III. Treatment of Adolescents With Co-Occurring Disorders: The Application of Best Practice Models

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Treatment of Adolescents With Co-Occurring Disorders: The Application of Best Practice Models

This monograph of the workshop “Treatment of Adolescents With Co-Occurring Disorders: The Application of Best Practice Models” provides an overview of the concept of co-occurring disorders and theories of treatment related to best practice models. A key focus will be the application of these models to the adolescent population, especially concerning the confounding variables that are present in this age group, including physical and emotional development and peer culture.

Research has found that a person who has been diagnosed with co-occurring substance use and psychiatric disorders has a high likelihood of having more than one disorder of either type. In other words, the vast majority of those who have co-occurring disorders do not have only one substance use disorder and one psychiatric disorder. The outmoded term "dual diagnosis" implies that there is only one of each disorder and is usually not accurate. Therefore, the term "co-occurring disorders" will be used throughout this monograph.

Physiological and Emotional Maturity of Adolescents

From a clinical perspective, adolescence is defined as occurring between the ages of 10 to 24. The two major components of this stage are physiological and emotional development. In recent years, the younger end of the age span for physiological adolescence has been lowered to age 10 because, due to nutrition and other factors, adolescents are transitioning into puberty much earlier. The upper end of adolescence has been raised to age 24 because adolescents are actually developing emotionally at a slower rate than they did 20 to 30 years ago. Although they may have more adult responsibilities, these responsibilities do not necessarily bring maturity. When a 13-year-old adolescent has a baby, that does not make the girl mature. It makes her a 13-year-old adolescent with a baby.

Twenty or thirty years ago, adolescents in the age range from 18 to 24 had work apprenticeships, moved into actual employment, got involved in relationships, had children, and were self-supporting. Currently, 18- to 24-year-olds often graduate from college at age 22, 23, or 24 with few skills that are useful in today’s job market and little emotional perspective on structuring the rest of their lives. The two ends of this adolescent age spectrum have expanded rather drastically and this has treatment implications from a physiological as well as a psychological perspective. Previously an 18-years-old adolescent would be diagnosed as an adult and enter the treatment system as such. Now, those who are 18, 19, and 20 enter treatment with the maturity level of 13- 14- or 15-year-olds. If one looks at chronological age alone and does not consider emotional maturity, the response of the system will not be appropriate to the maturity level of the client.

A significant percentage of people with co-occurring disorders tend to be high and chronic users of the system from the moment they enter. They also tend to be in the system for a very long period of time, if not for a lifetime. Part of the problem is that the interventions attempted are not appropriate, and individuals are therefore set up to re-enter the system.

Core Competencies

There are 18 core competencies that define basic clinical competence for work with co-occurring disorders. The State of Connecticut developed these competencies to ensure a minimum clinical competency level. Based on this work, the State now provides credentialing on two levels specific to co-occurring disorders. This is a major move forward in the development of acceptable guidelines for baseline competency.

Appendix B provides a detailed description of the 18 core competencies.

DSM-IV Criteria and Diagnosis

The *Diagnostic and Statistical Manual, Fourth Edition* (DSM-IV) axes (1994) are used to diagnose mental health and substance use disorders. All mental health and substance use disorders are found on Axis I with the exception of mental retardation and personality disorders. Co-occurring disorders are defined as at least one psychiatric disorder and one substance use disorder. Both can be on Axis I, or there can be a combination of Axis I and Axis II disorders. By most definitions, mental retardation is not part of a co-occurring disorder. A substance use disorder on Axis I and a mental retardation disorder on Axis II are not diagnosed as co-occurring disorders by most mental health agencies. Mental retardation has typically been seen as a separate type of condition.

Frequently, Axis III diagnoses are actually medical problems for which the appropriate DSM-IV guidelines for diagnosis have not been followed. Medical problems should only be placed on Axis III if they are related to a problem on Axis I, II, IV, or V. Medical problems that either exacerbate or are the result of an Axis I and/or II disorder should be placed on Axis III. If an adolescent is admitted with a major depressive disorder, single episode and cocaine abuse, severe acne might be an appropriate Axis III diagnosis because in adolescence, severe acne has a strong impact on self-image and interaction with others. It is sometimes tied to depression and substance use. An ulcer might also be a valid Axis III diagnosis if the person has an alcohol disorder; but it might not be valid if the person has schizophrenia. If a medical disorder is completely unrelated to disorders on other axes, it does not belong on Axis III.

Axis IV records social stressors. The list of social stressors in the DSM-IV has been added since the DSM-III. Axis IV previously used a numerical scale.

There are three scales for Axis V: Global Assessment of Functioning and a numerical scale (GAF), Global Assessment of Relational Functioning (GARF), and the Social and Occupational Functioning Assessment Scale (SOFAS). GAF is currently the most commonly used. When the GARF and the SOFAS are added to reach the diagnosis, a more accurate assessment of the client is possible, because GARF describes interpersonal functioning.

Common Adolescent Disorders

Conduct disorder is the most common adolescent diagnosis for those who enter the treatment system. The diagnosis of conduct disorder has traditionally been very male-based. If a male adolescent came in for treatment because he caused problems, he was immediately seen as conduct disordered. If the adolescent was female, she was usually assumed to have a borderline personality disorder.

Sociologically, over the last 5 to 10 years, we have seen the emergence of a generation of young women who are very violent. Men in gangs tend to engage in impersonal and distanced violence, such as drive-by shootings. Women in gangs want face-to-face confrontation and rarely commit acts of violence in a cold, calculated manner with a gun. They want to be "up close and personal," and the most common weapon used is a razor blade. Their goal is to scar the other person for life so they will be branded by the interaction. The goal is not to kill.

When the DSM-IV was last revised, the decision was made to change the criteria for conduct disorder to include more female-specific behaviors, so that women who truly have conduct disorders and were moving toward antisocial personality disorder would be diagnosed appropriately. To meet the diagnostic criteria for antisocial personality disorder after the age of 18, one must meet the diagnostic criteria for conduct disorder before the age of 15. If these criteria are not met, the individual will not be given an antisocial personality disorder diagnosis. Some common behaviors associated with conduct behavior are as follows: has stolen without confrontation, has run away from home overnight at least twice, often lies, sets fires, is physically cruel to animals, and initiates physical fights. These criteria make the pathology less gender-specific. Cruelty to animals has a much higher correlation with antisocial personality disorder than the other symptoms. It is a significant predictor of serious pathology in the future.

In diagnosing borderline personality disorder, there is still female gender bias because the criteria focus on self-image, unstable and intense personal relationships, extremes of behavior, and affective instability. This terminology tends to be associated by the general public with females. The phrase "interpersonal relationships" tends to cause people to think of females. Borderline personality disorder is diagnosed much more frequently in women than in men. These may be accurate diagnoses, but it is important to examine why young men and young women tend to go in these two different directions (males move toward antisocial; females move toward borderline). Most of the basis is sociological.

Another factor to consider is the difference between psychoactive substance abuse and dependence. Some adolescents are clearly dependent; however, some adolescents are diagnosed as chemically dependent when they are not. The presenting problem may actually be substance abuse exacerbated by the adolescent phase of life. Adolescents tend to do everything in the extreme; it's about "testing the limits." If something feels good, they want to do as much of it as possible. The diagnostician must therefore take into account the biopsychosocial impact of adolescence as a developmental stage.

If a 30-year-old woman meets the criteria for borderline personality disorder, she is very likely borderline personality disordered. However, if a 16-year-old girl meets the same criteria, she may be an adolescent who is acting out. She should not immediately be given an Axis II diagnosis. The first step in treatment is to perform

an intervention and look for areas in the client's life to stabilize. If the problem improves, it's likely that the problem behavior is related to adolescence. Personality disorders can be modulated at times, but they are resistant to change. They are pervasive and enduring, which is why they are found on Axis II.

Adolescents should not be given a diagnosis of personality disorder if they are under the age of 18. The traits should be noted on Axis II. Unfortunately, antisocial behavior is the only personality disorder that has an age limit such that the clinician cannot diagnose it until the age of 18. Other personality disorders have no such age limitation. This is very problematic. It is preferable to use the continuum of traits on Axis II to indicate that some criteria are present. This does not become a permanent diagnosis until it is assigned a diagnostic code. This is a valid way to approach diagnosis. The use of Axis II personality disorder traits to list what is seen can be very helpful to another clinician working with the same client in the future.

One of the things to look for when diagnosing adolescents is the adolescent culture, which changes from year to year and decade to decade, redefining what is normal behavior. This affects the interpretation of the diagnostic criteria. Written diagnostic criteria in an adult-based clinical document might not take into account what is currently normal behavior within the adolescent culture. For example, if a teenager came in with a ring through his or her nose 20 years ago, a clinician may have been comparing that behavior with the DSM criteria and looking for a self-mutilation disorder.

Characteristics of Healthy Families

Family, friends, and peers help adolescents look at things in a different way. A commonly used checklist describes approximately 30 characteristics found in a healthy family. Examples are:

- My family communicated and listened.
- My family affirmed and supported its members.
- My family taught respect for others.
- My family had time for play and humor.
- My family taught me right and wrong.
- My family shared a sense of values.
- My family shared leisure time.
- My family had many outside friends.

These characteristics show a broad range of the types of qualities families may have that can help a child filter the other messages they receive. If these filters are in place, the child is likely to have good ego strength and a foundation upon which to build as they go through adolescence. If they are not in place, the child is left to flounder and figure these things out on their own. Influences outside the family have a much stronger impact in adolescence.

Unfortunately, many families do not have a family historian anymore. A family tree begins the family identification process; but, in many cases, there is no historian to pass the information on. This is sad, because adolescents are very interested in family trees as a way of understanding who they are. Often this information has never been shared with them. Their sense of identity is therefore incomplete. In adolescence, it is natural for children to want to know their roots. The more

fragmented the family of origin is, the more the adolescent needs to know what came before.

One of the most important circles from Gestalt Therapy is the foundation circle that asks “Where do I come from?” and “What guides me to understand who I am and where I want to go”? That seems to be missing for many adolescents who come for treatment and who, in many cases, don’t know anything about their heritage or history. This history could be a place from which to draw strength. Looking back three generations in the most dysfunctional families, there was someone who was a survivor or the family would not have gotten this far. If someone can take the adolescent back as far as that person, they have a place from which to gain strength.

The experience of doing family work with genograms can be almost as cathartic for the parents as for adolescents. Often, the parents do not have historical information to give to their children, so they become involved in researching the family history. This exercise can bring the two generations together with the understanding that there was strength somewhere in the family because they survived well enough to get to the present. The fact that there was fortitude, strength, and tenacity somewhere in the family is very helpful for adolescents.

An Integrated Model of Treatment

Traditionally, patients with co-occurring disorders have been bounced back and forth between the substance abuse and mental health treatment systems. The mental health system wants the substance abuse problems stabilized before they begin treatment. The substance abuse programs want the psychiatric problems stabilized before they begin treatment. What is the answer?

An integrated model of treatment uses staff members who are both substance abuse and mental health specialists to treat those with co-occurring disorders. These specialists have the capacity to look at clients with co-occurring disorders in an integrated way. Both mental health and substance abuse personnel tend to have certain areas in which they resist this integrated model, but it has been shown to work. The model focuses on harm reduction.

Stages of Change

There are several philosophies about the Integrated Model. Prochaska and DiClemente's stages of change model (1992) discusses the following stages: pre-contemplation, contemplation, preparation, action, and maintenance/relapse.

- *Pre-contemplation* means that the person does not conceive of the substance abuse or other treatment issue as a problem.

- *Contemplation* means that they are now aware of the problem but are not willing to do anything about it. They acknowledge that the problem is present but not that it is a causative factor of their current distress.

- *Preparation* means the individual is getting ready to make a change.

- *Action* means the person is actively working on the problem.

- *Maintenance* means the person continues to move forward.

- *Relapse* means there is a setback. This is not an unusual occurrence for those with addiction problems. An individual might be sober for a year and then suddenly start thinking "Maybe I was never really an addict in the first place." This sets the stage for a relapse.

Use of the integrated model in terms of these stages of change means looking at the person as a whole. The clinician identifies which stage of change the person is in for each disorder and uses this information to determine how to intervene. Most of this treatment is conducted in a group format. Groups should not, however, have a mix of variously diagnosed patients in the same group. Individuals should be separated and the groups defined by the stages patients are in. It may not be useful to have someone who is in the pre-contemplation stage in the same group with someone in the action stage. Those in the action stage might, over time, have a favorable impact on those in pre-contemplation, but the pre-contemplation people may have nothing to offer those in the action stage. Mixing them together could waste a group's potential strengths.

During the initial interview and screening assessment, the clinician using this model determines the stage of change the individual is in, as well as the diagnosis. Diagnosis does not have any relevance if the client does not "buy into" treatment. The client is then routed toward appropriate treatment based on stage of change. A pre-contemplative patient might only come to a facility twice a week for a 2-hour psychoeducational group, for example.

Individuals arrested for drunk driving are good examples in the adult population of the most pervasive pre-contemplation group. In Maine, those who are arrested for a DWI charge are sent to accelerated rehabilitation groups. By and large, these people are in pre-contemplation. They say things like, "Well, there were 50 other guys out there like me and I just happened to be unlucky and get picked up. Or, "I wasn't really drunk, I just accidentally went over the middle line." Or, "The lab botched the urine sample."

The components of a good process for assessment are:

- Comprehensive assessment
- Accurate diagnosis
- Stage of change definition for each of the disorders present.

What should be done if a client comes in with a major depressive disorder in the preparation/action stage and cocaine dependence in the pre-contemplation stage? How do we group this person with other clients in a way that makes sense and that assists in supporting them for preparation, action, and maintenance concerning the depression?

After screening and intake, the person is sent to an outpatient psychoeducational treatment program on substance abuse that meets in the evening. A staff psychiatrist meets with the client once a week to oversee medication for depression. As a result, the individual receives education about cocaine dependence and the depression is stabilized. When he or she is ready for treatment for the cocaine dependence, the treatment will move up a notch. If the major depressive disorder was single-episode and stabilizes, and the client is on medication, he or she might be

ready to enter a substance abuse treatment program. However, if the depression is a recurring major depressive disorder and can't be stabilized, the client can be placed in a Co-occurring Disorders Unit, where they can work with these combined issues. This example illustrates how the stages of change can be used to determine the treatment modality.

A true co-occurring integrated model looks at three things to determine whether the person is moving along the continuum from unhealthy to healthy:

- Periods of relapse are shorter
- Periods of stability (for substance abuse and psychiatric symptoms) are longer
- Intensity of relapse periods are lessened

Those with true co-occurring disorders are likely to be somewhere on this continuum throughout their lives, moving back and forth. However, if they meet the above criteria, they are moving in the right direction. That is the definition of success.

If a client has four treatment episodes available to them, it is much more logical for them to have the four treatments in an integrated model, in which the stages of change for the various disorders are addressed head on. It is not as productive to put the client through a static model that does not take into account the stages of change. In the first approach, we are working on building blocks around each of the disorders. In the second case, the clinician is not necessarily even building a foundation.

Phases of Treatment

The traditional system has had clients "start over" at the beginning of treatment when they relapse repeatedly. Something has been missing in this approach. There is a population called "chronic relapsers." They have been seen as the “resistant clients” who remained in denial and did not really want to get sober. About 15 years ago, Terry Gorski asked, "What are we going to do about this group of people"? He found that the chronic relapsers were often those putting forth the most time and effort toward staying sober. However, they were least able to stay sober because the system was not addressing the missing pieces. The major missing piece was an undiagnosed co-occurring disorder. These individuals went into treatment, did well in treatment, got out of treatment, and tried to stay sober. However, the symptoms returned and there was no cure for them. These clients relapsed because they believed the only way to lessen their unpleasant symptoms was to go back to using.

Placing people in treatment in mixed groups does not solve such problems. The field needs to look at ways to effectively separate these patients. It is sometimes possible to mix pre-contemplation and contemplation groups. But the clinician cannot take any eight clients and form a group. This hinders the recovery of some and the material is above the comprehension level of others. Perhaps only one person in the group may be helped and the rest are not having their needs met. It is also ineffective to mix those with depressive disorders and those with schizophrenia in one group, even if they are all in the contemplation stage. The range of these disorders is too wide.

Understanding the phases of treatment in the recovery process can help alleviate this problem. They are described in six stages:

- Transition and engagement
- Stabilization
- Early recovery
- Middle recovery
- Late recovery
- Maintenance

Pre-contemplative and contemplative people are in the transition and engagement stage. Those in preparation are in stabilization; early recovery relates to the action stage.

From a harm reduction model, relapse is part of an overall process. People frequently relapse but then rebound and do well. Therefore, the appropriate response to someone who has relapsed is an invitation to rejoin a maintenance group. Although this person made some bad choices, he or she does not need to be sent back to the beginning of treatment. Rather, they move back one stage, to the group they were last in. Sending a client to the very beginning of the treatment process is punitive, as if saying, "You failed because you used again." This punitive approach is typically the orientation of the traditional model.

The following has been found concerning time frames for groups in different phases:

- Maintenance is the longest running group. The purpose of the maintenance group is to have a tremendous impact on the person's overall life. Clients in a maintenance group can be helped by others in the group who have dealt with the same issues.
- It is usually possible to set a time frame concerning the length of time a person needs to be successful in the action group before they can enter maintenance.
- The groups that are most difficult to define in terms of length are transition and engagement, stabilization, and early recovery. For example, someone with schizophrenia and a cocaine addiction may need years before they are ready to look at additional problems. In some cases, the individual may feel so much better when they achieve sobriety, or when the schizophrenia stabilizes, that the impact of the other disorders is minimized.
- These groups last different lengths of time, with individuals moving back and forth in a very fluid process.

With adolescents especially, it is important to be extremely careful not to mix groups. If a person who is pre-contemplative is placed in an action group, for example, they can pull the entire group back with them. The peer issue is much stronger for adolescents than for adults. In a case like this, the group can be lost by mixing together those in different stages of change.

Appendix A
Reference List

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Appendix B
Training In 18 Core Competencies

1. **DEMONSTRATES RESPECT FOR PERSONS WITH CO-MORBID MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

   a) Uses language and behavior which consistently reflect and perpetuate the dignity of those with co-occurring mental health and substance use disorders.

   b) Understands the holistic (social, emotional, physical, and/or spiritual) issues facing persons with co-occurring mental illness and substance use problems.

   c) Appreciates the diversity among individuals with dual diagnosis. Dual diagnosis can affect persons in every walk of life, every economic class, geographic area, sex, sexual orientation, age, education, lifestyle, race, and ethnicity. Treatment must recognize and address the differences among clients with specific dual diagnosis subtypes.

   d) Understands and applies the disease and recovery model to clients with substance abuse and mental illness.

2. **DEMONSTRATES A KNOWLEDGE OF MENTAL ILLNESS AND SUBSTANCE USE ETIOLOGY AND COURSE OF ILLNESS**

   a) Differentiates characteristics of psychopathology (Axis I and Axis II psychiatric disorders/use, abuse, or addiction) in the dually diagnosed client.

   b) Recognizes the overlap of symptoms across disorders.

   c) Outlines the various diagnosis, duration, and levels of disability present in the dually diagnosed client.

   d) Understands various theories of the causation and etiology of co-occurring mental health and substance use disorders, including a bio-psycho-social-spiritual perspective.

   e) Recognizes the unique needs of individuals with co-occurring mental health and substance abuse issues.

   f) Views dual diagnosis treatment as a process of recovery and relapse requiring various treatment modalities matches with the client's present level of pathology.

3. **DEMONSTRATES AN UNDERSTANDING OF THE PHARMACOLOGICAL ASPECTS OF MENTAL HEALTH TREATMENT AND SUBSTANCE USE DISORDERS**

   a) Understands the basic withdrawal symptoms and required detox protocols for each drug category.

   b) Identifies the major medications used to treat psychiatric, substance use, and dual disorders, including their actions, and their side effects.

   c) Identifies the major addictive substances of abuse, to include nicotine, alcohol, OTC drugs, prescription drugs, and illicit drugs, their category of effect, and their prevalence within the substance-abusing client population.

   d) Recognizes high-risk side effects and appropriate interventions of various drug categories.

e) Recognizes the behavioral changes in clients due to medications and substance abuses.

f) Identifies high-risk drug interactions and appropriate intervention strategies.

g) Recognizes basic medical complications and their interaction with pharmacological treatment.

h) Explain risk/benefit factors in pharmacological treatment.

i) Explains the appropriateness/availability of pharmacological treatment.

j) Facilitates a longitudinal perspective on the recovery of the client with co-occurring mental health and substance use disorders.

4. **DEMONSTRATES A WORKING UNDERSTANDING OF THE FACTORS THAT DETERMINE A CLIENT'S APPROPRIATENESS AND ELIGIBILITY FOR VARIOUS TREATMENT MODALITIES**

a) Engages and develops initial rapport with the prospective client and collateral contacts.

b) Solicits collateral input and corroboration from family/natural supports of initial admission information.

c) Involves collateral contacts from family/natural supports in the support of the identification of treatment needs and their role in the referral process.

d) Has a knowledge of treatment settings as alternative resources for client care which is the least restrictive and most appropriate to the client's needs (i.e., specialized, linked, psychiatric, or substance abuse residential, partial hospitalization or outpatient.

e) Facilitates the placement of the client in the least restrictive treatment environment in which s/he can be successful in recovery.

f) Understands placement criteria and levels of care.

g) Understands the family's role in the client's life to determine how best to integrate the level of family involvement.

h) Determines how the living, learning, legal, and working environment determines the eligibility, entitlements and appropriate level of care.

5. **DEMONSTRATES THE ABILITY TO EXPLAIN THE NATURE, GOALS, AND RULES OF THE PROGRAM TO THE CLIENT IN A MANNER WHICH DEVELOPS RAPPORT AND REDUCES CLIENT ANXIETY**

a) Provides an overview of the treatment program's goals to the client, taking into account comprehension levels, literacy, and language issues.

b) Provides the client with a comprehensive overview of the program rules, the client's obligations and the client's rights.

c) Explain the various treatment modalities and their purpose within the treatment protocols.

6. **DEMONSTRATES THE ABILITY TO ASSESS THE EFFECTS AND IMPACT OF THE CO-MORBIDITY OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

   a) Explains to the client the process of assessment and its goal of facilitating rapport and the engagement process.

   b) Assess the specifics of the substance use and psychiatric components of dual disorders and their interrelationship.

   c) Utilizes the indicated substance abuse or psychiatric assessment tools to facilitate accurate diagnosis.

   d) Understands both the benefits and limitations of the toxicology screening process.

   e) Identifies the signs and symptoms of withdrawal and implements the appropriate interventions.

   f) Understands that the assessment of psychiatric and substance use disorders is a process that evolves over time.

   g) Has proficiency in understanding the major symptoms and criteria in the DSM-IV diagnostic categories.

   h) Recognizes the importance of the onset of the illness while assessing co-occurring mental health and substance use disorders.

   i) Assess societal, cultural, and gender issues and their impact on clients.

   j) Assess the stage of change and level of engagement.

   k) Performs risk assessments and acts appropriately upon the assessment data.

7. **DEMONSTRATES THE ABILITY TO DESIGN, IMPLEMENT, AND ENSURE A HIGHLY INDIVIDUALIZED PLAN OF ACTION.**

   a) Outlines a process, with the client, to assist the client in setting goals taking into account their motivation levels and stage of treatment.

   b) Assists the client in identifying practical strategies for achieving their personal recovery goals.

   c) Provides current and accurate information regarding treatment options and resources to the client with co-occurring mental health and substance use disorders.

   d) Designs personal service plans based upon negotiation with the individual client based upon their chosen goals, choices, and preferences.

   e) Facilitates planning based upon the client's strengths, resources, and abilities.

   f) Updates planning with the client to accommodate new learning and changes in goals and objectives.

   g) Integrates knowledge about societal, cultural, and gender issues and their impact on clients with co-occurring mental health and substance use disorders into the assessment process.

   h) Matches the type and intensity of support services to the individual client's circumstances.

   i) Advocates for and utilizes services and resources that meet specific individual

needs of the client.

8. **DEMONSTRATES INTERVENTIONS AND SUPPORT STRATEGIES, PROGRAM MODELS, AND PHILOSOPHIES**

   a) Exhibits supportive interpersonal skills such as attending, listening, showing empathy, prompting, summarizing, and responding to feelings and content.

   b) Appreciates and has knowledge of the common biological-psychological-social-spiritual treatment interventions.

   c) Establishes and maintains a productive therapeutic relationship and ongoing rapport with clients with co-occurring mental health and substance use disorders.

   d) Utilizes an understanding of the unique issues facing family member of persons with co-occurring mental health and substance use disorders to facilitate recovery.

   e) Provides assistance with and reinforcement of appropriate decision making and problem-solving skills.

   f) Recognizes the impact of behavioral dynamics in relationships.

   g) Assists individuals in recognizing their personal patterns of behavior and in understanding how those patterns affect decision-making.

   h) Identifies and reinforces the client's identity, individual skills, strengths, and resources.

   i) Recognizes the multiple ways in which a client's core needs are expressed.

   j) Assists clients in developing effective strategies for managing internal and external stresses.

   k) Productively outlines a plan of support service integration, identifying the least restrictive environment necessary to facilitate the client's recovery.

   l) Understands the importance and impact of the environment on dual diagnosis clients.

   m) Utilizes a working knowledge of the role that motivation plays in the treatment of clients who are dually diagnosed.

   n) Applies knowledge and skills in the areas of pre-engagement, engagement, persuasion, active treatment, relapse prevention, and recovery.

9. **DEMONSTRATES THE ABILITY TO ACCESS, COORDINATE, AND FACILITATE COMMUNITY, PEER, AND NATURAL SUPPORT SYSTEMS TO MAXIMIZE TREATMENT AND RECOVERY OPPORTUNITIES**

   a) Identifies a client's ongoing clinical status to facilitate decisions regarding the utilization of current treatment and support services.

   b) Involves the client in all aspects of service planning and support activities.

   c) Utilizes a knowledge of family support resources.

   d) Develops a knowledge of community support and rehabilitation resources.

   e) Mediates conflicts within the client's support network or encourages clients in self-intervention within that network.

f) Recognizes and facilitates the client's connection with natural and peer supports, and aids the client when appropriate.

g) Facilitates the use of spiritual and/or religious resources in the ongoing recovery process for the client when appropriate.

h) Possesses knowledge in current local, state, federal, and private sector entitlements and health care benefits available to the dual diagnosis client.

i) Assesses and determines a dual diagnosis client's eligibility for benefits and entitlements due to their individual circumstances.

j) Accesses and facilitates ongoing services through appropriate contacts and follows up with various payers.

k) Maintains a knowledge of various resources in the areas of housing, financial services, and vocational issues.

10. **DEMONSTRATES THE ABILITY TO TEACH BOTH SIMPLE AND COMPLEX SKILLS AND INFORMATION TO CLIENTS WITH CO-EXISTING MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

a) Understands adults learning theory and its application to psycho-educational groups with dual diagnosis clients.

b) Provides information about mental illness, substance abuse, self-help resources, medications, and community resources.

c) Integrates information in all groups to address a blended dual diagnosis perspective.

d) Designs group presentations and facilitates psycho-educational skills development dual diagnosis groups from blended perspective.

11. **DEMONSTRATES A PRACTICAL KNOWLEDGE OF A RANGE OF CRISIS PREVENTION, INTERVENTION, AND RESOLUTION APPROACHES**

a) Performs risk assessments and acts appropriately upon the assessment data.

b) Utilizes community resources, when necessary, to resolve a client's crisis.

c) Understands "duty to warn"/"duty to protect" issues and possesses knowledge of signs and symptoms that indicate the need for a risk assessment or psychiatric evaluation.

d) Facilitates the reduction of acute emotional or physical distress in a client (and the development of crisis-avoidance skills).

e) Performs ongoing monitoring of the client at risk for medical complications, withdrawal symptoms, or psychiatric decomposition.

f) Recognizes the signs and symptoms of chemical impairment and the associated risk factors.

12. **DEMONSTRATES THE KNOWLEDGE AND SKILLS NECESSARY TO ASSESS AND RESPOND TO THE NEEDS OF THE CLIENT THAT CANNOT BE MET BY THE TREATMENT PROGRAM**

a) Identifies and records client needs or problems which the treatment program cannot resolve.

b) Matches client needs, issues, and problems to appropriate alternative or additional resources.

c) Explains the rationale and process of referral to the client and collateral contacts.

d) Facilitates utilization of alternate treatment resources through referral and follow-up.

e) Possess knowledge about community resources available to the dual diagnosis client and the eligibility requirements for each.

13. **DEMONSTRATES THE SKILLS TO APPROPRIATELY DOCUMENT ALL INFORMATION NECESSARY TO MEET LEGAL REQUIREMENTS AND TO FACILITATE EFFECTIVE TREATMENT**

a) Documents screening, assessment, and treatment planning information, progress notes, discharge summaries, correspondences, and other client-related data to facilitate treatment.

b) Integrates written materials into ongoing client care and the continuum of care.

c) Possesses knowledge of the current industry standards of reports and record keeping.

d) Understands the legal ramifications of documentation use of appropriate clinical discretion in the report and record keeping process.

e) Demonstrates an awareness of confidentiality laws as applied to reports and record keeping.

14. **DEMONSTRATES AN AWARENESS OF THE NEED FOR ONGOING CONSULTATION AND CLINICAL SUPERVISION TO FACILITATE THE APPROPRIATE TREATMENT OF THE CLIENT**.

a) Solicits and accepts consultation and feedback to improve professional skills.

b) Works cooperatively and collaboratively as a treatment team member to facilitate comprehensive treatment services.

c) Seeks out learning opportunities through clinical supervision, in-services, and other training events.

d) Monitors and improves work performance and effectiveness through the solicitation of supervisory, collegial, client, and collateral feedback in a structured and evaluative format.

e) Integrates new learning into daily work practices.

f) Remains current in best practice models in the field of dual diagnosis through ongoing training and consultation.

15. **DEMONSTRATES A WORKING KNOWLEDGE OF ETHICAL PRINCIPLES, INDIVIDUAL CLIENTS' CIVIL RIGHTS, AND THE LAW**

a) Advocates for clients with community resources and organizations. Understands the components and impact of commitment laws on the treatment of the dually diagnosed client.

b) Observes and follows all State and Federal regulations regarding metal health

and substance use disordered clients.

c) Adheres to the Dual Diagnosis Certification Code of Ethics.

d) Evaluates relationships and treatment decisions according to the Dual Diagnosis Certification Code of Ethics.

e) Understands the grievance and appeals processes as their agency effectively locates the client on the process.

f) Possess knowledge of consumer rights and the resources available to the consumer for advocacy.

g) Protects client's rights and confidentiality by adhering to all laws governing the release of treatment information between service organizations.

h) Understands the requirements and responsibilities concerning mandated reporting, including issues of Tarasoft, child or geriatric abuse and specific infectious diseases.

16. **DEMONSTRATES A MULTI-LAYERED UNDERSTANDING OF THE NEEDS AND CONCERNS OF SPECIAL POPULATIONS, INCLUDING THE PHYSICALLY CHALLENGED, HEARING IMPAIRED, GERIATRIC AND HIV POPULATIONS, AS WELL AS CONCERNS REGARDING THE ADDITIONAL COMPLEXITY OF GENDER, SEXUAL ORIENTATION, RACE, ETHNICITY AND RELIGIOUS BELIEFS**

a) Demonstrates a working knowledge of the concept of "Special Populations".

b) Demonstrates a working knowledge of the specific identity and issues of the populations cited above in relation to Dual Diagnosis treatment concerns.

c) Demonstrates an understanding of the multi-layered complexity of Special Populations and how their needs and concerns are both similar to and different from other populations in relation to Dual Diagnosis treatment.

d) Demonstrates the knowledge and skills necessary to assess and respond to the identified needs of Special Populations and determine:

1) if the treatment program can meet these needs or

2) if the needs can better be met by other providers or by a creative combination of service providers.

e) Demonstrates a commitment for continuing individual and professional growth in understanding and working with Special Populations.

17. **DEMONSTRATES A WORKING KNOWLEDGE OF MEDICAL AND LEARNING IMPAIRMENT CONCERNS AND HOW THESE CONCERNS IMPACT ON DUALLY DIAGNOSED INDIVIDUALS**

a) Demonstrates a working knowledge of common medical and learning impairment concerns, including but not limited to HIV, TBI, ABI, LDC, MR, Dementia, pregnancy and geriatric concerns.

b) Demonstrates the ability to identify the need for specialized medical and learning impairment consultations as necessary.

c) Demonstrates sensitivity for medical and learning impairments within Dual Diagnosis treatment.

d) Demonstrates an awareness of risk factors in various medical conditions.

18. **DEMONSTRATES A WORKING KNOWLEDGE OF FORENSIC AND LEGAL CONCERNS INCLUDING INVOLVEMENT WITH PSRB, PROBATION, PAROLE, DCF, THE COURT AND MANDATED TREATMENT, AND HOW THESE CONCERNS IMPACT DUAL DIAGNOSIS TREATMENT**

a) Demonstrates sensitivity to the concerns raised when an individual is simultaneously involved legally and in Dual Diagnosis treatment.

b) Demonstrates an awareness of the impact of mandatory treatment regarding motivational level and attitude toward treatment.

c) Demonstrates a working knowledge regarding special documentation requirements.

d) Recognizes the impact of probate court and conservatorship on the individual in Dual Diagnosis treatment.