struggles from their point of view.” [Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 22, 95-103.]

- 59 samples, 3,599 cumulative subjects;
- Effect size = .31, making empathy a moderately strong predictor of outcome;
Empathy


- **Emotional simulation** aspect – practitioner identifying emotionally with the client;

- **Perspective-taking** cognitive aspect – practitioner understanding the client’s frame of reference;

- **Emotion-regulation** aspect – practitioner manages own distress at client’s pain to be able to provide useful helping behavior

Measurement of the client perception of empathy is key, since client-perceived empathy predicted outcome better than practitioner-rated empathy, or observer-related empathy.
Empathy – practice implications

a) Convey empathy to individuals in all forms of service delivery, making an effort to understand the service recipient, and to communicate this understanding in a person-centered manner.
R3 - Collecting Client Feedback

• Although 75% typically improve, therapy outcome studies suggest that 5-14% of clients got worse during treatment, and that practitioners are unable to identify a substantial portion of such cases.

• Research indicates that this level of treatment failure can be cut in half through the use of one or more feedback instruments/processes.
R3 - Collecting **Client Feedback**


- Partners for Change Outcome Management System (effect size = .23)
  - Session Rating Scale (Duncan & Miller, 2008)
  - Outcome Rating Rating Scale (Miller et al, 2003)
Collecting **Client Feedback – SRS**

I did not feel heard, understood, and respected.

We did not work on or talk about what I wanted to work on and talk about.

The therapist's approach is not a good fit for me.

There was something missing in the session today.

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**Relationship**

I felt heard, understood, and respected.

We worked on and talked about what I wanted to work on and talk about.

The therapist's approach is a good fit for me.

Overall, today's session was right for me.

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**Goals and Topics**

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**Approach or Method**

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**Overall**
Motivational Enhancement as Pre-treatment

1. Engagement
2. Focusing
3. Evoking
4. Planning
Target Hierarchy

1. Engagement
2. Focusing
3. Evoking
4. Planning
CBT Essentials

1. Cognitive-behavioral model
2. Behavior chain analysis
3. Skill-building
1. The Cognitive-Behavioral Model

- Neutral stimulus
- Attached meaning
- Emotional response
- Behavioral disposition
Examples:

- Freeway driving scenario
- Gas pump experience
- Couples counseling (*a of i*)
- Others?
2. Chain Analysis of Target Behavior
3. CBT: Skill-building

- Back-filling missing skills, or practicing and strengthening weak skill areas:
  - Interpersonal interactions
    - Boundary management, communication skills
  - Emotion self-regulation
    - Including anger management skills
  - Cognitive self-regulation
    - Centering/refocusing skills, reality-testing skills
  - Managing stress/distress
    - Coping skills, resiliency development skills
Applied Stage-wise Treatment: Targets and Techniques

1. Engagement
2. Persuasion
3. Active Treatment
4. Maintenance
Substance Abuse Treatment Scales (SATS)

1. Pre-engagement
2. Engagement
3. Early Persuasion
4. Late Persuasion
5. Early Active Treatment
6. Late Active Treatment
7. Relapse Prevention
8. In Remission or Recovery
Precontemplation: “Huh? What problem?”

- A **Precontemplation**-stage person is described as, “It’s not that they can’t see the solution. *It’s that they can’t see the problem.*”

- This stage of change has been given the label of “**Denial**” in times past.
Precontemplation: “Not interested”

+ Intervention for someone in the **Precontemplation** stage would seek to engage them in the process of objectively evaluating whether they have a problem, and supporting movement along to the **Contemplation** stage of change.

+ **Intervention task:** Engage in becoming interested and concerned.

- Contemplation-stage folks may know their destination, and even how to get there, but they are “not ready yet.”

- Someone in this stage of change may be ambivalent about doing anything about a problem that they can clearly identify having.
Contemplation: “Considering”

- Intervention for someone in the **Contemplation** stage would seek to engage them in the process of gaining motivation to address their problem, and supporting movement along to the *Preparation* stage of change.

- **Intervention task:** Engage in risk-reward analysis and decision-making.
Preparation:
“Almost ready to take action . . .”

- **Preparation**-stage individuals are planning to take future action, but are still making the final adjustments before committing.

- Someone in this stage of change may be *working through the final obstacles* that are getting in the way of taking action.
Preparation: “Preparing”

- Intervention for someone in the **Preparation** stage would seek to engage them in the process of taking action to address their problem, i.e., supporting movement along to the **Action** stage of change.

- **Intervention task:** Engage in the process of gaining commitment, and creating an effective and acceptable plan.
Action: “Let’s get going”

The **Action** Stage is described as the one in which individuals most overtly *modify their behavior and surroundings* to accomplish their goal.

Someone in this stage of change is taking visible steps and making visible changes in order to work to change behavior.
Action: “Initial change”

- Treatment for someone in the **Action** stage would seek to assist them in taking all indicated steps to be successful in their recovery, and to support movement along to the **Maintenance** stage of change.

- **Intervention task:** Assist in implementing an initial plan, and revising it as indicated.
Maintenance:
“\textit{I’m in a good place, let’s keep it up!}”

+ In the \textbf{Maintenance} Stage, the focus is on consolidating gains and preventing relapse.

+ Someone is this stage has an \textit{effective set of tools} and a \textit{program of change} that they commit to continuing to practice.
Maintenance: “Sustained change”

- Intervention for someone in the **Maintenance** stage would seek to strengthen and increase their “tool kit,” and to support ongoing behavior change success.

- **Intervention task:** Focus on consolidating the change into one’s lifestyle.
Relapse / Recycle: “How can I get back on track?”

+ **Relapse** is often part of the picture when it comes to changing in an area of difficult behavior, and individuals need to be prepared to deal with it / respond to it if/when it happens, including developing **damage-control strategies**.
Relapse / Recycle: “How can I get back on track?”

+ “Progress not perfection,” supports gentleness and freedom from shame, and “Progress not permission” emphasizes the importance of personal responsibility to stay active in one’s own behavior change, even when slips or relapses occur.

+ The Recycling aspect of relapse supports the view that change-enhancing lessons can be learned from relapse episodes – “The only bad relapse is a WASTED relapse”
Substance Abuse Treatment Scales (SATS), aka “Stages of Treatment”

1. **Pre-engagement**: no contact
2. **Engagement**: irregular staff contact, no working alliance
3. **Early Persuasion**: regular contact, decreased use < 1 month
4. **Late Persuasion**: discussing use or attending dual group, reduced use > 1 month
5. **Early Active Treatment**: discussing use or attending dual group, reduced use > 1 mo, identified abstinence goal
6. **Late Active Treatment**: acknowledges substance use as a problem, achieved abstinence but < 6 months
7. **Relapse Prevention (Early Maintenance)**: acknowledges substance use as a problem, achieved abstinence for > = 6 months
8. **In Remission or Recovery (Late Maintenance)**: ongoing goal of abstinence
Substance Abuse Treatment Scales (SATS)

1. Pre-engagement
2. Engagement
3. Early Persuasion
4. Late Persuasion
5. Early Active Treatment
6. Late Active Treatment
7. Relapse Prevention
8. In Remission or Recovery
1. **Pre-engagement:** The person (not client) does not have contact with a case manager, or substance abuse counselor.

   **Precontemplation**

2. **Engagement:** The client has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contact implies lack of a working alliance.
Engagement Stage of Tx

- Goal is to develop regular contact & a trusting relationship with the client
  - Outreach
  - Active listening
  - Practical assistance
  - Help with establishing goals
  - Assessment
  - Treatment planning
3. **Early Persuasion:** The client has regular contacts with a case manager or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

4. **Late Persuasion:** The client is engaged in a relationship with case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.
Goal is to explore the impact of substance use in your client’s life

- Motivational counseling
- Education about effects of substance use on physical health, overall functioning, and mental health
Substance Abuse Treatment Scales (SATS)

5. **Early Active Treatment:** The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.

6. **Late Active Treatment:** The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.
Active Stage of Treatment

- Goal is to help your client get control of their substance use disorder
  - Substance abuse counseling to manage cues to use
  - Skills training
  - Self-help & 12-Step groups
  - Family involvement
Relapse Prevention: The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least six months. Occasional lapses, not days or problematic use, are allowed.

In Remission or Recovery: The client has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment.
Goal is to help your client maintain & expand their recovery

- Relapse prevention plan
- Substance abuse counseling
- Skills training
- Self-help & 12-Step groups