Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders

SAMHSA's Co-Occurring Center for Excellence (COCE)

Overview Paper Number 3

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Center for Mental Health Services
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About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through various means including its Web site, curriculum and materials development, and telephone and in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current and reliable science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of overview papers, see the back cover.

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EXECUTIVE SUMMARY

This overview paper outlines 12 overarching principles for working with persons with co-occurring disorders (COD). These principles are intended to help guide, but not define, systemic and clinical responses. They can be used as benchmarks to assess whether plans in development, or programs in operation, are grounded in the field's best thinking. Definitions of key terms used in this paper may be found in Table 1, Key Definitions. (See below.)

LITERATURE SYNTHESIS

Many authors and groups have articulated principles for working with persons with COD (American Association of Community Psychiatrists, 2000; Center for Mental Health Services [CMHS], 1996, 1998; Center for Substance Abuse Treatment [CSAT], 2005; Minkoff & Cline, 2004; National Institute on Drug Abuse, 1999; Osher, 1996). Because these principles are derived from the accumulated experience of mental health and substance abuse professionals over many decades of practice, they are well established in the field. These principles for treating COD may overlap, but should not conflict with the principles that underlie the delivery of mental health or substance abuse treatment services alone. In this overview paper, COCE aggregates the wisdom of both fields in presenting 12 principles to assist in the development, delivery, and evaluation of efforts to improve the lives of persons with COD.

THE NEED FOR PRINCIPLES OF CARE
(See Table 1, Key Definitions, page 1)

Overarching principles for working with persons with COD serve two major purposes. First, they provide a foundation for planning, delivering, financing, and evaluating services and systems of care. These principles shape our vision, and adherence to them should help us formulate and attain our goals and objectives. Principles, by their nature, are consistent with a concern for the well-being of the client and his loved ones. Second, in the absence of evidence-based practices, these consensus-based overarching principles can serve to inform system design and service intervention. Research in the field of COD has led to the development of evidence-based practices associated with positive outcomes for consumers with COD. While these advances are critical to our efforts to improve treatment, it will be some time before all of the many conditions and needs of persons with COD can be directly linked to evidence-based interventions.

Table 1: Key Definitions

Principle	"A basic generalization that is accepted as true and that can be used as a basis for reasoning or conduct" (WordNet ® 2.0, © 2003 Princeton University). Principles serve to guide the design of systems and implementation of service interventions.
No Wrong Door	An approach to service organization that provides individuals with or links them to appropriate service interventions regardless of where they enter the system of care. This principle commits all service agencies to respond to the individual's stated and assessed needs through either direct service or a linkage to appropriate programs, as opposed to sending the person from one agency to another.
Evidence	Evidence is information that suggests a clearly identified outcome will result from a clearly identified practice or intervention. Evidence can be derived from different approaches yielding different degrees of certainty. The most reliable evidence comes from multiple published, peer-reviewed studies done by different investigators using (1) rigorous design, measurement, and analysis techniques; (2) random assignment to control and experimental conditions; (3) large number of subjects; and (4) multiple settings. Departures from these optimal study characteristics will yield weaker evidence. Important observations can be made by clinicians or administrators about the relationship of outcomes to interventions. The collection of evidence from such observations is generally considered to be a first step in gathering evidence of effectiveness.
Consensus	Consensus is general agreement among a group of experts in the field about the implications of available evidence concerning practices or interventions. When evidence for the effectiveness of a specific practice is limited, the process of achieving consensus is informed by clinical experience consistent with clear theoretical underpinnings. The judgments arrived at by most of those concerned are used to identify evidence-based, promising, and emerging practices as well as to develop practice guidelines and clinical recommendations.

PRINCIPLES THAT GUIDE SYSTEMS OF CARE FOR PEOPLE WITH COD

Principle 1

Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.

This principle is established through a rich literature of epidemiologic and clinical studies that document considerable prevalence rates of COD in the general population and high rates of COD within populations seeking treatment (see COCE Overview Paper titled "Epidemiology of Co-Occurring Disorders"). Failure to address COD in either substance abuse treatment or mental health programs is tantamount to not responding to the needs of the majority of program participants.

The implications of this principle are far reaching. For mental health or substance abuse systems to be effective with their target populations, all programs within the system must be competent to screen, assess, and address COD. Policies and procedures must explicitly acknowledge COD and define requirements for addressing the needs of persons with COD. Regulations concerning program and professional licensing and certification must explicitly detail requirements regarding COD activities and skill sets (see COCE Overview Paper titled "Workforce Development and Training for Treating Persons With Co-Occurring Disorders"). Financing mechanisms also must be developed that facilitate rather than impede meeting the multiple services needs of persons with COD. The goal of system design and implementation is to offer any person with COD access to a range of programs that provide individually matched services consistent with the rest of the principles enumerated here.

Principle 2

An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.

In order to plan for an ideal system of care, it is necessary to have a common vision of that system, what its goals and objectives would be, and how one would measure its effectiveness. The shared vision guides the development of programs and policies, and the allocation of scarce resources. A truly integrated system promotes the seamless delivery of mental health and substance abuse treatment services through a variety of agencies across all behavioral health settings. The strength of existing systems to serve individuals with "only" a mental or an addictive disorder must be preserved in the transformation to integrated models.

While not all programs within a system must provide comprehensive integrated care, the system must provide consumers with services matched to their specific needs within levels of care matched to the immediate intensity of these needs. Ongoing monitoring to assess whether the services supplied meet consumer demand is integral, and systems of care must be flexible enough to shift resources based on monitored outcomes.

Administrators, providers, and consumers should be informed of the range of available mental health and addiction services to facilitate access to programs providing integrated services. Continuity of care requires mechanisms for client movement between service levels and over periods of time determined by clinical necessity rather than administrative policy. Achieving quality requires a systemic commitment to define and monitor desired outcomes, hire and train competent staff, review and regulate programs, and provide feedback within a quality improvement framework. It also requires reimbursement structures that support and encourage integrated care.

Principle 3

The integrated system of care must be accessible from multiple points of entry (i.e., have "no wrong door") and be perceived as caring and accepting by the consumer (see Table 1, Key Definitions, page 1).

It is unreasonable to assume that consumers understand the cause(s) of their mood, thought, or behavioral problems prior to seeking help. To overcome the stigma associated with behavioral health difficulties and seek treatment is a major step on the road to resolution of these problems.

Many people with COD lack the capacity to navigate complicated service systems and often feel rejected when they try to get help. Even when sources of help are found, financial barriers may prevent them from accessing services. Discouraged, they join the ranks of the untreated, awaiting the next crisis. In addition, geographic barriers to care often are cited by people with COD who do not get the help they need. Either access to a clinic is remote (e.g., in rural settings) or transportation to local agencies is unavailable. For these reasons, any person seeking care for a substance-related and/or other mental disorder must be accepted and actively engaged wherever she seeks treatment, and financial

barriers should not prevent someone who wants help from receiving it. Any time a person or her family seeks help but is turned away, an opportunity is lost and potentially devastating personal and community consequences may result.

Principle 4

The system of care for COD should not be limited to a single "correct" model or approach.

There is no single set of treatment interventions that constitute integrated screening, assessment, and treatment for COD. Integrated services comprise an array of physical, psychological, and social service interventions outlined in a single integrated treatment plan. This plan is based on an assessment of individual needs and preferences, matched to appropriate levels of care, and provided or coordinated by a single treatment team or within a comprehensive treatment model.

Services for people with COD are delivered in the context of a broad range of social services, provider networks, financial coverage, and community priorities. As such, the shaping of services for people with COD requires a flexible and responsive set of providers and programs. Mutually agreed upon responsibilities and outcomes will shape the approaches implemented. Continuous quality improvement efforts should dictate future adaptations.

Principle 5

The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence- and consensus-based practices for persons with COD and evaluation of the efforts of existing programs and services (see Table 1, Key Definitions, page 1).

The advantages of evidence- and consensus-based practices have been articulated and validated across the mental health and substance abuse treatment fields (see COCE Overview Paper titled "Treatment, Volume 1: The Use of Evidence- and Consensus-Based Practices in Treating Persons With Co-Occurring Disorders"). The appropriate application of these practices maximizes benefits to consumers. Evidence- and consensus-based practices generated in one field of service may require modification in their application to COD, yet the core features of these modified interventions increase the likelihood of their effectiveness.

Behavioral sciences have a rich investment in research to draw upon, but technological advances must have capable providers to ensure that what works under controlled research conditions *(efficacy)* is translated into practical, high-quality, real-world services *(effectiveness)*. The Surgeon General identified a gap in the introduction of scientific advances to community settings that deprives many people of up-to-date treatment (U.S. Department of Health and Human Services, 1999). System design must support providers of services to people with COD in their application of the existing science and encourage their development of new findings and approaches through participation in research and evaluation efforts.

Principle 6

Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.

Having COD increases the likelihood of having additional medical, social, and legal problems. Persons with COD are often among the most disadvantaged and impoverished members of our society. At various times, employment, education, housing, and legal assistance must be provided as part of integrated COD treatment approaches. This breadth of need requires partnerships beyond the behavioral health field to allow consumers to develop and sustain recovery. It is necessary and possible to engage partners with common interests in supporting the integration of people with COD into their respective communities. Successful strategies for systems collaboration include shared case management models, the creation of local service coalitions, the State use of special waiver authorities, and interagency task forces.

PRINCIPLES THAT GUIDE PROVIDER ACTIVITY FOR PEOPLE WITH COD

Principle 7

Co-occurring disorders must be expected and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.

Just as systems must be designed so that all programs are competent to address COD, all providers should be cross-trained and competent to screen for COD, coordinate assessments, and develop individualized treatment plans that directly address a broad range of co-occurring conditions and disorders. The high prevalence of persons with COD in all mental health and substance abuse treatment settings requires a minimal level of competency for all clinicians

(see COCE Overview Paper titled "Workforce Development and Training for Treating Persons With Co-Occurring Disorders"). While not all providers can be expected to address the myriad issues associated with COD, they should understand how to identify COD and have a clear sense of how to assist the consumer in accessing essential services.

Principle 8

Within the treatment context, both co-occurring disorders are considered primary.

For persons with COD, symptoms of either disorder may vary over time. It is possible for one set of symptoms to be under relatively good control while the other set causes significant impairment. The interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly. It is a disservice to the person with COD to emphasize attention to one disorder at the expense of the other. There is always a relationship between the two disorders that must be evaluated and managed. While billing and financial implications of identifying and recording diagnoses and treatment interventions may require a simplification of the clinical issues, the true complexity of COD must be reflected in all treatment plans.

Principle 9

Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.

In all behavioral interventions, the quality of the treatment relationship is the most important predictor of success. Persons with COD often have long histories of exclusion from treatment or exposure to ineffective treatment. They often are demoralized by the systemic barriers they encounter and/or the limitations imposed by the symptoms of their multiple disorders. Data support the capacity of persons with COD to recover, and treatment providers must believe in any consumer's capacity for behavioral change. CSAT's TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005) identifies the following essential attitudes and values for clinicians who work with this population:

- Desire and willingness to work with COD
- Appreciation of complexity
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the provider's limitations
- Recognition of the value of consumer input
- Patience, perseverance, and therapeutic optimism
- Flexibility
- Cultural competence
- Belief in clients' ability to change
- Recognition of the rights of clients

These attitudes and values form the basis of a recovery perspective and foster treatment relationships based on mutual respect. A recovery perspective provides a positive context for interpreting the inevitable ups and downs of treatment. A solid treatment relationship provides stability for both clinician and client through changes in the course of the client's COD and the application of specific interventions.

Principle 10

Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.

There can be no one clinical model of care for all people with COD. Each individual's treatment plan must be derived from a careful assessment inclusive of, but not limited to, immediate and acute needs, diagnosis, disability, motivation, and stage of readiness for change (see COCE Overview Paper titled "Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders"). Cultural differences must be ascertained, respected, and incorporated into all aspects of treatment, but the uniqueness of each individual also must be appreciated.

Each consumer's needs at a given point in time require a therapeutic response that balances care and detachment. The stages of change (Prochaska & DiClemente, 1984) and phases of treatment (Osher & Kofoed, 1989) models reflect the longitudinal process of recovery and the need for stage-specific responses. Motivation for change is a dynamic dimension influenced by the application of appropriate interventions.

At the outset of treatment, engaging the individual in the treatment process is of paramount importance. This often requires a collaborative exploration of what consumers define as their needs and goals. Motivational interventions (Miller & Rollnick, 2002) can be tailored to this shared definition and personal menus of choice constructed at multiple junctures in recovery. The iterative process of goal refinement moves treatment from the generic delivery of service to groups of consumers to a nuanced and specific plan for any individual.

Principle 11

The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.

It has become a cliché to note that children and adolescents are not simply small adults. Yet, the importance of this distinction cannot be overemphasized (DHHS, 1999). Physical and neurological development continues through the 20th year (Giedd et al., 1999) and the drives, impulses, and emotions that accompany puberty arise before self-control and judgment are fully developed (Dahl, 2000). The social roles of, and societal expectations for, children and adolescents change as they grow older. The nature and severity of substance use and mental health problems must be judged against a continuum of developmental and age-appropriate thoughts and behaviors, and the range of what is "normal" is wide (DHHS, 1999). Challenges to normal development (e.g., physical problems, intellectual disabilities, low birth weight, family history of mental and addictive disorders, multigenerational poverty, and caregiver separation or abuse and neglect) constitute additional risk factors for behavioral health problems. The developmental perspective guides all aspects of screening, assessment, treatment planning, and service delivery. The question, "What is appropriate (either behavior or services)?" always begs the question, "At what age?"

Family involvement is an essential part of service planning and delivery, especially for children and early adolescents, unless circumstances dictate otherwise (e.g., emancipated minors). Particular emphasis should be placed on prevention, early identification of problems, and early intervention (Klitzner et al., 1992), especially in schools, primary care settings, and the juvenile justice system.

Principle 12

The contribution *of the community* to the course of recovery for consumers with COD and the contribution of consumers with COD *to the community* must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

Persons with COD are, first and foremost, fellow citizens and community members. Acceptance of and responsiveness to their needs by neighbors, policymakers, and public officials can facilitate access to care, improve functioning, and facilitate full integration into the fabric of the community. However, societal attitudes regarding mental and substance use disorders currently pose significant barriers to recovery. Stigma and discrimination prevent the person with COD from seeking treatment services and are a barrier to establishing the comprehensive services that science has demonstrated are necessary for recovery (DHHS, 1999). Community intolerance of behavioral disorders has led to the criminalization of persons with COD, resulting in incarceration instead of treatment. Post-treatment living environments, critical for long-term stabilization, are far too often incompatible with recovery.

Treatment is effective and recovery is possible for persons with COD. They can join with other citizens as workers and tax payers to build healthier, more prosperous, and more rewarding communities. Their special experiences and understanding can inform the development of services for other persons with similar disorders. They can enrich their communities with their unique gifts and talents. This can only occur if they are afforded the same opportunities that a free society guarantees to all its citizens.

CONCLUSION

Principles for working with persons with COD can serve as a touchstone for transforming evolving systems or improving the quality of mature systems. These principles will be used by COCE to guide its efforts to transmit advances in treatment, promote enhancement of infrastructure and clinical capacity, and foster infusion of consensus- and evidence-based practices. Adherence to principles will advance our shared desire to support recovery from often devastating illnesses. People with COD and their families deserve no less.

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