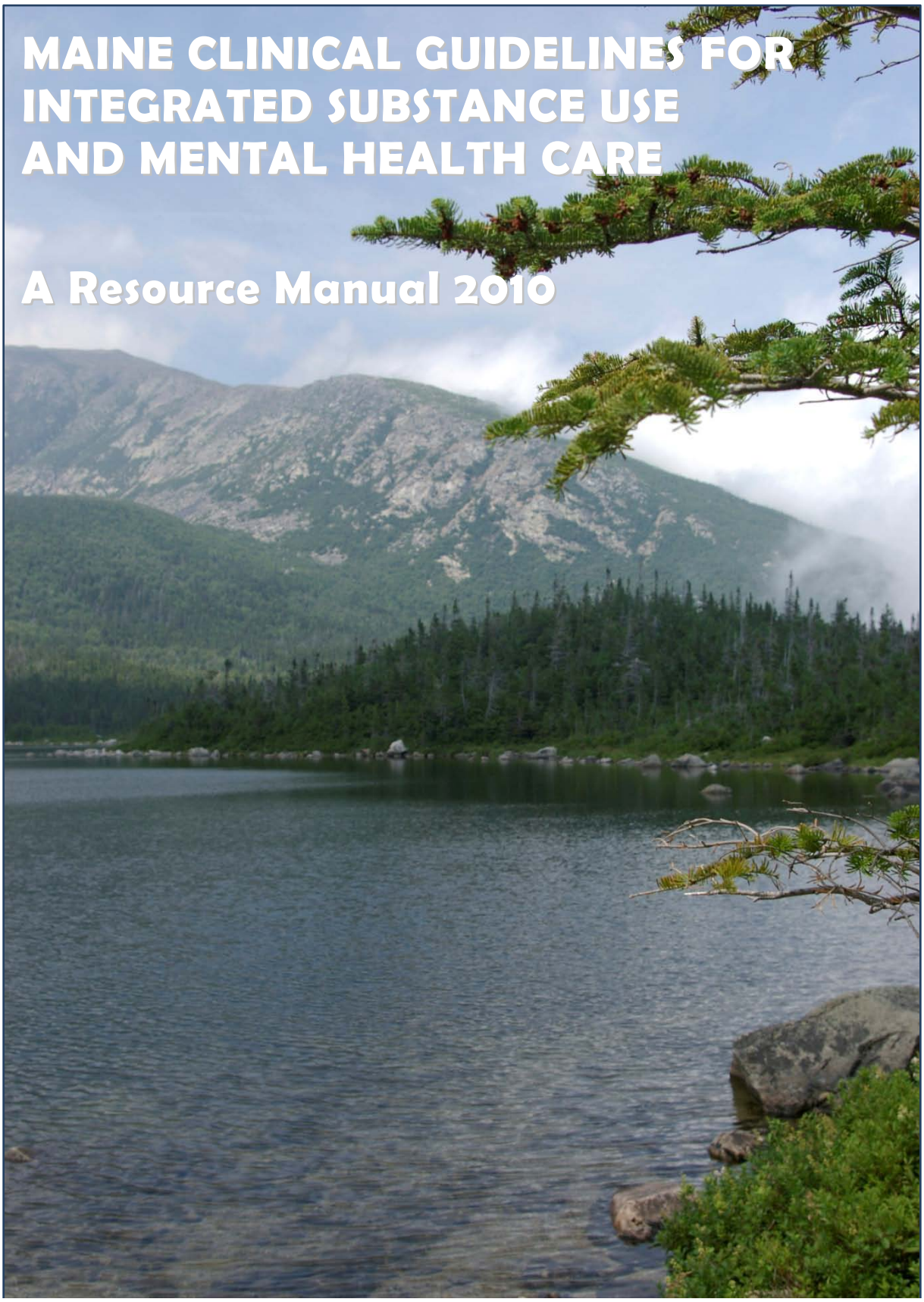
MAINE CLINICAL GUIDELINES FOR INTEGRATED SUBSTANCE USE AND MENTAL HEALTH CARE

A Resource Manual 2010



Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor
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Co-occurring State Integration Initiative
COASII

MAINE CLINICAL GUIDELINES FOR INTEGRATED SUBSTANCE USE AND MENTAL HEALTH CARE

A Resource Manual

Edition 1

2010

This manual was produced through the Maine Department of Health and Human Services by the Clinical Practices Committee of the *Maine Co-occurring State Integration Initiative* (COSII). It is also available on the DHHS website at www.maine.gov/dhhs/cosii.

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Neither the State of Maine nor the COSII Clinical Committee assumes responsibility or liability for any outcomes related to the information contained in this document. Providers are ultimately responsible for all decisions related to client care and must remain knowledgeable about current or future changes to state regulations and service definitions.

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INTRODUCTION

Welcome to the *Maine Clinical Guidelines for Integrated Mental Health and Substance Use Care.* This Resource Manual has been produced by the Clinical Practices Committee of the Co-occurring State Integration Initiative (COSII) to provide accessible information about integrated, co-occurring treatment. It is meant to be useful to practitioners at all levels of care, in both adult and child services, as well as to administrators as they make decisions about policy, program changes, and staff training related to integration. We hope that it reflects a standard understanding of methods of practice from both the substance abuse and mental health disciplines as it focuses on merging those two perspectives into a broader model of integrated care.

The Co-occurring Initiative began in 2005 with the award to DHHS of a five-year Co-occurring State Incentive Grant (COSIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the grant was to change state infrastructure so that it could better support providers in integrating substance use and mental health work. This manual is a product of the work of the committee focused on clinical aspects of integrated mental health and substance use services.

While the COSII initiative focuses specifically on mental health and substance use conditions, we acknowledge that people may have many combinations of co-occurring issues, particularly ones related to physical health. This awareness is reflected in the Commissioner's Integrated Services Policy (available on the COSII web site). However, while some basic principles apply to the consideration of the complex range of conditions that may occur for one person, this manual addresses only the service issues related to mental health and substance use disorders.

These services are best provided through a person-centered, recovery oriented approach. Integrated mental health and substance use services delivery involves collaboration with individuals, state agencies, providers, families and physicians. Continuity is required as people move through different levels of care and stages of change. Recognizing there are limited resources, the goal is to utilize evidence-based practices, integrated co-occurring treatment being one, to improve outcomes.

This committee first worked on a policy related to screening and assessment, since a first goal of the grant was to initiate routine screening for co-occurring disorders. It then focused on defining co-occurring competency and on

working with other committees to define the skills required to do good co-occurring work. Finally, as the work of the grant led to a better understanding of what practices are effective in integrated care, it began its work on defining the ways that integrated treatment looks different from traditional treatment that operates in parallel "silos."

At first, the Committee assumed the guidelines outlined in this manual would need to be developed as policy statements. However, the group soon realized that policies are too formal and that what they wanted to provide were simple guidelines for good co-occurring, integrated work. Hence, these guidelines are presented as templates, rather than a set of rules requiring compliance. One of the hallmarks of integrated mental health and substance use care is flexibility. Within the limits of regulatory standards and the basic principles of integration, it is assumed that providers will make use of these documents as resources and guidelines pointing a direction for integration.

The hope is that this manual serves as a comprehensive resource for providers in developing the capacity to provide integrated care. Research and national trends show that the need for a focus on and access to co-occurring treatment will only increase in the years to come. Maine has been one of only 19 states chosen to benefit from Federal support for developing co-occurring capacity. Sustaining this focus going forward is a major responsibility of DHHS, providers and consumers.

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The Committee would like to acknowledge and thank Dr. Kenneth Minkoff for his review and work on revisions of these Guidelines.

DEFINITIONS

ASAM (American Society of Addiction Medicine)

ASAM refers to the Patient Placement Criteria for the Treatment of Substance Related Disorders. ASAM criteria define standards for placement of those with substance use and co-occurring disorders at all levels of care based on six dimensions of functioning. This level of care assessment is required for substance use and co-occurring treatment providers.

See Appendix 2 for more information.

Complex Needs

People with complex needs or conditions may have any combination of functional, protective, or concrete service needs as well as any behavioral or medical healthcare need. Conditions that may co-occur include physical health problems, trauma, mental health diagnoses, brain injury, developmental disabilities, substance use disorders, financial, vocational or housing need, family and child support needs, crisis support needs, acute or chronic psychiatric conditions and need for protection from risk of harm.

Continuous, Comprehensive, Integrated System of Care (CCISC)

The CCISC, developed by Dr. Kenneth Minkoff and Dr. Christie Cline, is a model for organizing services for individuals with co-occurring psychiatric and substance use disorders. It is designed to improve treatment capacity for individuals in systems of any size and complexity. The ultimate goal of CCISC is to help develop a system of care that is welcoming, recovery oriented, integrated, culturally competent, and attentive to the potential presence of trauma. The goal of such a system is to help people with co-occurring disorders make progress in achieving recovery.

The model has the following four basic characteristics:

1. **System-Level Change:** the model is designed for implementation throughout the entire system of care at all levels including policy, program, procedure and practice
2. **Efficient Use of Existing Resources:** the model is designed for implementation within the context of current resources
3. **Incorporation of Best Practices:** the model is itself a SAMHSA-recognized best practice and encourages the incorporation of evidence

based practices for the treatment of all types of co-occurrence throughout the system

4. **Integrated Treatment Philosophy:** The model is based on principles of successful treatment intervention derived from available research and incorporated into an integrated treatment philosophy that makes sense from the perspective of both mental health and substance abuse providers

In a CCISC process, every program and every person delivering clinical care engages in a quality improvement process – in partnership with one other, with system leadership, and with individuals and families who are receiving services - to become welcoming, recovery or resiliency oriented, and co-occurring capable.

See Appendix 2 for reference.

Co-occurring Capable:

Co-occurring capability is defined as the capacity of a substance abuse, mental health, or dually licensed program to design its policies, procedures, screening, assessment, program content, treatment planning, discharge planning, interagency relationships, and staff competencies to routinely provide integrated co-occurring disorder services to individuals and families who present for care within the context of the program's mission, design, licensure, and resources.

See the entry on co-occurring capability in the Integrated Practice Principals section of this manual for additional information.

Co-occurring Disorder (COD)

- Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)
- There are no specific combinations of substance abuse disorders and mental disorders that are defined uniquely as co-occurring disorders
- Substance abuse and mental health problems (such as binge drinking by people with mental disorders) that do not reach the diagnostic threshold are also part of the co-occurring disorders landscape and may offer opportunities for early intervention
- Both substance abuse disorders and mental disorders have biological, psychological and social components

- Co-occurring disorders may vary among individuals and in the same individual over time
- Both disorders may be severe or mild, or one may be more severe than the other

Co-occurring Enhanced:

Co-occurring Enhanced programs are organized to welcome, identify, engage and treat members with co-occurring substance use and mental health conditions who have moderate to high symptom acuity. Such programs are dually licensed to provide both mental health and substance use disorder services, and their *primary focus* is on providing integrated treatment under one roof where all staff are cross trained and where a range of psychopharmacologic and addiction pharmacotherapy, psychiatric, crisis, and co-occurring program services are available. One clinician or team is able to provide both mental health and substance use disorder treatment concurrently along with coordinating multiple other appropriate interventions.

Evidence-Based Practices (EBP):

A practice which, based on research findings and expert or consensus opinion about available evidence**,** is expected to produce a specific clinical outcome (measurable change in client status). Evidence-based practices encompass three categories that reflect practices with varying levels of evidence: those based on scientific evidence, promising practices, and emerging practices. All levels of evidence-based practices must include the following to various degrees:

- They are accepted practice for a specific group or problem
- There is literature in peer-reviewed journals providing data regarding efficacy
- Implementation guidelines exist
- They have a sound theoretical basis

At the *treatment level*, interventions that have their own evidence to support them as EBPs are frequently a part of a comprehensive and integrated response to persons with co-occurring disorders (COD).

Some of these interventions are:

- **Psychopharmacological Interventions**, *e.g.*, desipramine and bupropion for people with cocaine dependence and depression (Rounsaville, 2004)
- **Motivational Interventions**, *e.g.*, motivational enhancement therapy (Miller, 1996; Miller & Rollnick, 2002)
- **Behavioral Interventions**, *e.g.*, contingency management (Roth et al.,2005; Shaner et al., 1997)

At the program level, the following models have an evidence base for producing positive clinical outcomes for persons with COD:

- **Modified Therapeutic Communities** (CSAT, 2005; De Leon *et al.*, 2000; Sacks *et al.*, 1998, 1999)
- **Integrated Dual Disorders Treatment** (CMHS, 2003; Drake *et al.*, 1998b, 2004; Mueser *et al.*, 2003)
- **Assertive Community Treatment** (Drake et al., 1998, Essock *et al.*, 2006; Morse *et al.*, 1997; Wingerson and Ries, 1999)

Four Quadrant or Quadrant of Care Model:

The quadrants of care are a conceptual framework that classifies clients in four basic groups based on relative symptom severity, not diagnosis.

Psychiatric High **Substance High** *Serious & persistent mental illness with substance dependence* **Quadrant IV**	**Psychiatric Low** **Substance High** *Substance dependence with some psychiatric complications* **Quadrant III**
Psychiatric High **Substance Low** *Serious and persistent mental illness with substance abuse* **Quadrant II**	**Psychiatric Low** **Substance Low** *Mild psychopathology with substance abuse* **Quadrant I**

Quadrant I: Less severe mental disorder/less severe substance disorder
Quadrant II: More severe mental disorder/less severe substance disorder
Quadrant III: Less severe mental disorder/more severe substance disorder
Quadrant IV: More severe mental disorder/more severe substance disorder

The quadrant of care model was an outgrowth of a National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, supported by SAMHSA and co-sponsored by The National Association of Mental Health Program Directors and The National Association of State Alcohol and Drug Abuse Directors. The Quadrants help to conceptualize a client's treatment and to guide improvements in system integration. They generally predict or correspond to the person's entry point into the system of care and suggest some direction for the integration of services.

See TIP 42 (SAMHSA Treatment Improvement Protocol) for further information on both the Four Quadrant Model and Evidence-Based Practices for co-occurring disorders

Guideline:

Advice or instructions given in order to guide or direct an action. A guideline is an optional practice. Although guidelines are generally voluntary, the implication is that practitioners will use the concepts or principles in meeting their objectives.

Integrated Services:

Any of a broad range of appropriately matched services that may be combined to address multiple needs. Services are designed to assist individuals or families with multiple problems and to make progress toward identified goals and objectives in all domains where needs have been identified. The service response is coordinated, comprehensive, collaborative and continuous. Rather than the person needing to navigate a complex system, the system organizes itself around the person's complex array of needs.

Intentional Peer Support:

Intentional Peer Support is a model for developing relationships with others in ways that promote growth, recovery and wellness. Developed by Shery Mead, this model focuses on helping peers to learn skills for supporting one another in new and different ways. The four tasks of relationship in this model are connection, understanding world view, enhancing mutuality and moving towards goals rather than away from them. After being trained in the Intentional Peer Support Model, peers may work in various settings such as warm lines, hospitals, ACT teams, peer centers and crisis shelters providing support to those in crisis or newly in recovery.

See Appendix 2 for Shery Mead's website.

LOCUS and CALOCUS:

The LOCUS (Level of Care Utilization System) is a level of care assessment tool used in Maine to determine eligibility for care for specific services. The tool employs six assessment parameters or scales, rated on a scale of 1 through 5, with specific criteria or anchor points. The six parameters are: risk of harm, functional status, medical, addictive, and psychiatric comorbidity, recovery environment, treatment and recovery history, and engagement. The CALOCUS is the child/adolescent version of the assessment tool. The LOCUS defines six levels of care and each describes a flexible array of services at different levels of intensity. Generally, the LOCUS must be administered by mental health counselors and case managers to determine eligibility for care based on specific target scores.

Multi-axial Diagnosis:

A multi-axial system involves an assessment on several axes. The use of a multi-axial system facilitates comprehensive and systematic evaluation with attention to the various mental health conditions, general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem.

The multi-axial system is described in the *Diagnostic and Statistical Manual of Mental Disorders*-V*ersion IV (DSM-IV)* and consists of five axes that have traditionally been used to establish a diagnosis that directs treatment. Both substance abuse and mental health diagnoses are developed from this system, along with a general assessment of level of functioning, physical health and the presence of other complicating disorders besides the primary focus of concern.

Peer Support:

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement about what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of living with mental health and/or substance use issues.

Recovery:

Recovery is a journey of healing and transformation that enables a person to live a meaningful, satisfying, and contributing life in a community of his or her choice. Recovery is an individual process, a way of life, an attitude, and a way of approaching life's challenges. The need is to meet the challenges of one's life and find purpose within and beyond the limits of illness while holding a positive sense of identity.

Recovery-Oriented System of Care:

A recovery-oriented system of care focuses on recovery and the activities that support it. Such systems are strengths-based and include people in recovery as the primary actors in systems development and delivery of support. Such a system provides multiple ways of supporting individual recovery in community and recognizes that there are many pathways taken by the person who recovers based on which one works best at any given time.

The system is empowering of people and does not view them as having a pathology, but rather as actively striving to manage their life circumstances. Recovery-oriented care is what mental health and substance use treatment and rehabilitation practitioners offer in support of the person's own long-term recovery efforts. Behavioral treatment is only one element of a recovery-oriented system of care.

Strengths-Based Approach:

A strengths-based approach to care recognizes and validates the skills, knowledge, insight and strategies that a person uses or has used to meet the challenges of life. Care plans are developed to use and enhance the strengths of the people seeking services. A strengths-based approach is intended to achieve outcomes not through a focus on deficits, but on efforts to utilize and increase resilience and natural abilities. It seeks to validate psychological strengths such as self-regard, self-efficacy, hope, optimism, and clarity of values, purpose and identity. It seeks to enhance interpersonal skills such as social competence and social connectedness.

Strengths-based approaches are common to case management work, especially with children, and are a foundation of social work theory and practice emphasizing person-centered, resiliency-based treatment. This concept has become familiar in many disciplines including education and organizational development. Its core message is one of empowering the person and motivating change through a focus on strength and on what works well in the person's life.

Trauma-Informed Services:

Trauma-informed services are designed to respond to consumers who experience a cluster of symptoms, adaptations and reactions that interfere with their functioning related to their exposure to physical or sexual abuse, injury or exploitation, witnessing or surviving severe community, military, or domestic violence, including accidents or natural and human-caused disasters. This may include the effects of mistreatment, neglect, abuse or coercive treatment in the broad context of health services provided in multiple types of settings. Trauma creates a sense of fear, helplessness, and horror and overwhelms a person's resources for coping.

A trauma-informed system of care bases its services in knowledge about trauma and its impact. It promotes and ensures a basic understanding of symptoms, feelings and responses associated with trauma and traumatizing relationships. It avoids the use of approaches or techniques that are contraindicated for those who have experienced physical and sexual violence

such as shaming, confrontation, or intrusive monitoring. It ensures physical and emotional safety, maximum consumer choice and control, clear boundaries, and ensures collaboration and sharing of power. It maximizes empowerment and skill building and operates in ways that avoid re-traumatization.

Welcoming:

Welcoming is a core principle that emphasizes that all people, and particularly those with complex needs, are a priority for access and engagement in the service system, that no program refuses service based on the presence of multiple conditions alone, and that all individuals are proactively assisted to get connected to the services that best meet their needs. All programs have the capability to address the needs of individuals with complex conditions by providing integrated services within the scope of the program's mission, design, licensure, and resources. When a program cannot provide a service directly, it assists consumers in finding another appropriate source of that service.

INTEGRATED PRACTICE PRINCIPLES

PRINCIPLES OF INTEGRATED MENTAL HEALTH AND SUBSTANCE USE CARE

The following eight best practice principles (Minkoff and Cline, 2004, 2005) reflect the integrated recovery philosophy of the CCISC model.

1. Co-occurring conditions are an expectation, not an exception.

2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strengths-based relationship.

3. All people with co-occurring conditions are not the same; different parts of the system have responsibility to provide co-occurring capable services for different populations.

4. When co-occurring issues and conditions co-exist, each issue or condition is considered primary, meaning that each condition or issue receives appropriately matched intervention(s) at the same time.

5. Recovery involves moving through stages of change for each co-occurring condition or issue. Mental illness and substance dependence are examples of biopsychosocial conditions that can be understood using a disease and recovery model. Each condition has parallel phases of recovery and stages of change. Interventions and outcomes must be matched to stage of change and phase of recovery.

6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue. For each co-occurring condition, treatment involves learning new skills. Learning needs to be supported and skills-based work provided.

7. Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct co-occurring program or intervention for everyone.

8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery oriented, and co-occurring capable. Each program has a different job, and programs partner to help each other to be successful with their own complex populations.

CO-OCCURRING CAPABILITY

Co-occurring capability is defined as the capacity of a substance abuse, mental health, or dually licensed program to design its policies, procedures, screening, assessment, program content, treatment planning, discharge planning, interagency relationships, and staff competencies to routinely provide integrated co-occurring disorder services to individuals and families who present for care within the context of the program's mission, design, licensure, and resources.

Interpretive Statement:

A singly licensed, co-occurring capable mental health facility would provide mental health treatment, and for those individuals with co-occurring substance use issues or disorders, would provide integrated services to address the co-occurring substance use, abuse, or dependence *within the context of the mental health services being provided.* The facility would not represent itself as providing independent, free-standing substance abuse treatment, but rather would represent itself as providing integrated care to individuals with mental health conditions who have co-occurring substance issues or disorders.

A singly licensed co-occurring capable substance abuse facility would provide substance abuse treatment, and for those individuals with co-occurring mental health issues or psychiatric disorders, would provide integrated services to address those issues or disorders *within the context of the substance abuse services being provided*. The facility would not represent itself as providing independent, free-standing mental health treatment, but rather would represent itself as providing integrated care to individuals with substance use disorders who have co-occurring mental health issues or disorders.

Examples of Integrated Co-occurring Services:

- Routine screening for both psychiatric and substance use disorders
- Routine integrated assessment of both conditions that outlines the way the two conditions interact with and affect one another
- Treatment planning that includes appropriately matched interventions for both conditions
- Crisis intervention protocols that take both disorders into account
- Education on co-occurring disorders in both individual and group formats

- Stage-matched or motivational interventions for either or both disorders (*This example refers to the practice of motivational interviewing or the Transtheoretical Model of Change developed by James Prochaska and James DiClementi.)*
- Stage-matched educational or motivational interventions for substance using parents or caregivers of children receiving care for emotional disturbance
- Assistance with skill-building to manage the symptoms of one disorder in the context of receiving treatment for the other (*e.g.*, teaching how to avoid using substances to manage feelings or mental health symptoms; teaching individuals with substance conditions how to take medication as prescribed, and so on)
- Assistance with developing peer or professional support systems related to either or both conditions
- Family psychoeducational and support interventions that provide assistance to families and affected others in understanding or addressing both conditions
- Interagency coordination and collaboration (including collaborative treatment planning) if referrals for additional care are necessary
- Discharge planning that establishes plans for both conditions

CO-OCCURRING COMPETENCIES

This document represents a consensus statement developed by the Maine COSII Workforce Development Committee. It reflects current thinking about core skills important for the worker who provides services to people with co-occurring conditions. The scope of activity and functions of any specific practitioner depend on job description, role within the specific program, level of training, and the regulations governing practice. The competency levels reflect attention to all potential types of services provided in a program including those of support staff. They assume that each new level incorporates the competencies of the prior one.

Basic:

1. Convey a welcoming, empathic, hopeful attitude towards people with co-occurring conditions and support a philosophy of dual recovery
2. Demonstrate awareness of and capacity to work with one's personal reactions, feelings and attitudes about people with co-occurring conditions
3. Be familiar with and willing to learn about multiple co-occurring conditions
4. Engage and welcome people in ways that convey respect for diversity; know how to access information and resources about diversity, and how to provide them in a culturally and linguistically appropriate way

Intermediate:

5. Recognize, in partnership with the person receiving services, possible high-risk behaviors and feelings, and support and engage the person respectfully to be able to maintain safety for self and others
6. Understand the professional, legal and ethical requirements for working with people with co-occurring conditions
7. Identify basic symptoms of substance abuse and mental health disorders
8. Screen for co-occurring conditions, including history of trauma
9. Conduct or obtain a comprehensive, longitudinal, integrated, strength-based assessment of the person's supports and needs that incorporates an evaluation of both their stage of change and, using ASAM criteria, their level of care

10. Work with the person to design and implement individualized support plans based on an integrated mental health and substance use assessment
11. Help the person identify and make use of natural and community supports and resources to further their recovery
12. Provide the person with resources and information about co-occurring disorders and the skills that may be most effective in managing their challenges
13. Demonstrate knowledge of and skills in using relevant evidence-based practices, such as motivational interviewing, relapse prevention, or illness self-management strategies
14. Advocate for and facilitate timely referrals, and monitor coordination of services to ensure integrated continuity of care, including coordination with primary care providers
15. Partner with the person seeking co-occurring services in achieving their goals and in developing a clearer understanding of the dynamics impacting their current situation
16. Recognize the classes of psychotropic medications (including addiction medications), as well as their actions, medical risks, side-effects, and possible interactions with other substances
17. Understand and support Continuous Quality Improvement (CQI) practices related to co-occurring conditions within organizations and service systems

Advanced:

18. Based on the comprehensive assessment of the person's supports and needs, provide a diagnosis in keeping with individual licensure. This assessment may include diagnoses of substance abuse disorders within a multi-axial mental health diagnosis or may include mental health diagnoses within a substance abuse diagnosis.
19. Work with the person to develop an integrated, progressive treatment plan (as opposed to parallel treatment plans) that accurately reflects the person's goals and abilities. Revise the plan as the person makes progress on goals.
20. Demonstrate knowledge of defined, evidence-based practices for co-occurring disorder treatment; and employ diverse theories, models and intervention methods, including relapse-prevention approaches to treatment

SCOPE OF PRACTICE

This document represents a consensus paper developed by the Maine COSII Workforce Development Committee on recommended scope of practice for certified and/or singly licensed practitioners who provide services for people with co-occurring conditions. It reflects current thinking on ways to address co-occurring conditions in an integrated way. The document outlines integrated services and activities that can and should be carried out by those with either mental health or substance abuse licensure and training. However, the requirements and scope of activity for any specific practitioner depend on job description, role within a specific program, level of training, and the regulations governing practice. Each level incorporates the skills included in the prior category.

All Practitioners at all Levels:

1. Convey a welcoming, empathic attitude that supports a philosophy of dual recovery
2. Administer a screen for co-occurring conditions
3. Recognize, in partnership with the person receiving services, possible high-risk behaviors and feelings, and respectfully support and engage the person so that they will be able to maintain their own safety and that of others
4. Engage people in ways that convey respect for diversity and cultural appropriateness
5. Support the goals of a treatment or individual service plan
6. Partner with the person to advocate with other providers regarding their health care, substance abuse or mental health treatment needs
7. Collaborate with other providers to ensure integrated care
8. Support the person in accessing community and family resources to enhance recovery
9. Provide resources and information to the person about co-occurring disorders and the skills most effective in managing their challenges

Intermediate-Level Practitioners: (for example case managers, support workers, counselors, and aides)

10. Conduct or obtain a comprehensive, integrated, longitudinal, strength-based assessment of the person's supports and needs that incorporates an evaluation of both their stage of change and, using ASAM criteria, their level of care

11. Use relevant, evidence-based skills such as motivational interviewing to identify stage of change and enhance motivation
12. Help the person to design and implement an individualized support plan based on an integrated assessment and their individual desires
13. Advocate for, make timely referrals, and coordinate services to assure integrated continuity of care
14. Communicate and collaborate with mental health, substance abuse, and primary care providers
15. Partner with the person seeking co-occurring services in achieving their goals and in developing a clearer understanding of the dynamics impacting their current situation
16. Provide specific skills training, including relapse-prevention techniques
17. Provide individual or group interventions that educate, enhance motivation, and help people manage their lives without using substances
18. Recognize and educate the person about classes of psychotropic medications (including addiction medications), as well as their actions, medical risks, benefits, side effects, and possible interactions with other drugs

Advanced-Level Practitioners:

19. Based on the comprehensive assessment of the person's supports and needs, provide a diagnosis in keeping with individual licensure
20. Work with the person individually to develop and implement a long-term, integrated treatment plan (as opposed to parallel treatment plans) that accurately reflects the person's goals and abilities. Under a single license, this plan can address each condition as it relates to or affects the others; it may also involve collaboration with licensed providers in other disciplines.
21. Treat the person for co-occurring disorders individually or in groups using evidence-based theories, models and methods, including relapse prevention techniques. Under a single license, treatment can address each condition as it relates to and affects the other, and – with written permission from the person being served – involve coordination or collaboration with licensed providers in other disciplines.
22. Provide family counseling and encourage family and community involvement

II

INTEGRATED PRACTICE GUIDELINES

1 SCREENING AND ASSESSMENT

Purpose:

This guideline defines the components of integrated screening and assessment for co-occurring conditions. The guideline emphasizes the importance of screening and outlines the ways that an integrated assessment differs from assessment for a single condition.

Scope:

These guidelines can be used by all programs and providers who serve those seeking behavioral health or other social and healthcare services. They should be used in conjunction with standard licensing and regulatory policies.

Screening:

Screening is the use of a simple set of questions that determine whether or not a person's presenting signs, symptoms or behaviors may be influenced by co-occurring substance abuse and mental health issues. In general, screening identifies whether there is a need for more thorough assessment of either or both conditions, the potential level of care indicated by this pattern of symptoms, the potential risk of harm to self or others, as well as the influence that one set of symptoms may have on the other. Screening may also address other co-occurring conditions including, but not limited to, trauma and health risks.

Integrated Assessment:

Assessment is an individualized, continual process of gathering information and engaging the person. It is a process that enables the provider to establish the presence or absence of a mental health disorder, a substance use disorder, or both, as well as the interaction between those if more than one is present. The assessment provides an historical perspective on both disorders, including periods of success with managing symptoms. It also provides a current description of the status of each disorder and outlines how each will be approached from an integrated perspective. The assessment determines the potential risk of harm to self or others and the person's readiness for change; it also identifies strengths and problem areas that may affect recovery, the influence one set of symptoms may have on the other, the level of care indicated by the pattern of symptoms, and engages the person in the development of treatment goals.

Welcoming:

Welcoming is a core clinical concept. A welcoming program or treatment relationship is one in which people with complex needs are viewed as a priority population for service access, and are proactively encouraged and engaged. Welcoming, at minimum, suggests that no program refuses service based on the presence of a co-occurring condition alone, and that all individuals are assisted at any door in getting connected to the services that best meet their needs.

Guiding Principles:

1. Providers under contract with DHHS are expected to be COD-capable, and every program (unless specifically exempted by DHHS) is mandated to administer a standard co-occurring screening, currently the AC-OK. The purpose of this screening is to establish the possible presence or absence of a mental health or substance use disorder or both.
   (See Appendix 1 for copy of AC-OK screening tool.)
2. Use of a standardized screening tool is helpful because it ensures reliable, valid and consistent data across sites
3. Screening is a discrete process that should determine the need for further assessment
4. The process of screening and assessment conveys a welcoming attitude and acceptance of the complex and unique presentation of the person's needs
5. Assessment is a process of defining the nature of the person's needs and strengths, and beginning the process of developing specific treatment recommendations
6. Screening and assessment are culturally and linguistically responsive
7. When a mental health and substance use condition are both present, each is discussed in the assessment in terms of its interaction with and impact on the other
8. The integrated assessment includes a summary statement that reflects attention to both (or all) conditions, how they interact with one another, and how they may be best approached. This assessment should include the person's perspective.
9. The assessment identifies the person's motivational stage of change for both mental health and substance use disorders

10. Assessment addresses risk of harm and level of care needed, determines appropriateness and eligibility for placement within the service continuum, and recommends treatment to meet the individual's needs
11. The assessment process explores co-occurring issues within a framework informed by a knowledge of trauma, medical conditions and other special needs, and their implications for both mental health and substance use disorders

Implementation:

1. Every program develops a *procedure for screening* that fits the need of the specific program. Each provider's use of the standard tool is determined by them. Screening is completed before assessment begins.
2. Engage the person in an empathic, welcoming manner, build rapport and facilitate open disclosure of MH and SA disorders
3. Elicit the person's strengths and supports and most recent stable baseline
4. Determine the person's goals
5. Identify and contact collaterals (family, friends, other providers) and identify *affected other issues* experienced by the person and/or family members
6. Identify cultural and linguistic needs and supports
7. Identify medical and other co-morbid conditions and other needs such as housing, employment, medical intervention, and the presence of domestic violence/trauma, neglect, abuse, and exploitation
8. Discuss any MH and SA disorder in the context of the other as well as the interaction between the two
9. Assess stage of change for each issue and begin to work with the person to match treatment planning to stage of change for each condition
10. Determine diagnosis and, using ASAM criteria, determine level of care

2 TREATMENT AND RECOVERY PLANNING

Purpose:

This guideline describes a framework for treatment or recovery planning with individuals or families with co-occurring disorders. People with co-occurring conditions benefit from an integrated, collaborative, strengths-based and hopeful plan that identifies and targets personal goals, strategies and actions the person wishes to take toward change and recovery. Individual treatment planning, if desired by that person, may include the family, significant other, or other members of a community support system.

Scope:

Treatment planning is a comprehensive set of staged, integrated program placements and treatment interventions for each co-occurring condition that is adjusted as needed to take into account issues related to the other disorder. This guideline refers to planning in all settings in which behavioral health care may be provided, including: inpatient and outpatient settings, mental health, substance use disorder, and primary health care settings, for both youth and adults. Consult general licensing standards for treatment planning in conjunction with this guideline.

Guiding Principles:

1. The treatment plan is based on a hopeful, continuous, ongoing process of screening and assessment that is matched to the individual's needs, readiness, preferences and personal goals
2. The plan is developed in partnership with the clinical team and those significant to the person
3. The plan reflects the person's stage of change for each condition as outlined in the integrated assessment
4. The treatment plan flows from the conclusions developed in the clinical assessment and from ASAM dimensions indicating level of care
5. The treatment plan is plainly written in the person's own words or in terms that are clear and understandable, incorporating time-limited, measurable, clinically guided objectives and action steps
6. The treatment plan reflects goals and wishes in multiple areas of the person's life, and identifies the most simple and basic steps needed to reach them so that success can be achieved, measured and recognized

7. The treatment plan addresses each issue through goals and objectives that are integrated, reflecting attention to the ways that substance abuse and mental health issues interact
8. The treatment plan involves anyone supporting the person, including family or significant others when indicated as desired by the person receiving services
9. The treatment plan is culturally sensitive and includes discharge/transition and crisis plans for all co-occurring conditions
10. The treatment plan includes community recovery self-help groups and peer supports whenever possible

Implementation:

1. The planning process may begin by working with the person to identify his or her goals for a happy, hopeful, and productive life, along with describing periods of relative success and the strengths to be used in making progress toward goals
2. The treatment plan, created with the person's input, determines the interventions, specific strategies, and review periods for achieving desired outcomes
3. The treatment plan outlines for the person how all services will be coordinated and how decisions will be made about the ongoing process. It describes how issues will be addressed in an integrated manner.
4. The treatment plan identifies all persons and providers involved in the treatment
5. In the event that the client's treatment involves other behavioral health agencies (*e.g.,* a psychiatrist providing medication services off site for a client in substance abuse program, or a client in a mental health program attending a substance abuse program elsewhere) or other types of services (*e.g.,* probation), there are mechanisms in place to include their input in the treatment planning process, and, with the person's agreement, document this input in the final plan
6. The treatment plan content reflects the level of care being provided for each condition
7. The treatment plan indicates how the clinician and the person will review and document progress
8. The treatment plan reflects informed consent with regard to the risks and benefits of the plan

9. The treatment plan can be revoked or changed at any time by the person receiving services

3 RECOVERY-ORIENTED TREATMENT

Purpose: The purpose of this guideline is to describe the important components of integrated treatment for co-occurring conditions as well as the recovery framework in which it is embedded.

Scope: These principles apply to all integrated services at all levels of care for those with co-occurring conditions.

Recovery-Oriented: Recovery is a journey of hope, healing and transformation that permits a person (or family) to live a happy, productive, and meaningful life in the community. In recovery, people strive to achieve their maximum potential for growth and change. Recovery emphasizes the empowerment and responsibility of the person or family and their network of family, peer, and significant other supports. Recovery-oriented services are designed to prioritize the vision and hope of recovery in all plans and interventions, to support the empowerment of the person or family as a partner in the treatment, and to recognize that the journey of recovery occurs over time, through stages and phases. Recovery builds on the strengths and successes of individuals and families as they make step-by-step progress toward their recovery goals.

Recovery tends to have somewhat different meanings in the substance abuse and mental health communities. The substance abuse "recovery" movement, active for well over 50 years and derived from the self-help community, focuses on achieving or maintaining abstinence from substance use and resuming increasing responsibility for one's overall life.

In the mental health community, the concept of recovery is a more recent development and derives primarily from the consumer advocacy movement. This sense of recovery involves viewing mental illness as only one aspect of a person who has assets, interests and aspirations and both the desire and ability to be in control of his or her own life.

(For more information, see Connecticut Department of Mental Health and Addiction Services publication referenced in Appendix 2.)

Recovery-Oriented Integrated Treatment: A collaborative process of working in partnership with a person or family and, when indicated, their support systems. Treatment interventions for both conditions are combined or coordinated within the context of a primary treatment relationship or service setting. An integrated treatment approach incorporates a recovery-oriented, hopeful, empathic relationship with an individual clinician or clinical team and uses appropriately matched best practice or evidence-based

strategies for each condition at the same time. It recognizes the need for a unified approach that may address not only substance abuse and mental health conditions, but also related needs such as health care, housing, employment, or medication needs, as well as trauma, legal or parenting issues.

Guiding Principles:

1. Individuals and families with co-occurring conditions are welcomed for care, wherever and whenever they present
2. Individuals and families are helped to identify hopeful goals for meaningful and productive lives, as well as the steps necessary to make progress toward those goals
3. Services are person or family-centered and reflect goals the individual is motivated to achieve. People are empowered to make decisions about their own care.
4. Integrated screening helps to identify each issue that may need to be addressed
5. Integrated assessment is an organized clinical process that determines appropriately matched interventions for each condition
6. Empathic, hopeful, integrated relationships are the most important contributors to treatment success
7. Integrated treatment supports a continuous learning process that takes place over time, recognizes that the process of recovery may be slow, and provides positive encouragement and recognition for each small change

Implementation:

1. All co-occurring conditions are considered simultaneously and require appropriately matched interventions that address each condition and the interactions between them. One condition is not of higher priority than another.
2. Treatment is individualized – there is no one correct intervention
3. Services are embedded within a "recovery" framework
4. Interventions for each condition are specific to phases of recovery and stages of change
5. Services are strength-based and trauma-informed for each condition
6. Services are matched to the individual's cognitive or learning ability

7. Services include the appropriate evidence-based or consensus-based, best-practice intervention for each condition. This may include strategies such as motivational interviewing, contingency management, psycho-education, skills training, relapse prevention, peer support, medication management, cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), functional family therapy, supported housing, supported employment, and supported education.
8. When services are provided by multiple clinicians or programs, each provider collaborates and consults with other team members
9. Discharge or transition planning provides for continuity of integrated interventions to support continuing progress

4 PROGRESS NOTES

Purpose: This guideline creates a framework for the appropriate documentation of integrated, co-occurring services in progress notes. Integrated progress notes reflect the work being done concurrently on all co-occurring conditions. The notes reflect progress towards the implementation of the goals and objectives in the treatment/recovery plan. Progress notes serve as a mechanism for communication with other providers and with the person or family receiving services.

Scope: These guidelines are relevant to all settings in which behavioral health care is provided. They assume an integrated record where mental health, substance use and potentially medical notes are included.

Note: See Agency licensing regulations for general standards relevant to documentation of treatment progress and events.

Guiding Principles:

1. Progress notes may address issues in one or more domains, including mental health, substance use and physical health
2. Documentation references one or more primary problems identified on the treatment/recovery plan if these issues were addressed in the session
3. The language used in the progress note is welcoming, hopeful and reflective of the individual or family's strengths
4. Progress notes document an individual's responses to treatment, changes in goals, and progress toward discharge planning
5. Progress notes reflect the ways that SA and MH issues, interventions, objectives, and progress towards goals interact
6. Notes reflect the motivation, insight, culture, language and concerns of the person receiving treatment as well as any disagreement the person may have with others providing treatment, the approach to treatment, or the requirements of treatment
7. Notes may document stage of change and stage-matched interventions

Implementation:

1. The event requiring the note is clearly stated (*i.e.,* individual, group, phone call, collateral contact, no-show, etc.)

2. The note refers back to specific goals in the treatment/recovery plan, using whatever standard format is used by the agency
3. Progress notes state objective facts as well as subjective assessments and clinical formulations
4. Each documented issue in a progress note is related to a problem, goal, or objective on the integrated treatment/recovery plan
5. Interventions documented in the note are consistent with the Integrated Scope of Practice of the individual providing those interventions
6. Each co-occurring issue or disorder is integrated into the note. The following are examples of potential ways to document clinical interventions :

EXAMPLE

Problem: Bipolar Disorder
We reviewed John's experience of his mood being somewhat hypomanic, even on his mood stabilizer. He reports that he finds alcohol (2-3 beers) useful in the short run to make himself feel more level. We had a conversation about how well that works for him in the long run. John is "contemplative," and was able to consider that the alcohol may make him feel agitated when it wears off. At the moment, he is not interested in reducing his drinking however, but he is determined to stay on his mood stabilizer so as not to get worse.

Another option would be to identify each problem or issue separately in the note, and then have an appropriate intervention for each issue documented in that single note:

EXAMPLE

Problem: Bipolar Disorder (Late Action)
We reviewed John's experience of his mood being somewhat hypomanic, even on his mood stabilizer. Even though his drinking may be contributing to mood instability (see below), he is determined to stay on his mood stabilizer so as not to get worse.

Problem: Alcohol Abuse (Contemplation)
He reports that he finds alcohol (2-3 beers) useful in the short run to make himself feel more level. We had a conversation about how well that works for him in the long run. John is "contemplative," and was able to consider that the alcohol may make him feel agitated when it wears off. At the moment, however, he is not interested in reducing his drinking.

7. Progress notes may include new information, issues or needs not related to the treatment/recovery plan
8. Recommendations and changes to the treatment/recovery plan are noted
9. Any communications with other providers are noted
10. Progress notes document all those present for the treatment event
11. Significant changes in the person or those impacting treatment are reported
12. Addendums are clearly marked as such

5 CRISIS-PREVENTION PLANNING

Purpose:

People with co-occurring disorders are at increased risk for experiencing crises, such as substance use or mental health relapses, housing instability and homelessness, and legal problems. Assessment and treatment planning needs to take these increased risks into account and develop crisis plans for responding to problems for either disorder. At a minimum, such plans should identify the early warning signs of relapse for any disorder in remission, should consider the interactions between the disorders, and should specify the steps to be taken in the event of a crisis (such as whom to contact and where to go).

Scope:

Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are elicited from the person served based on their preferences, what has been effective for them in the past, and what is most efficacious are combined in a single session or interaction. This guideline refers to planning for all interventions that are designed to respond to acute destabilizing events in the course of the person's recovery.

Guiding Principles:

1. Part of crisis planning for mental health conditions may be the use of a psychiatric advance health care directive. It is helpful to suggest that the person seeking services develop one to assist in guiding treatment when he or she may not be capable of doing so.

(Visit www.drcme.org for more information on how to develop a psychiatric advance directive)

2. The crisis plan reflects the experience and perspective of the person served, and should reflect what has previously worked for the person

   The crisis plan is simple and concise (limited to one page if possible), easily implemented, and is completed prior to any crisis

3. The crisis plan ensures the safety of the person served
4. The crisis plan reflects the interaction of both SA and MH and how they may affect each other
5. The crisis plan reflects the cultural context of the person served
6. The crisis plan is responsive to trauma, medical and other issues

7. The crisis plan helps the person to identify critical issues and describes the ways that support people will be called on and organized to help

Implementation:

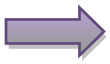
1. Describe what situations may have resulted in crisis in the past and what was and was not helpful at each stage of the crisis
2. The crisis plan clearly identifies each issue that needs to be addressed during a crisis (*i.e.*, mental health, substance use, medical, trauma)
3. The integrated crisis plan describes the look and feel of a crisis or relapse using the person's own words
4. The integrated crisis plan is developed as a collaborative effort with the individual and/or family, based on the individual or family's strengths, skills, and supports
5. The integrated crisis plan involves key supports in the person's life as part of the planning process
6. The integrated crisis plan lists the skills, supports and resources that the person has successfully used before, including how the person has previously asked for help
7. The integrated crisis plan identifies specific persons, groups, or resources that can be contacted for immediate support, as well as specific ways the individual can contact them. Each such individual is given a copy of the plan with appropriate releases.
8. The integrated crisis plan lists specific coping mechanisms that can be used by the individual or family
9. The integrated crisis plan describes behaviors or actions of others that might help resolve the crisis, including how to respond to co-occurring issues
10. The integrated crisis plan considers peripheral and collateral needs, *e.g.*, child care, pet care, transportation or housing
11. The crisis plan can be revoked by the person or changed at any time

6 RELAPSE-PREVENTION PLANNING (RECOVERY MANAGEMENT PLANNING)

Purpose:

This guideline, which might also be referred to as recovery management planning, provides a framework for the provision of planning for the potential of substance use relapse or return of psychiatric symptoms. Relapse-prevention planning includes a range of therapeutic interventions designed collaboratively with the person, and aimed at reducing return to alcohol or drug use or exacerbation of mental health symptoms.

Each relapse-prevention plan is individualized, with the person served placed in charge of choosing goals that may include abstinence and/or harm reduction strategies as their recovery progresses. The integrated treatment model assumes that relapse issues interact across mental health and substance abuse domains, since behaviors of relapse in one domain may undermine stability and increase chance of relapse in the other. Treatment interventions focus on teaching the person to anticipate their own early patterns of return to use of problem substances, to identify the signs of returning acute mental health symptoms, or both. The focus of planning is to build coping skills for early response to high-risk situations specific to that person, as well as to define approaches for more habitual behaviors likely to result in relapse.



See the Gorski website in the Resources section of Appendix 2 for a description of the relapse-prevention model familiar to the substance use field.

Scope:

This guideline addresses the development of integrated relapse-prevention plans in co-occurring capable programs and in any setting in which services are provided to individuals and their families with co-occurring issues. For more background on approaches to relapse prevention, please see the Resources section in Appendix 2 of this manual.

Guiding Principles:

1. Relapse or return of symptoms is an expected part of recovery rather than an indication of failure on the part of the person or an indication of lack of progress in treatment

2. The person may be in different stages of change for each condition, so that work on relapse prevention or management for one condition may co-exist with active symptoms or use in the other
3. Relapse-prevention planning and treatment are individualized for each person served and reflect the individual's experience, preferences, and cultural background
4. The integrated model for relapse prevention expects and addresses effects across mental health and substance abuse domains. Relapse may begin in mental health functioning or substance abuse behaviors and relapse prevention planning acknowledges this interaction by helping the person to develop skills to prevent the active symptoms of one condition from triggering relapse in the other.
5. Relapse-prevention planning begins with the first contact with the person
6. For substance use, an integrated treatment model distinguishes between "lapse" (single episode or brief return to drug use) and "relapse" as a matter of degree and severity and encourages intervention at the "lapse" phase to avoid escalation to full-blown relapse
7. The relapse-prevention plan includes all appropriate resources needed for response to threat of lapse or experience of relapse, developed in collaboration with the person served
8. The relapse-prevention plan provides specific coping mechanisms identified for the individual served
9. The plan attends to the immediate needs of the person served and it includes long term relapse-prevention components
10. The relapse-prevention plan utilizes the strengths of the person served, as well as considering various functional needs that may be affected by relapse intervention, such as child care or transportation

Implementation:

1. Describe the look and feel of a relapse or recurrence of symptoms using the person's own words
2. Identify periods of time when the person was functioning well and the skills used to maintain success
3. Inventory with the person the "high-risk for relapse" environments, situations, and emotional states specific for them. Inventory high-risk warning signs for relapse.

4. Offer the person a broad repertoire of cognitive and behavioral coping strategies for handling high risk signs and symptoms. The relapse prevention plan includes the coping skills, or "tool kit" most useful to the person.

(See the Resources section of this manual in Appendix 2 for suggestions)

5. List the supports and resources that the person has successfully used before. The relapse-prevention plan identifies persons, groups, or referral resources that can be contacted for immediate and long term support based on the person's experience and preferences.
6. Help the person to choose lifestyle changes that decrease their need for alcohol, drugs, or tobacco and that increase what they define as "healthy activities"
7. Anticipate lapses and prepare cognitive and behavioral coping responses that interrupt a lapse before it becomes full-blown relapse
8. Identify skills for accessing self-help or peer support along with skills for making effective use of mental health or treatment resources during or prior to relapse
9. When full-blown substance use relapse does occur, renew commitment to abstinence or harm-reduction goals as defined by the person

7 TRANSITION AND DISCHARGE PLANNING

Purpose:

This guideline provides a framework for developing transition or discharge plans that address all co-occurring conditions. In the course of integrated treatment for co-occurring conditions, individuals and families may make progress slowly over time, addressing each issue in small steps in order to achieve their recovery goals. People may have short-term episodes of care, or episodes of care preceding transition or discharge that can be longer, as in the case of admission to a hospital or residential substance abuse treatment. The process of planning transition from one episode of care to the next, or discharge into the community, is important in helping the person continue their recovery process.

Transition planning refers to the procedures and resources set in place for the person's movement from one program or service to another.

Discharge planning refers to the plan for the end of an episode of care and movement into the community, self help or peer support, or termination from treatment.

Both transition and discharge planning need to occur whether the termination of or change in level of care is planned or not. Discharge planning includes making arrangements for continuing recovery-management interventions and activities, including professional, family and peer support, as well as ancillary services, crisis plans, and recovery management plans.

Integrated transition or discharge planning for individuals or families with co-occurring conditions involves addressing transition and discharge planning for multiple interactive conditions simultaneously in the context of professional, family, and peer relationships that support recovery.

Scope:

The following guidelines focus on the application of transition or discharge planning for individuals or families with co-occurring mental health and substance use conditions. They are not intended to provide definitive guidance on all aspects of planning for all conditions and all levels of care. For more background on transition and discharge planning, consult the American Association of Community Psychiatrists' *Guidelines for Recovery Oriented Transition Planning.*

Guiding Principles:

1. The transition/discharge plan is driven by the person, and addresses all conditions identified in the recovery plan
2. If possible, rather than identifying multiple parallel referrals, the transition plan attempts to identify a primary treatment relationship or team through which interventions for all issues will be provided or coordinated
3. Discharge policies clearly state that no person is discharged from a program solely because of the use of substances or the need for psychotropic medications, including Medication Assisted Treatment (MAT)
4. Even in the event of an unplanned or administrative discharge, a complete, integrated plan is established
5. The transition plans address the skills acquired by the person and supports the development of those skills needed to be successful at the next level of care. Success in a contained environment does not necessarily predict success in a less restrictive one.
6. Transition planning occurs collaboratively throughout the course of treatment
7. The transition plan identifies and documents each co-occurring condition, and appropriately matched interventions needed for continuing success and progress at the next level of care or in the community
8. Planning is sensitive to trauma, the person's cognitive skill level, and empowers the person to make choices
9. The plan includes criteria for welcoming the person back into a program of treatment if necessary, and allows for ongoing clinical contact between the person and the provider as indicated
10. The plan provides for the supports needed to sustain the progress made in treatment. These may include family, significant others and friends, as well as recovery groups, peer-support networks, housing, case management and other community resources.
11. The plan ensures continuity of psychiatric medication management or MAT if indicated
12. The plan addresses relapse prevention and recovery management
13. The plan addresses all psychiatric, medication, substance abuse and mental health services that may or may not have been provided at the agency

14. The plan indicates risk factors and describes what worked and did not work in treatment

Implementation:

1. The provider determines with the person, at the beginning of treatment, how they will know when treatment is done
2. Planning for discharge begins at the time of service initiation
3. The discharge plan is developed with the input of the person receiving services. It includes attention to the person's stage-matched preferences
4. The discharge plan takes into account the ongoing need for integrated services that reflect the needs of a person with co-occurring conditions
5. Ideally, as treatment progresses, everyone involved with the person discusses potential resources for post discharge services and support
6. The integrated transition plan includes a documented integrated crisis plan and an integrated relapse-prevention plan
7. The integrated transition plan documents continuing peer support, if appropriate, for each co-occurring condition, including dual recovery peer support
8. Progress towards discharge is noted in progress notes and treatment plan reviews
9. When it is agreed that the goals of the treatment plan have been met, the discharge plan is finalized and implemented, and services identified are arranged by the primary clinician
10. Last date of service is agreed on
11. The recovery management plan (relapse-prevention plan) is developed and implemented
12. People are discharged in a manner and to a setting consistent with their discharge plan
13. Clinical justification for discharge is documented
14. A discharge summary describes the treatment, recommended services and outcomes of the treatment related to the treatment plan
15. The person is discharged in a way that assures safety, comfort, and dignity

8 CLIENT RECORDS

Purpose:

This guideline describes methods for maintaining integrated client records for individuals or families receiving multiple services for co-occurring conditions in a single program or agency.

Scope:

These guidelines are appropriate for all inpatient, residential, or outpatient programs or agencies in which mental health and substance use disorder services are being provided. These guidelines are not intended to provide general standards for maintaining medical records or client records. They are focused on issues related to integrating documentation of multiple services or programs within a single client record.

Please refer to your agency's licensing regulations for general standards relevant to client records and documentation.

Guiding Principal:

Individuals and families with co-occurring conditions achieve better outcomes to the extent that clinicians in separate programs and settings collaborate effectively to function as an integrated team – a team that all providers involved are aware of – and communicate regularly with each other about services being provided for co-occurring conditions in other programs. Such an approach improves continuity of care, minimizes adverse treatment interactions, and reduces stigma by ensuring that all providers consider the behavioral and medical origins and interactions of the conditions being treated.

Implementation:

A.) Integrating information from different providers and disciplines *within one location*

In programs with multiple services, disciplines and providers, clinical records can integrate information related to mental health, substance abuse, and/or health conditions into a single client record, in which services are documented sequentially.

Examples include:

- A person in a substance abuse program who sees an individual mental health therapist
- A person in a mental health program who attends a substance abuse group provided by a substance abuse counselor
- A person in a medical clinic who is seeing a behavioral health clinician in that clinic for evaluation and treatment.

1. The program's medical record policy states that a person's file contains information related to all services provided by all providers. Information is documented sequentially, whether in written or electronic form, and is accessible to all providers reading the record.
2. Demographic data can be documented once in the record, with program or provider-specific information or assessment data documented separately
3. Integrated records will be in compliance with all local, state and federal regulations governing all separate mental health services, substance use disorders, and primary health services, if applicable
4. In the event that different providers within the same program are accountable for billing different funding streams, or for meeting different regulatory standards, it may be helpful for progress note information to be color coded or similarly flagged for easy access during financial or regulatory audit
5. Integrated files will adhere to all federal confidentiality regulations as outlined in Title 42, Code of Federal Regulations, Part 2 and amendments thereof, in addition to the Rights of Recipients of Mental Health Service as is relevant to licensing requirements in the state of Maine for adults and children
6. At admission, each person will be informed in writing of the policy of sharing information among different providers within the program, and will have an opportunity to formally consent to that as part of their consent to treatment services. In the event that the person has concerns about information relating to substance abuse or mental health services being included in the same record, or being combined with their primary health care records, efforts will be made to educate the person on the value of the staff functioning as an integrated treatment team.
7. In the event that the person does not consent to information being shared among different providers within the same program, the

program should make accommodation to this request if it is clinically feasible within the nature of the program.

B.) Integrating information from different providers and disciplines *within the same agency/clinic but in different locations*

Examples include:

- A person in an outpatient behavioral health agency attending mental health case management services and substance abuse Intensive Outpatient (IOP) services
- A person in a large hospital having open heart surgery with medical follow-up, a history of inpatient psychiatric treatment, and attending outpatient substance abuse counseling, all at different times and/or locations
- A person in a federally qualified health center attending primary care visits, as well as attending outpatient co-occurring disorder group therapy provided in a different location (but within the same center/agency)

1. Given the variability in size and function of agencies that may use these guidelines (from relatively small outpatient providers with satellite sites to large medical centers), each agency will select the most appropriate method of integrating client record information from different programs
2. In smaller settings, it may be possible for medical record documentation from each program to be integrated into the paper or electronic record on a daily basis, so that all services are in a single, sequential record
3. More commonly, each separate program location will maintain its own record, and all records will be combined upon case closure. It will be necessary for the agency to have a policy and procedure for routine inter-program communication and record-sharing.
4. There will need to be specific policies and procedures for maintaining the records, facilitating audits and access to distinct program records, and adhering to all regulations, including those governing confidentiality of substance abuse and/or mental health information

9 PSYCHOPHARMACOLOGY SERVICES

Purpose: This guideline creates a framework for the provision of psychotropic medication to individuals with co-occurring psychiatric and substance use issues. It addresses basic approaches to engagement, assessment, selection and monitoring of medication, medication skill-teaching, continuity of care, and coordination of care.

Scope: These guidelines are relevant to all settings in which behavioral health care may be provided, including: inpatient and outpatient settings, mental health, substance use disorder, and primary health care settings, for both youth and adults. These guidelines are designed to be helpful for those who prescribe medication, but also relevant for non-prescribing clinicians, as well as for settings in which people are taking medication that is being prescribed elsewhere

See the References section in Appendix 2 for COD psychopharmacology practice guidelines.

Guiding Principles

1. Co-occurring mental health, substance use, and medical conditions are an expectation. Psychopharmacology services and program medication policies should be designed to welcome individuals with co-occurring conditions.
2. Psychotropic medication can be an important part of an individualized recovery plan
3. Prescribing medication requires timely, decisive efforts to plan a course of pharmacotherapy from onset to an expected outcome
4. In making psychopharmacology decisions for individuals with co-occurring disorders, each condition should be considered concurrently and with equal priority. Typically, the best medication for the individual's mental illness is likely to be the medication of choice even in the face of a co-occurring substance use disorder.
5. There is no barrier to evaluation for psychopharmacologic intervention based on rules or policies related to active substance use, length of sobriety, or alcohol/substance blood level. Evaluation begins immediately, and involves obtaining a history using the principles of integrated assessment.
6. There is no barrier to evaluation for addiction services based on rules or policies regarding psychiatric diagnosis

7. There is no barrier to evaluation for addiction services based on category of psychotropic or other medication previously prescribed, including benzodiazepines, opiates for chronic pain, or opiate maintenance treatment
8. Psychopharmacologic agents for addictive disorders are available for clients who may benefit from them, with or without co-occurring psychiatric conditions that may require medication
9. Programs provide organized individual and group education interventions to help clients with co-occurring issues make medication decisions
10. Individuals with serious mental health or medical conditions are maintained on necessary, non-addictive medication required for the treatment of the condition, even though they may be continuing to use substances
11. Individuals presenting for psychopharmacology services are screened for co-occurring substance use and co-occurring high-risk medical conditions (such as hepatitis)
12. All efforts are made to engage the client and family as partners, particularly if the client may be actively using substances or having difficulty taking medication regularly
13. For individuals with co-occurring conditions, collaboration between those prescribing medication and other members of the treatment team is particularly important. Programs make every effort to organize routine teamwork and collaboration between prescribers and other members of the treatment team.
14. For individuals with co-occurring conditions, collaboration with primary care prescribers is particularly important because of greater health risks. All people seeking treatment are assisted to obtain a primary care provider.
15. For individuals with substance dependence, it is recommended that clients are educated regarding the limitations of medication for mental illness. Risks and benefits need to be explained and discussed with all who may receive medications, no matter the diagnosis.
16. For individuals with substance dependence, it is recommended that medication for mental illness is prescribed in a fixed dosage regime if possible, rather than on an “as needed” basis
17. For individuals with known substance dependence, ongoing prescription of medications with addictive potential (antihistamines, benzodiazepines, opiates for pain) should be done with great caution

18. Ongoing psychopharmacologic treatment of individuals with co-occurring illnesses often requires continuing evaluation and re-evaluation, as diagnoses may change or evolve over time
19. Discharge and transition planning always makes adequate provision for continuation of psychopharmacologic interventions, for both mental illnesses and addictive disorders

Implementation:

1. The medical provider caring for the person completes a comprehensive evaluation indicating the need for the prescription of medication
2. Prior to prescription of medication, clinicians and prescribers ensure that the medical information sheet in the client record is complete and up-to-date
3. A review of a person's medical history is conducted prior to prescribing any new medications
4. The monitoring of medication is the responsibility of a physician, as well as of the primary therapist, counselor or case manager and the person
5. Monitoring of the person's response to medication therapy includes attention to compliance, adequacy of response, and adverse results
6. The treatment team considers the need to notify a family member or other contact close to the person, especially if there are concerns about the person's capacity to self-administer medication, when there are significant changes in medication, or when new medication is prescribed
7. Discharge criteria specific to each person related to their medication regimen is identified during the completion and/or review of the comprehensive assessment, and identifies the desired results with the person receiving treatment
8. Treatment planning related to a medication regimen includes all involved members of the person's treatment team, as well as appropriate family and significant others
9. The need for medication management is evaluated on an ongoing basis by the medical provider and the person
10. Medical legal standards for discharging or transferring a person are adhered to and follow accepted practice guidelines

10 CONTINUITY OF CARE

Purpose:

Continuity of care refers to the *coordination* of care as a person moves across different service systems and through different levels of the care continuum. The following guidelines support the development of a continuous integrated mental health and substance use treatment experience for individuals and families.

Scope:

Treatment involves engagement in an ongoing process of recovery-oriented, integrated, strength-based, community-based learning for each condition. This care is best implemented within the context of an ongoing empathic, hopeful relationship with an individual clinician, a clinical team, or a community of recovering peers and clinicians. Individuals and families may experience multiple episodes of different levels of care at different points in time.

These features characterize continuity of care for any individual or family with co-occurring conditions:

- Continuity of a treatment relationship
- Coordination of multiple services in a primary relationship
- Seamless transitions as clients move through levels of care
- Coordination of care through multiple treatment episodes

Guiding Principles:

1. An integrated service delivery system will include outreach, after-care, employment, housing, health care, medication, financial supports, recreational activities, and social networks or peer supports
2. Individuals and families with co-occurring conditions ideally have a single treatment relationship with one provider, team, or program in which they can address multiple issues over time
3. Ideally, access to continuing care is not time-limited
4. Individuals and families with co-occurring conditions are not discharged from services because of continued symptoms or because of difficulty adhering to treatment recommendations without a

careful review of the treatment process and goals. Ideally, the clinician or team and person/family should regroup and develop alternative strategies.

5. The clinician or clinical team coordinates ongoing services provided in other settings that address multiple domains of service need such as primary health care, criminal justice, housing, employment, and child welfare
6. The provider helps to guide treatment and transition planning when the person is admitted to a higher level of care
7. When individuals are admitted to a higher level of care, and they do not have a continuing integrated treatment relationship in place, it is a priority of treatment planning to help them to establish that relationship, ideally prior to discharge
8. When individuals are moving between levels of care, transition planning emphasizes overlapping or shared responsibility between all providers
9. Planning for continuity in the event of premature discharge is done early in the assessment process
10. Initial and ongoing treatment planning is targeted toward helping the individual transition successfully to the next level of care
11. A person or family who does not have a single care provider, and has multiple short-term episodes of treatment at different levels of care, (hospitalization, crisis intervention, residential addiction treatment) is helped to identify a clinician or clinical team (including peer support) that may provide continuity
12. Recurrent crises or relapses as well as multiple needs for higher levels of care may be viewed as an opportunity to reengage with a primary provider and as an opportunity for brief intervention to support continued learning and recovery
13. The differing histories and cultures of the mental health and substance abuse systems are taken into account when planning for continuity, since each may view service needs differently
14. Gaps between clinic and community-based services are taken into account in planning

Implementation:

1. Begin the process of planning for transition and continuity at the point of admission

2. Ensure that any referred services are consistent with the needs of the person and with the work being done in the primary treatment setting
3. Develop policies that indicate people are not to be discharged because of continuing symptoms, relapse, or difficulty with treatment adherence
4. Develop clear procedures for coordinating care with other service providers (*e.g.*, primary health care, housing) as well as peer support, so that attention to all those issues is experienced by the person as integrated into the treatment plan
5. Develop clear procedures for the primary clinician to maintain involvement with the person if or when the person is admitted to a higher level of care
6. Develop procedures for facilitating continuity of treatment plan, and facilitating successful transition if or when the person is admitted to a higher level of care
7. Ensure overlapping responsibility for success during transition between levels of care
8. Welcome back individuals who have been previously served by the agency, including those who may have been prematurely discharged
9. Provide episodic continuing care for individuals who have no other connection to services, and have processes in place for helping those individuals find ways to easily engage in low-demand services with clinicians and/or peer support
10. Actively work to close gaps in access to needed services within the community
11. Arrange for follow-up on referrals to other services at discharge
12. If coordination of care is beyond the scope of work for the provider, assign a case manager or other support person
13. Involve peer supports whenever possible or acceptable to the person

11 INTEGRATED MENTAL HEALTH AND SUBSTANCE USE PROGRAMMING

Purpose:

This guideline clarifies the definition of integrated programming and identifies its primary components. An integrated program is one that is inclusive of people with co-occurring disorders. It provides treatment for both mental health and substance use disorders. An integrated program selects, modifies, combines, and tailors interventions for each specific person.

In a *co-occurring capable program*, this means that one disorder is treated and discussed in the context of the way it affects and interacts with the other. If all services cannot be provided in a way that meets the person's needs because of scope of practice, capacity, or licensure issues, then the clinician either obtains consultation or refers out and coordinates care with the other agency or provider.

In a *co-occurring enhanced program*, staff are dually licensed and provide integrated treatment under one roof with the same clinician or team. In either case, the agency's mission statement or policy is inclusive of people with co-occurring disorders.

Scope:

This guideline refers to any behavioral health program, either capable or enhanced, in which integrated services are provided. No one program is assumed to provide all levels of care or modalities of treatment. Integrated services are structured to address multiple conditions as comprehensively as possible given the program's mission and scope of practice.

Guiding Principles:

1. Integrated services are comprehensive, long-term, and motivation-based, and incorporate multiple modalities of treatment. These may include, but are not limited to:
    - Individual therapy
    - Group Therapy
    - Skills Training
    - Psychoeducation
    - Motivational Enhancement
    - Family Therapy
    - Cognitive Behavioral Therapy (CBT)

- Trauma treatment
- Medication-Assisted Treatment (MAT)
- Medication Management
- Case Management to address housing, vocational, transportation and other concrete needs such as primary care integration
- Peer Support
- Self-Help groups

2. Integrated service programs employ a recovery perspective
3. An integrated program promotes shared decision-making among all providers or team members, including the person being treated and significant others
4. To whatever degree possible, the person participates in one program that provides treatment for both disorders
5. To whatever degree possible, the person's mental and substance-use disorders are treated by the same person
6. Clinicians are trained in assessment and treatment strategies for both disorders
7. The program displays, distributes, and uses literature and educational materials addressing both mental health and substance use disorders
8. Different components of treatment work in harmony by addressing different dimensions of service delivery
9. The first goal of an integrated program is to reduce the harmful effects of co-occurrence
10. Substance abuse and mental health services are provided simultaneously
11. The primary counselor (the clinician first assigned to work with the person) assumes the responsibility for coordinating and integrating services so that there is no need for the person to reconcile differing or conflicting messages if there are multiple providers involved
12. Programming is comprehensive in addressing the multiple levels of the person's needs

Implementation:

1. Treatment is characterized by a slow pace and long-term perspective

2. Twelve-step and other recovery-oriented groups are available to those who choose to participate
3. Peer support services are either available in-house or by referral
4. Emphasis is placed on trust, understanding, and learning within the context of a supportive relationship
5. The person's psychiatric, medication and medical needs are addressed
6. Support systems are used to maintain and extend treatment effectiveness
7. The person and the counselor or team work to reduce the negative consequences of substance abuse, and they develop a good working alliance that supports the person's motivation to address mental health issues
8. Every effort is made to actively engage reluctant individuals in the process of recovery

III

CO-OCCURRING DISORDERS

SPECIAL TOPICS

CHILDREN/ADOLESCENTS AND COD

Children and adolescents with co-occurring mental health and substance use disorders require approaches that may be different from those for adults. As an outcome of the COSII project we have, in general, much more data on adults than we do on children. However, there were at least four pilot sites whose programs were child-focused, and as a result we were able to isolate some concrete data on children and adolescents with COD.

Our juvenile enrollees (*n*=29) were predominantly male and over 60% of them live in residential treatment. The majority attend school and report having eight or more supports in their lives. Over 90% of them receive MaineCare. The group has significant criminal justice involvement and 73% have been arrested in the past year. For this group, anxiety and mood disorders were most prevalent, and drug use was more prevalent than alcohol use. These juveniles tended to report having more sense of control over their lives than our adult population, and they appear to have significantly more support in their lives than adults with COD.

The following are some general facts about COD and children/adolescents to keep in mind:

- Eighty percent of people with co-occurring disorders report onset *before* age 20
- Adolescents who have a substance use disorder have an increased risk of experiencing mental health problems. Children with conduct disorders, mood disorders and ADHD are at especially high risk for substance-use disorders.
- Almost 50% of youth who are treated for mental health disorders have a co-occurring substance abuse disorder
- Youth with untreated COD have high rates of suicide, medical problems, homelessness, unemployment, incarceration, truancy, and educational difficulties
- Working with COD in the youth/adolescent population is typically more challenging than working with either condition alone, and may be accompanied by higher dropout rates and poorer long-term success
- Many mental health disorders may develop in children before age 10. It is equally true that children may be exposed to use of substances before age 10.
- Children in the child welfare system have a higher incidence of mental health disorders

- Assessment of adolescents frequently misses the presence of a mental health disorder
- The time between the onset of a mental disorder and a subsequent substance-use disorder represents an important "window of opportunity" in which a co-occurring disorder may be prevented
- Some risk factors for substance abuse in youth:
    - Family history of substance abuse
    - History of trauma and/or diagnosis of PTSD
    - Being a victim of bullying or peer rejection
    - Sexual orientation conflicts
    - A peer group that uses substances
    - Poor and inconsistent family supervision and management
    - Low family bonding and high conflict

Family engagement is critical to treatment for COD in adolescents, yet may be very difficult to achieve. Treatment approaches for youth with COD have inconclusive research outcomes and are not as easily identified or implemented as those for adults. However, all tend to be family-focused and include a multi-service approach that involves case management, family treatment and psychoeducation, motivational enhancement, cognitive behavioral work, and medication management.

Some promising or evidence-based approaches include: CYT (Cannabis Youth Treatment), MST (Multisystemic Therapy), MDFT (Multidimensional Family Therapy), FBT (Family Behavior Therapy), and CRA (Community Reinforcement Approach). Consult the SAMHSA website (link available in Resources section of Appendix 2) for more information on these models.

No matter what the approach, it is critical to involve the youth in the development and directing of treatment, and to recognize that treatment will proceed differently for them than it does for adults. For instance, while it is customary to track stages of change in adults, it is much more difficult to stage treatment for a child or adolescent. Issues of motivation for change are equally difficult to determine.

See Appendix 2 for more information.

Guiding Treatment Principles for Children and Adolescents

1. Build a strong relationship and motivate people to attend treatment
2. Create a treatment plan that centers on person-generated goals
3. Apply empirically supported treatments, focused on interventions specific to the person's diagnostic presentation
4. Use culturally and developmentally sensitive content
5. Focus on people's strengths, with an emphasis on impulse control, communication, problem solving, and regulation of affect
6. Design goals and objectives that focus on change that is sustainable over the long term
7. Monitor motivation, substance use and medication compliance, if utilized
8. Increase intensity of treatment if the intended response is not achieved
9. Use relapse-prevention strategies
10. Foster positive peer group influences
11. Conduct psychoeducation for parents

(Hills, 2007)

STAGES OF CHANGE AND MOTIVATIONAL ENHANCEMENT

The use of the Transtheoretical or "Stages of Change" model (Prochaska and DiClementi, 1994) is central in work with people with co-occurring conditions.

Determining both level of care and level of treatment intervention depends on the results of a discussion with the person of their readiness to change. When a person is dealing with two or more conditions, they may be at very different levels of readiness for changing each of them, so any work with them must take this into account. The most effective treatment for co-occurrence is stage-matched.

Most providers of integrated services who worked with the COSII project as pilot sites have integrated an assessment of the stage of change for each condition into their standard assessment process. That stage is noted on their standard assessment forms and taken into account in the diagnostic summary. Briefly, this model, which is widely used in healthcare practices as well as substance-abuse treatment, outlines six stages:

1. Pre-Contemplation: not currently considering change
2. Contemplation: Ambivalent about change but thinking about it
3. Preparation: Making plans to change or "testing the waters"
4. Action: Practicing new behaviors
5. Maintenance: Continued commitment to sustaining new behavior
6. Relapse: Resumption of old behaviors

Multiple resources are available for learning this model and some are listed in the Resources section in Appendix 2 of this manual. See Appendix 1 of this manual for examples of assessment tools used for this model.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) was developed by psychologists William Miller and Stephen Rollnick. (Miller and Rollnick, 2002) This set of practices is based in part on the Transtheoretical model. It focuses on engaging people and on enhancing their motivation to change. Motivational Enhancements Therapy is a form of treatment that makes use of MI, and is one of the evidence-based practices endorsed by SAMHSA for the treatment of co-occurring disorders.

The basic strategies of Motivational Interviewing are:

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self Efficacy

The main goals of MI are to establish rapport, elicit change talk, and establish commitment language. Stages of Change and MI are the framework used to engage people in work on their co-occurring conditions. Whether this work is being done by a mental health, substance use, or physical health provider, training in these models is essential. While the ideas and steps of MI seem simple, in fact they are quite complex to practice effectively.

For additional references and resources on MI, see the Resources section in Appendix 2 of this manual.

MEDICATION-ASSISTED TREATMENT

Treatment of substance-use disorders and dependence with pharmacotherapy (Medication-Assisted Treatment or MAT) is an increasingly important part of integrated care, just as it is for mental health conditions. This section is intended to describe the salient features of MAT.

Medication-Assisted Treatment (MAT) is a form of pharmacotherapy and refers to any treatment for a substance-use disorder that includes a pharmacologic intervention as part of a comprehensive substance abuse treatment plan with an ultimate goal of patient recovery with full social function.

In the US, MAT with Food and Drug Administration-approved drugs such as disulfiram (including Antabuse® and Antabus®), naltrexone or naltrexone hydrochloride (including ReVia®, Depade®, or Vivitrol®) and acomprosate calcium (Campral®) has been demonstrated to be effective in the treatment of alcohol dependence. The FDA has found that MAT involving drugs such methadone, naltrexone and buprenorphine (Suboxone® or Subutex®) to be effective in the treatment of opioid dependence.

The goals of MAT are:

1. Prevention or reduction of withdrawal symptoms
2. Prevention or reduction of drug craving
3. Prevention of relapse to use of addictive drugs
4. Restoration to or toward normalcy of any physiologic function disrupted by chronic drug use

As part of a comprehensive treatment program, MAT has been shown to

- Improve survival
- Increase retention in treatment
- Decrease illicit opiate use
- Decrease hepatitis and HIV seroconversion
- Decrease criminal activities
- Increase employment
- Improve birth outcomes with perinatal addicts

Effective treatment of drug addiction requires comprehensive attention to all of an individual's medical and psychosocial co-morbidities. Pharmacological therapy alone rarely achieves long-term success.

See references in Appendix 2 to SAMHSA and ASAM material, compiled by Diane Geyer.

IMPORTANT REGULATORY ISSUES

Scope of Practice:

Scope of practice is a concept that refers to the individual professional licenses of each provider or clinician. The multiple professional licensing boards that regulate individual licenses dictate the specific parameters within which each individual may practice. Without a specific license in marital and family therapy, for instance, one may not represent oneself, or bill insurers, as a marital and family therapist. This does not mean, however, that someone without this license will never conduct a treatment session with families or couples in the room. It does not mean that they have no training or background in working with couples and families, and it does not mean that they never make use of that knowledge in their work.

The co-occurring competencies and scope of practice definitions for integrated work were developed in a way that should permit those with a singular license as either a mental health or a substance abuse provider to offer integrated services. The definition of COD capability on page I-15 specifically outlines the ways that knowledge and skills related to integration can be incorporated into practice.

The final word with regard to scope of practice rests with professional licensing boards and with the DHHS Department of Licensing and Regulatory Services (DLRS) agency licensing. Please be sure to consult the published rule in both cases. However, the COSII initiative has worked closely with DLRS and has been in touch with all professional licensing boards about the department's requirements for co-occurring capability. The DLRS is in full support of this effort, and there have been no negative responses from professional licensing boards to date.

MaineCare:

Since 2008, language that describes requirements for integrated, co-occurring treatment and practices has been included in the MaineCare rule for chapter II, section 65, covering all outpatient treatment services. This section also establishes a separate code to bill for co-occurring services.

However, *providers should bill under the singular code that represents their primary service area, even when providing co-occurring capable, integrated care.* Given that many providers and agencies do not yet have either the competencies or range of services available to provide all services that may be needed through one provider or team, using either a MH or SA billing code

will permit referral to an additional provider should the person need additional, coordinated mental health or substance abuse treatment.

The integrated services, or co-occurring code, should be used only in a dually licensed agency by a provider who can provide both the mental health and substance abuse care required as indicated by assessment – in other words, only when one provider who is dually licensed provides fully integrated treatment.

HIPAA and 42CFR: Confidentiality Issues in Co-occurring Treatment

Since integrated treatment combines both substance use and mental health treatment, most programs and providers will need to understand and comply with federal law 42CFR, Part 2 that governs confidentiality and communication related to alcohol and drug treatment.

Federal law 42CFR applies to any person or organization that *in whole or in part* provides alcohol or drug abuse diagnosis, treatment, referral for treatment, or prevention. The program must also be "federally assisted," either directly or indirectly. This law also prohibits the release of records or *any* client-related information that would directly or indirectly reveal a person's status as diagnosed with a drug or alcohol problem. This includes any information that would directly reveal a person's status as a current or former patient.

HIPAA laws also forbid disclosure of health information. Implicit as well as explicit disclosures are prohibited under both rules without express patient consent. The patient must give express consent to authorize both disclosure and re-disclosure of health information. Both laws permit disclosure to internal program staff who may be involved in the treatment of the person or evaluation of program data. Whenever a disclosure is made to a party with patient consent, it must be accompanied by a written statement that the information being disclosed is protected by 42CFR and that the recipient may not make any further disclosure.

In the case of mental health providers, if the provider conducts a diagnosis – even if he or she does not provide treatment and only refers the client to drug or alcohol treatment – that provider, if working in a federally assisted program, is bound by 42CFR. Similarly, if the provider is providing mental health treatment and only secondarily treating the client for an alcohol or drug problem (as would be the case for a singly licensed MH provider doing integrated co-occurring capable work), that provider is also bound by 42CFR.

Treatment of Minors:

Both HIPAA and 42CFR, Part 2 leave the issue of who is a minor, and whether a minor can obtain health care or alcohol and drug treatment without parental consent, entirely to state laws. In Maine, the law authorizes licensed counselors to treat a minor for alcohol and substance abuse issues without the authorization of the minor's parent or guardian (32 MRSA & 6221).

The age of majority in Maine is 18. Therefore, anyone under the age of 18 is considered a minor. Both 22 MRSA & 1711-C (12) indicate that if a minor has consented to health care pursuant to the laws of Maine, the health care practitioner may only disclose health care information with the minor's consent. According to 42CFR, Part 2, programs must always obtain the minor's consent for disclosures, and if parental consent is not required to treat the minor, then their consent is not required for disclosure. The requirement for the minor's consent for disclosure extends to disclosure of information to the parent or guardian. If consent is not granted, substance abuse treatment may not be discussed or implied in any way with the parents.

These statements cover the main aspects of these laws for co-occurring treatment. There are multiple exceptions to each law and differences that may apply in specific situations, such as the requirement to warn of threats of harm. It is important to have the legal counsel in each agency review and develop a policy statement in relation to 42CFR, Part 2 and HIPAA that represents each agency's best understanding of how it must function in relation to them.

See References section of Appendix 2 of this manual for additional information from the Legal Action Center regarding confidentiality and communication.

SUPERVISION AND SUPERVISION GUIDELINES

Clinical supervision is a critical aspect of support for integrated care. The following are the COSII guidelines for supervision of cases that involve co-occurring disorder treatment or services. Following these guidelines is a section outlining some of the state and professional regulatory standards that apply to clinical supervision in general.

Clinical Supervision

Purpose:

This guideline outlines recommendations for clinical supervision in co-occurring capable programs, or in any setting that provides services to people or families with co-occurring conditions.

Scope:

This document is designed for supervisors in any type of behavioral health programs, whether mental health or addiction focused, and for licensed and non-licensed clinical or non-clinical staff. It focuses on the general areas related to supervision of co-occurring capable staff and programs. It does not reiterate guidelines for general clinical supervision, and does not supersede credentialing requirements for operating within the scope of individual and agency licenses.

Guiding Principles:

These guidelines address the supervision of staff and programs.

Supervisors of Staff:

1. Have the ability and/or credential to model, teach and support supervisees in COD capability
2. Maintain the expectation that all staff are working to become COD-capable, and partner with staff to help them make progress in strengths-based approaches to treatment
3. Support a welcoming, strengths-based stance between agency team members, as well as between agency team members and people in treatment
4. Identify situations in which people are at high risk due to co-occurring conditions and help staff to intervene to maintain safety

5. Support co-occurring integrated approaches in screening, assessment, treatment planning, treatment, and discharge planning, and enable staff to use these approaches
6. Assist the staff in resolving conflicts and work to promote co-occurring individual and team practices
7. Identify their own limits in supporting co-occurring capability and participate in ongoing consultation and training on this subject

Supervisors of Programs:

1. Are knowledgeable in continuous quality improvement (CQI) for co-occurring capable programs
2. Support an organizational culture that is welcoming, strengths-based, recovery-oriented and responsive to clients who have complex needs
3. Use resources for co-occurring program assessment (*e.g.*, COMPASS EZ or Maine DDCAT)
4. Use technology and change processes that are effective and support organizational change (*e.g.,* NIATx, champion teams, improvement plans)

See Resources section of Appendix 2 for NIATx link.

5. Participate in system-level activities such as training, technical assistance and consultation, as well as state, regional or local collaboratives or partnerships that provide support for the development of co-occurring-capable services
6. Ensure the availability of resources and training on co-occurring disorders and services for the individual and organization
7. Maintain their own up-to-date knowledge, skills and attitudes to support co-occurring-capable services and organizational development

Implementation:

1. Formally communicate the expectation and goal of co-occurring capability
2. Use co-occurring competency self-assessment tools (*e.g.*, CODECAT-EZ) to help staff to identify learning needs, and to assist staff in creating development plans for themselves.

3. Use individual and group supervision sessions, team meetings and case discussions to reinforce the development of co-occurring competency for staff
4. Ensure the availability of resources and training on co-occurring conditions and programming
5. Assess organizational competencies and procedures with available tools (such as COMPASS EZ and/or Maine DDCAT)
6. Develop organizational continuous quality improvement (CQI) plans to support COD capability
7. Develop policies and procedures within the organization to support co-occurring-capable services, including human resource policies and personnel evaluations
8. Develop partnerships for mutual collaboration, consultation and learning with collateral programs serving co-occurring conditions
9. Recognize and celebrate successes and support a climate of learning and growth for co-occurring capability

Individual and Individual Licensee Requirements for Providing Clinical Supervision

This section outlines some of the basic regulatory and professional standards related to clinical supervision.

Office of Substance Abuse

All clinical supervisors must be credentialed as Certified Clinical Supervisors (CCS) by the Maine State Board of Alcohol and Drug Counselors.

The agency is responsible for demonstrating that one or more clinical supervisors has credentials, and/or training, and/or experience, and/or access to mental health consultation, to provide supervision to all staff in the provision of COD-C services.

There must be at least one hour of supervision every week for clinical staff who provide at least 20 hours of direct services a week. There must be at least one hour of supervision *every two weeks* for clinical staff who provide less than 20 hours of direct services per week.

Adult Mental Health Services/Children's Behavioral Health Services

Clinical supervisors are trained to provide supervision as evidenced by documentation of supervisory training and licensure or certification specific to the supervision of the service provided.

Minimum supervision requirements are one hour consultation per month for those licensed to practice independently, or the amount of supervision required by their professional licensing authority, whichever is greater. Practitioners not licensed to practice independently must have four hours of supervision per month.

Professional Licensing Authorities

Board of Alcohol and Drug Counselors

CCS (Certified Clinical Supervisor):

A psychologist, physician, registered clinical nurse specialist, clinical professional counselor or clinical social worker who is licensed in Maine, and any other licensed or certified mental health professionals who are qualified to provide alcohol and drug counseling services at the independent practice level by virtue of the requirements for that profession, may be certified to

provide clinical supervision upon meeting the qualifications set forth in this section and achieving a passing score on the examination.

Practice Experience

Documented proof of 1000 hours of practice in alcohol and drug counseling under the applicant's qualifying license

Training in Clinical Supervision

Documented proof of 30 hours of didactic training in clinical supervision, which includes at least six hours of training in each of the following areas: skills assessment/evaluation; counselor development; management/administration; and professional responsibility

Licensed Alcohol and Drug Counselors (LADC):

A licensed alcohol and drug counselor may be certified to provide clinical supervision upon meeting the qualifications set forth in this section and achieving a passing score on the examination.

Practice Experience

An LADC with a high school diploma or its equivalent shall submit evidence of 4000 hours of documented, clinically-supervised work experience as an LADC. An LADC with an associate or bachelor degree shall submit evidence of 2000 hours of documented, clinically-supervised work experience as an LADC. An LADC with a Master's degree or higher shall demonstrate 1000 hours of documented, clinically-supervised work experience as a LADC.

Training in Clinical Supervision

Documented proof of 30 hours of didactic training in clinical supervision, which includes at least six hours of training in each of the following areas: skills assessment/evaluation, counselor development, management/administration, and professional responsibility.

Examination

The applicant shall achieve a passing score as determined by the board on the examination for clinical supervision designated by the board.

LCPC (Licensed Clinical Professional Counselor):

Supervision

The licensed counselor, acting as a clinical supervisor, provides professional assistance to individuals or groups in order to clarify and resolve issues or

problems related to clients. They are also responsible for monitoring client welfare, encouraging compliance with relevant legal and ethical standards, monitoring clinical performance and professional development of supervisees, and evaluating and verifying current performance of supervisees. The supervisor must be knowledgeable and experienced in providing supervision, as well as aware of the limits of his or her skill, knowledge and competence. One overriding assumption is that supervision should be continuous throughout a counselor's career.

"Supervisor" is a person not related to, living with, or having a personal relationship with a conditional licensee and who is also:

1. A licensed clinical professional counselor, licensed marriage and family therapist, licensed pastoral counselor, licensed master social worker conditional (clinical), licensed clinical social worker, certified social-worker-independent practice, licensed psychologist or licensed psychiatrist not under suspension or probation who is approved to provide supervision to the conditional licensee through meeting one of the following additional criteria:

    a. Licensed practice for a minimum period of five years, including not more than two years of practice as an entry-level conditional licensee.

    b. Certification by a national professional organization in training and/or supervision, (for example, certification as an approved clinical supervisor by the National Board of Certified Counselors (NBCC); or

    c. 30 contact clock hours of training in supervision; or

2. A licensed professional counselor not under suspension or probation who is approved to provide supervision to a licensed professional counselor – conditional through meeting one of the additional criteria set forth in Section 1(23)(A) of LCPC board regulations.

Social Work:

There are no specific requirements for supervisor training, education or preparation.

MAINE'S CO-OCCURRING CAPABILITY SELF-ASSESSMENT

Maine Co-occurring Capability Self-Assessment

This tool assesses an agency's level of integration and capability to deliver co-occurring services. It was based on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and the Dual Diagnosis Capability in Mental Health Treatment tools developed by Mark McGovern and his colleagues at the Dartmouth Psychiatric Research Center. Hornby Zeller Associates, Inc., the program evaluator, has made the tool available online for those wishing to complete a web-based version to be scored by them.

It's located at http://tiaa.hornbyzeller.com/mccsa.asp

A second agency assessment tool, the COMPASS-EZ, was developed by Ken Minkoff and Chris Cline, and is available at their website (a link is located in Appendix 2 of this manual), or you may obtain a copy by contacting a member of the COSII project team.

Maine's Co-occurring Capability Self Assessment[1]

August 2009

Version 3.3

Date: **Rater(s)**: **Time Spent:**

Agency Name:

Program Name:

Program Type(s): **Level of Care:**

Address:

Contact Person: **Title:**

Telephone: **Fax:** **E-mail:**

Sources used (check all that apply):

- ☐ **Chart Review**
- ☐ **Agency Brochure Review**
- ☐ **Program Manual Review**
- ☐ **Team Meeting Observation**
- ☐ **Supervision Observation**
- ☐ **Observe Group/Individual Session**
- ☐ **Interview with Program Director**
- ☐ **Interview with Clinicians**
- ☐ **Interview with Consumers** (#:)
- ☐ **Interview with Other Service Providers** (Specify:)
- ☐ **Physical Site Tour/Observation**

Total # of sources used:

NOTES:

[1] Formerly known as the DDCAT, modified by the COSII Project Team

I. ORGANIZATIONAL STRUCTURE (whole agency): What is permitted in agency policy, agency organizational structure and by licensure? Are there impediments to providing certain types of services? Are these impediments real?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
IA. Focus of written mission, principles, values or philosophy	Mental Health (MH) or Substance Abuse (SA) only ☐	☐	People with COD are welcomed ☐	☐	Primary focus on people with COD ☐
IB. Organizational certification and licensure	Permits only MH or SA treatment and is not co-occurring capable[2] ☐	☐	Demonstrates co-occurring capability within a single license ☐	☐	Is certified and/or licensed to provide both MH and SA within a single program, including medication management ☐
IC. Organizational Policy					
1. Clinical standards	MH or SA only ☐	☐	All reflect COD capability ☐	☐	All target enhanced COD capability ☐
2. Clinical resources	MH or SA only ☐	Separate MH and SA services can be accessed simultaneously within agency ☐	Policy provides integrated services for MH and SA which are accessed under a single license ☐	☐	Policy provides specialized integrated treatment programs or services that include medication management ☐
3. Human resources	MH or SA only with no defined co-occurring competencies ☐	☐	Policy requires all staff to possess defined co-occurring competencies ☐	☐	Policy requires program teams or individuals to have dually licensed staffing and psychiatrists to have co-occurring competencies ☐
4. Finance / fiscal	Billing for MH or SA only ☐	☐	Co-occurring services can be billed under either MH, SA or COD ☐	☐	Agency has the capacity to bill multiple funding streams for enhanced COD services ☐
5. Management Information System (MIS)	No MIS or for MH or SA only ☐	☐	Collects data on MH and SA separately for prevalence or outcomes of COD ☐	☐	Consistently collects integrated data on prevalence and outcomes of COD ☐

[2] Co-occurring capable definition can be found in the corresponding manual

I. ORGANIZATIONAL STRUCTURE (whole agency): What is permitted in agency policy, agency organizational structure and by licensure? Are there impediments to providing certain types of services? Are these impediments real?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
6. Quality Improvement (QI)	MH or SA only ☐	☐	Promotes, monitors and uses indicators to improve organizational structure and clinical outcomes (*e.g.*, level of functioning, treatment completion) ☐	☐	Promotes and monitors enhanced COD capability and outcomes ☐
D. Organizational structure	Single-purpose agency with no formal means of collaboration ☐	☐	Formal collaboration across internal and external programs for SA and MH ☐	☐	Aligned to provide co-occurring treatment through continuum of care from intake to crisis, case management, inpatient and outpatient services ☐
E. Consumer / family involvement	No involvement ☐	☐	Built into some organizational structures for planning, implementation and delivery ☐	☐	Throughout all organizational structures for planning, implementation and delivery ☐

Notes:

Chart / Documentation:

II. PROGRAM STRUCTURE: How are specific programs structured to deliver co-occurring services? Do billing structures limit or promote COD services?					
	1 No Integration	**2**	**3 Integration**	**4**	**5 High Integration**
A. Primary treatment focus as stated in program description	MH or SA only ☐	☐	COD are addressed ☐	☐	COD are the target of treatment ☐
B. Program licensure	Permits only MH or SA treatment ☐	☐	Either single license (MH or SA) permits co-occurring treatment ☐	☐	Programs possess licenses which permit highly integrated co-occurring services, including medication management ☐
C. Treatment delivery	No means provided to obtain co-occurring treatment ☐	Informal case input from clinical staff or other disciplines within or across programs ☐	All programs provide co-occurring capable treatment ☐	Some teams provide integrated treatment through single staff member or treatment team ☐	All programs provide co-occurring enhanced treatment through treatment staff or team ☐
D. Financial incentives	Can bill only for MH or SA treatment ☐	☐	Can bill for only MH or SA and able to provide co-occurring capable treatment under that code; may also use COD billing code ☐	☐	Can bill for both services or can use the COD code ☐

Notes:

Chart / Documentation:

III. PROGRAM MILIEU What kind of information is posted on walls, on display in waiting areas, and included in consumer and family handouts and printed materials?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Routine expectation of and welcome to treatment for both disorders	Expect MH or SA only, refer or ignore other ☐	☐	Expect COD and treat both within scope of license ☐	☐	Actively accepts and addresses all issues within the program scope and level of care ☐
B. Display and distribution of literature and consumer educational materials	MH or SA only ☐	☐	Available for MH, SA and COD ☐	☐	Available for MH, SA and COD; most literature refers specifically to interaction between disorders and to integrated treatment ☐

Notes:

Chart / Documentation:

IV. CLINICAL PROCESS: ASSESSMENT Is stage of change assessed and documented for each disorder? Does it influence what treatment a consumer gets or how s/he is approached?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Routine screening methods for MH and SA	No screening or screens primarily for one disorder ☐	☐	Standardized screening for both MH and SA ☐	☐	Standardized screening for both disorders as well as trauma (*e.g.*, AC-OK) ☐
B. Routine screening for health risks and conditions	Physical health care issues not addressed ☐	☐	Screening for health conditions ☐	☐	Screening for health conditions and risks (*e.g.*, sharing needles, obesity, medication side effects, unprotected sexual activity) ☐
C. Routine integrated assessment if screened positive for MH and SA	Ongoing monitoring for appropriateness or exclusion from program related to treating diagnosis ☐	☐	Formal, integrated assessment for both MH and SA and their interaction when indicated ☐	☐	Formal, integrated assessment for both MH and SA and their interaction in all cases ☐
D. MH and SA diagnoses made and documented	Non-treating diagnoses are not made or recorded ☐	☐	All diagnoses recorded in chart regardless of where diagnoses are made ☐	☐	Standard and routine MH and SA diagnoses made on site and recorded in chart ☐
E. MH and SA history reflected in medical record	History of one or other not present ☐	History of both MH and SA variable by individual clinician ☐	Routine documentation of history of both in record ☐	☐	Specific section in record devoted to integrated history and chronology of both disorders ☐
F. Initial assessment of stage of change	No assessment for stage of change ☐	Assessed and documented variably by individual clinician ☐	Assessed and documented routinely for each identified MH and SA condition ☐	☐	Assessed and documented for all identified conditions (*e.g.*, trauma, medical, wellness) ☐

Notes:

Chart / Documentation:

V. CLINICAL PROCESS: TREATMENT

Do treatment plans show an equivalent, integrated focus on SA and MH?
Are there defined protocols for consumers who arrive for treatment high/intoxicated and/or those at high risk?
What procedures are in place if you send your consumers to a SA emergency provider such as detox? Do you receive feedback from detox? What if you send person to crisis shelter or psychiatric hospital?
Are medications acceptable? Are certain medications unacceptable? Are medications routine and integrated?

	1 No Integration	2	3 Integration	4	5 High Integration
A. Treatment plans	Address MH or SA only ☐	Variable by individual clinician ☐	One disorder is the focus, with attention to how the other disorder influences it ☐	☐	Addresses COD specifically in plan ☐
B. Assess and monitor interactive courses of both disorders	Separate treatment for MH or SA only ☐	Treatment for MH or SA and evidence of interactive course of other disorder ☐	Treatment for both issues with evidence of interaction between the conditions ☐	☐	Comprehensive treatment for COD with evidence of interaction between all conditions ☐
C. Procedures for suicidal, violent or psychotic consumers	Few documented or explicit in-house guidelines ☐	☐	Routine capability to ascertain risk and make appropriate referral with clear communication back and forth ☐	☐	Routine capability to ascertain risk and treat on site ☐
D. Motivational Interviewing (MI)	Few or no staff are trained in or utilize MI techniques ☐	☐	A majority of staff are trained in MI techniques, but not all utilize them ☐	☐	Most staff are trained in and utilize MI techniques for a majority of their consumers ☐
E. Ongoing treatment strategies reflective of stage of change	Treatment strategies not explicitly based on stage of change ☐	Treatment strategies based on stage of change vary by individual clinician ☐	Treatment strategies reflect stage of change for each MH and SA condition ☐	☐	Treatment strategies reflect stage of change for all identified conditions ☐
F. MH and/or SA counseling	MH or SA counseling is not routinely provided within this agency ☐	MH or SA counseling is provided by referral in parallel or sequential mode ☐	MH or SA counseling is integrated to address the other disorder ☐	MH and SA counseling is provided in specialized integration programs ☐	MH and SA counseling is provided in an integrated fashion throughout all programs ☐

V. CLINICAL PROCESS: TREATMENT

Do treatment plans show an equivalent, integrated focus on SA and MH?
Are there defined protocols for consumers who arrive for treatment high/intoxicated and/or those at high risk?
What procedures are in place if you send your consumers to a SA emergency provider such as detox? Do you receive feedback from detox? What if you send person to crisis shelter or psychiatric hospital?
Are medications acceptable? Are certain medications unacceptable? Are medications routine and integrated?

	1 No Integration	2	3 Integration	4	5 High Integration
G. Evidence-based Practices (EBP)	No use of EBP ☐	☐	EBP for MH or SA that accommodates COD ☐	☐	EBP for CODs ☐
H. MH and SA group counseling	No availability of group treatment ☐	MH or SA groups available ☐	Access to integrated groups ☐	☐	Regularly scheduled COD groups ☐
I. Procedures for consumers who are intoxicated and/or at risk for withdrawal	No capacity or willingness to treat ☐	☐	Routine capability to ascertain risk and make appropriate referral with ongoing communication ☐	☐	Routine capability to treat on site ☐
J. Medication evaluation, management, monitoring and adherence	Consumers on meds routinely not accepted ☐	Certain types of meds are not acceptable or must have own supply for entire treatment episode ☐	Use of prescription meds is acceptable with consultation and collaboration of prescriber ☐	On-site capability to prescribe medication is limited ☐	On-site capability to prescribe mental health and substance abuse medication ☐
VK. Health promotion and treatment	Not addressed ☐	☐	Make referrals for health conditions and routinely address heath promotion ☐	☐	Health promotion and treatment routinely available in house ☐
VL. Education about MH and SA treatment interaction	No education provided ☐	☐	Presented on an individual basis ☐	☐	Psychoeducation groups address COD ☐

V. CLINICAL PROCESS: TREATMENT

Do treatment plans show an equivalent, integrated focus on SA and MH?
Are there defined protocols for consumers who arrive for treatment high/intoxicated and/or those at high risk?
What procedures are in place if you send your consumers to a SA emergency provider such as detox? Do you receive feedback from detox? What if you send person to crisis shelter or psychiatric hospital?
Are medications acceptable? Are certain medications unacceptable? Are medications routine and integrated?

	1 No Integration	2	3 Integration	4	5 High Integration
VM. Family education and treatment	For MH or SA only, or minimal to no family involvement ☐	☐	Access to family or group counseling for COD ☐	☐	Routine COD family group integrated into standard program format by staff member ☐
VN. Family support	Not present, not recommended ☐	Off site, recommended variably ☐	Present off site with facilitated connections to support ☐	☐	Present on site, through agency or collaboration ☐
O. Specialized interventions to facilitate use of COD and 12-step or other self-help groups	Not present ☐	☐	Education about and referral to 12-step or other self-help groups ☐	☐	Education about group and special COD groups and programs available on site ☐
P. Peer recovery supports for consumers with CODs	Not present, not recommended ☐	Off site, recommended variably ☐	Present off site with facilitated connections to support ☐	☐	Present on site, though agency or collaboration ☐

Notes:

Chart / Documentation:

VI. CONTINUITY OF CARE Is recovery from both MH and SA considered when developing a discharge plan? What types of services are people referred to? Are referrals followed up on?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Continuity of care maintained for both disorders	Referral for MH or SA treatments off site with no back and forth communication ☐	☐	MH or SA treatment referral as needed with back and forth communication ☐	☐	Monitoring and ongoing treatment of MH or SA throughout the continuum of care on site ☐
B. COD addressed in discharge planning process	Not addressed ☐	☐	Both disorders systematically addressed and documented in the planning process ☐	☐	Both disorders are systematically addressed and documented in the planning process with follow-up to support implementation ☐
C. Focus on ongoing recovery issues for both disorders	Not present ☐	☐	MH or SA with the other issue as potential relapse concern ☐	☐	Focus on recovery from both disorders, both are primary and ongoing ☐
D. Use of self-help support groups and/or aftercare/peer support groups	Referral to MH or SA only ☐	☐	Referral is routine and systematic with education and support ☐	☐	Referral routine, systematic and available on site ☐
E. Sufficient supply and adherence plan for medications	No plan for continuation of medications and no adherence plan ☐	☐	Provides 30-day prescription or supply to next appointment off site; medication adherence plan addresses all disorders ☐	☐	Maintains medication management in agency with ongoing adherence support ☐
F. Continuity of care maintained for health promotion	No consideration of health issues ☐	☐	Consideration of identified health needs ☐	☐	Standard consideration of health and wellness needs ☐

Notes:
Chart / Documentation:

VII. STAFFING What is the relationship with a psychiatrist, physician, nurse practitioner (or other licensed prescriber)?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Psychiatrist, physician, physician's assistant (PA) or nurse practitioner (NP)	No formal relationship with program ☐	☐	Consultant or contractor for clinical services and/or case supervision ☐	☐	COD qualified staff on site for clinical services and/or case supervision ☐
B. On-site, professionally licensed staff	No staff member is dually certified or qualified[3] ☐	☐	At least 25% of staff members are dually certified, licensed or qualified ☐	☐	At least 50% of staff members dually certified, licensed or qualified ☐
C. Access to supervision or consultation	Access to MH or SA only ☐	☐	COD supervision or consultation as needed ☐	☐	On-site, documented, regular supervision by COD-qualified staff ☐
D. Peer/alumni programming is available	No programming present ☐	☐	Alumni programming available within the organization; accommodates COD, volunteer peer involvement ☐	☐	Alumni programming within agency, specific COD focus, peer support person on staff ☐

Notes:

Chart / Documentation:

[3] Dually certified or qualified = certified, licensed or qualified to provide both MH and SA services in the State of Maine

VIII. TRAINING Who has basic training in screening and assessment for both disorders?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Training in COD	Not trained in basic skills for COD ☐	☐	All staff (clinical and non-clinical personnel) have training on COD ☐	☐	All staff have training on COD and clinical staff have specific training on COD EBP or modalities ☐

Notes:

Chart / Documentation:

MAINE'S CO-OCCURRING CAPABILITY SELF ASSESSMENT SUMMARY SCORE SHEET					
Program:				**Date of Review:**	
Level of Care:				**Reviewer(s):**	
I. Organizational Structure		**V. Clinical Process: Treatment**		**VII. Staffing**	
A.		A.		A.	
B.		B.		B.	
C.	, , , , ,	C.		C.	
		D.		D.	
D.		E.		**VII. Total= /4 Domain Score=**	
E.		F.		**VIII. Training**	
I. Total= / 10 Domain Score=		G.		A.	
II. Program Structure		H.		**VIII. Total / Domain=**	
A.		I.		**OVERALL SCORE=**	
B.		J.		**DUAL DIAGNOSIS CAPABILITY**: MH/SA only (≤49); Somewhat Integrated (50-98); Integrated (99-147); Quite Integrated (148-196); Highly Integrated (197-245)	
C.		K.			
D.		L.			
II. Total= /4 Domain Score=		M.			
III. Program Milieu		N.			
A.		O.			
B.		P.		**AVERAGE DOMAIN SCORE:** Sum of all Domain Scores / 8	
III. Total= /2 Domain Score=		**V. Total= /16 Domain Score=**			
IV. Clinical Process: Assessment		**VI. Continuity of Care**			
A.		A.		**NOTES:**	
B.		B.			
C.		C.			
D.		D.			
E.		E.			
F.		F.			
IV. Total= /6 Domain Score=		**VI. Total= /6 Domain Score=**			

CASE STUDIES

This section provides sample cases of people with co-occurring conditions that have been used in various COSII training exercises.

ADULT CASE STUDIES

Case 1 – Maria M.

The client is a 38-year-old Hispanic/Latina woman who is the mother of two teenagers. Maria M. presents with an 11-year history of cocaine dependence, a two-year history of opioid dependence, and a history of trauma related to a longstanding abusive relationship (which has been over for six years). She is not in an intimate relationship at present and there is no current indication that she is at risk for either violence or self-harm. She also has persistent major depression and panic treated with antidepressants. She is very motivated to receive treatment.

Ideal Integrated Treatment Plan:

The plan for Maria M. might include medication-assisted treatment (*e.g.*, methadone or buprenorphine), continued antidepressant medication, attendance at a 12-step program, and other recovery group support for her cocaine dependence. She also could be referred to a group for trauma survivors that is specifically designed to help reduce symptoms of trauma and resolve long-term issues.

Individual, group, and family interventions could be coordinated by the primary counselor from methadone maintenance treatment. The focus of these interventions might be on relapse prevention skills, taking medication as prescribed, and identifying and managing trauma-related symptoms without using. An appropriate long-term goal would be to establish abstinence and engage Maria in longer-term psychotherapeutic interventions to reduce trauma symptoms and help resolve trauma issues. On the other hand, if a local mental health center or substance abuse program had a psychiatrist trained and licensed to provide Suboxone® (the combination of buprenorphine and naloxone), she could have her care based in the mental health center or substance abuse center.

1. Identify which programs/agencies in your area could be involved in providing services to this client.
2. What, if any, adjustments to existing services would have to be made?
3. Would there be gaps in service? How might these be filled?
4. Who would be the best suited to act as case manager for this client?
5. What barriers would exist for care coordination?

Case 2 – George T.

The client is a 34-year-old married, employed African-American man with cocaine dependence, alcohol abuse, and bipolar disorder (stabilized on lithium) who is mandated to cocaine treatment by his employer due to a failed drug test. George T. and his family acknowledge that he needs help not to use cocaine, but do not agree that alcohol is a significant problem (nor does his employer). He complains that his mood swings intensify when he is using cocaine.

Ideal Integrated Treatment Plan:

The ideal plan for this man might include participation in community-based addiction rehabilitation, plus continued provision of mood-stabilizing medication. In addition, he should be encouraged to attend a recovery group such as Cocaine Anonymous or Narcotics Anonymous (NA). The addiction counselor would provide individual, group, and family interventions. The focus might be on gaining the skills and strategies required to handle cocaine cravings and to maintain abstinence from cocaine, as well as the skills needed to manage mood swings without using substances. Motivational counseling regarding alcohol and assistance in maintaining medication (lithium) adherence also could be part of the plan.

1. Identify which programs/agencies in your area could be involved in providing services to this client.
2. What, if any, adjustments to existing services would have to be made?
3. Would there be gaps in service? How might these be filled?
4. Who would be the best suited to act as case manager for this client?
5. What barriers would exist for care coordination?

Case 3 – Jane B.

The client is a 28-year-old single Caucasian female with diagnoses of paranoid schizophrenia, alcohol dependence, crack cocaine dependence, and a history of multiple episodes of sexual victimization. Jane B. is homeless (living in a shelter), actively psychotic, and refuses to admit to a drug or alcohol problem. She has made frequent visits to the local emergency room for both mental health and medical complaints, but refuses any follow-up treatment. Her main requests are for money and food, not treatment. Jane has been offered involvement in a housing program that does not require treatment engagement or sobriety, but has refused due to paranoia regarding working with staff to help her in this setting. Jane B. refuses all medication due to her paranoia, but does not appear to be acutely dangerous to herself or others.

Ideal Integrated Treatment Plan: The plan for Jane B. might include an integrated case management ACT team. The team would apply a range of engagement, motivational, and positive behavioral change strategies aimed at slowly developing a trusting relationship with this woman. Engagement would be promoted by providing assistance to Jane B. in obtaining food and disability benefits, and using those connections to help her engage gradually in treatment/rehab for either mental health disorders or addiction – possibly by an initial offer of help in obtaining safe and stable housing. Peer support from other women also might be of value in promoting her sense of safety and engagement.

1. Identify which programs/agencies in your area could be involved in providing services to this client.
2. What, if any, adjustments to existing services would have to be made?
3. Would there be gaps in service? How might these be filled?
4. Who would be the best suited to act as case manager for this client?
5. What barriers would exist for care coordination?

These case studies are adapted from CSAT. (2005). TIP 42.

V

ADOLESCENT CASE STUDIES

Case 1 – Gina.

Gina was a 17-year-old Latina female. She had a 2-year-old daughter and they were both living with her parents. Gina had been previously admitted to a hospital because of a suicide attempt. She had had a 1-month history of mild depression after high school graduation caused by concerns about what she was going to do after graduation. She had become more depressed and had attempted to kill herself by overdosing on medication. Gina was then admitted to a local hospital intensive care unit. A psychiatrist released her from the hospital because he felt that she was not suicidal and referred her to a local psychologist who has treated her with psychotherapy.

For six weeks she was given no medications and did not see a psychiatrist. Gina reportedly functioned well during this period but developed depression with constant suicidal ideation one week prior to her current admission. She also related that she had had periods of time during which she did not know her own name or where she was living on at least six occasions previously. Her mental status examination, medical and substance abuse work ups were unremarkable.

Initial Diagnosis:
Axis I Major Depressive Disorder
R/O Panic Disorder
Possible Dissociative Disorder

Gina maintained that she had no substance use problems except for smoking marijuana once and occasional alcohol. She demonstrated symptoms of severe depression and was started on anti-depressants. Gina was initially started on a normal dosage, but she had a great deal of difficulty tolerating even minimal dosages due to side effects. The dosage was reduced to 1/4 of normal dosage and was later slowly increased to normal adult dosage. After several weeks of treatment, Gina admitted to heavy use of marijuana and ecstasy. She stated that her symptoms had not started until she began using these drugs. As treatment progressed, she recognized problems in her own behavior, including ignoring her daughter and going out with friends to do drugs and attend parties. She demonstrated additional issues in treatment that focused on her over involvement with male patients. She was able to address this in treatment.

Final Diagnosis;
Axis I Polysubstance Abuse
Major Depressive Disorder

Comment:

In hindsight, it is evident that Gina should have received counseling from the time her pregnancy became known. The fact that she had become pregnant should have raised concern that she was experiencing other problems in addition to her early sexual activity, including possible substance use. The second point at which she could have been helped was when she made her first suicide attempt. She should not have been released from the hospital without outpatient therapy. Her antidepressant intolerance can also be found in people with panic disorders.

The most striking thing about the case is that substance abuse was not initially diagnosed because Gina presented with clear depressive symptoms, had made a suicide attempt and had a negative drug screen. It was only after the passage of time and start of counseling that she recognized she had used drugs and that the drugs had probably contributed heavily to her symptoms. This demonstrates that it is very important not to make snap judgments or diagnoses when treating an adolescent, and to assess how the use and abuse of substances are contributing to their symptoms and problems.

Case 2 – Warren.

Warren was a 15-year-old white male who had failed 8th grade and was failing summer school. He had been ordered into psychiatric evaluation by the courts. His mother stated that he had been very depressed, angry and hostile and had had dramatic mood swings from being calm to screaming and yelling. Warren had reportedly thrown a brick through a window and beat up the mailbox at their house. He often stated that he was stupid and not worth anything. He had a very poor relationship with his father.

His parents first noticed that something was very wrong one year prior to the evaluation when they started receiving complaints about him from the school system. He was reported to be hyperactive with decreased attention span, inappropriately touching female students, pushing and talking out of turn. He received weekly counseling for two or three months, which was unhelpful. His behavior continued to deteriorate and became so far out-of-control that he started striking his parents' truck and boat, stating "I'll just kill myself" and threatening to kill both of his parents. One year previously, a general practitioner had treated Warren with Ritalin® for presumed hyperactivity. His grades did improve, but he did not like how it made him feel and he threw it away. His mental status revealed extremely flat affect, depressed mood and no thought disorder.

Initial diagnosis:
Axis I R/O Major Depression
R/O ADHD
R/O Polysubstance Abuse or Dependence
Parent-Child Problem

Warren's affect brightened somewhat in the hospital and he was no longer suicidal. As an outpatient he continued to deny any drug use until he made an attachment with one of the substance abuse counselors. Approximately six weeks into treatment he confessed to daily use of marijuana, frequent use of LSD, and copious amounts of alcohol. The focus of his treatment was then shifted to emphasize his substance use and how it affected his behavior and mood.

Final diagnosis:
Axis I Substance Induce Mood Disorder (depressed)
Cannabis Dependence
Hallucinogen Abuse (LSD)
Alcohol Abuse

While in treatment he did very well. His depression remitted and he did not require treatment with medication.

Adolescent case studies adapted from Anderson & McNellis 2010 – Trainer's Manual.

Fourteen Myths About Co-occurring Integration

The following are common myths people hold about regulatory issues related to integrated treatment. We present them here to debunk them for good!

MYTH 1. Mental health client files and substance abuse client files need to be maintained in separate records.

REALITY: ***FALSE*** – **Client mental health and substance abuse treatment files can be integrated.**

MYTH 2. Clients cannot have mental health and substance abuse goals on their treatment plans.

REALITY: ***FALSE*** – **Mental health and substance abuse treatment goals can be integrated within a treatment plan.**

MYTH 3. To do integrated treatment, a clinician must be dually credentialed.

REALITY: ***FALSE*** **– Integrated treatment can be delivered in mental health and substance abuse programs by non-dually credentialed personnel.**

MYTH 4. Substance abuse counselors cannot write a mental health diagnosis in a substance abuse treatment plan or in a substance abuse client file.

REALITY: ***FALSE*** – **A mental health diagnosis can be part of a substance abuse integrated treatment plan, provided the plan documents the clinician who made the diagnosis.**

MYTH 5. New assessments must be done for each level of care for clients.

REALITY: ***FALSE*** – **A new assessment is not required for changes in levels of care, provided it meets regulatory requirements and supports the treatment.**

MYTH 6. Substance abuse counselors cannot counsel a client about their emotional reactions.

REALITY: ***FALSE*** **– The purpose of integrated treatment is to include all areas that influence client needs.**

MYTH 7. If I practice under an LADC, I cannot discuss depression or emotions with clients.

REALITY: ***FALSE*** **– Substance abuse counselors need to include a client's reactions to what they are experiencing within the treatment.**

MYTH 8. CADC and LADC can only diagnose on Axis I.

REALITY: ***FALSE*** **– CADCs and LADCs can only diagnose Substance Abuse on Axis I, and CADCs must have a supervisor's signature to make the diagnosis valid.**

MYTH 9. Integrated treatment plans can only be initiated or changed by the same counselor.

REALITY: **FALSE – Integrated treatment plans involve multiple persons that support the client's treatment and can be changed at any point in time by a clinician and the client. If the treatment plan is modified with only one of the clinicians present, and a team meeting is not possible, the modified plan should be reviewed and signed off by the other clinician(s) involved in the plan.**

MYTH 10. If symptoms of mental health disorders occur, they cannot be documented in the chart.

REALITY: ***FALSE*** **– Mental health issues can surface and need to be documented as part of continuity of care. A mental health diagnosis can only be made by a properly credentialed clinician.**

MYTH 11. Medical issues cannot be documented on the treatment plan.

REALITY: ***FALSE*** **– Medical issues impact clients and should be included in the treatment plan where appropriate and agreed to by the client.**

MYTH 12. 42 CFR requires that if substance abuse is mentioned in the chart, everyone needs to abide by the federal regulations.

REALITY: ***FALSE*** **– In order to determine if 42 CFR is applicable, agency leaders must determine if they are 1.) a program and 2.) federally assisted.**

- **1.) A program includes any person or organization that, in whole or in part, provides alcohol and drug abuse diagnosis, treatment, referral for treatment or prevention. *(See 42 CFR § 2.11.)***

- **2.) A program is federally assisted, and therefore covered by these regulations if it: receives federal funds in any form, even if the funds do not directly pay for alcohol or drug-abuse services, is assisted by the IRS through grant of tax-exempt status or allowance of tax deductions for contributions.**

Patient records maintained by a hospital or medical center are not covered under 42 CFR Part 2 unless the patient receives treatment (or diagnosis or referral for treatment) from

- **a) a specialized drug or alcohol abuse unit of the hospital, or**
- **b) medical personnel or other staff whose primary function is to provide services for alcohol or drug abuse.**

MYTH 13. If you are doing COD treatment in a mental health program, you don't have to abide by 42 CFR.

REALITY: ***FALSE*** **– See definitions for 1.) program, and 2.) federally assisted, in Myth 12 above; *i.e.* "program includes any person or organization that, in whole or in part, provides alcohol or drug abuse diagnosis, treatment, referral for treatment or prevention.**

- **Treatment means "the management and care of a patient suffering from alcohol or drug abuse, a condition of which is identified as having been caused by that abuse, in order to reduce or eliminate adverse effects upon the patient."**
- **Federally assisted means for example: funded with federal dollars; a block grant; billing Medicaid, Medicare; or, tax exempt status, etc.**

MYTH 14. If you are doing COD treatment in a substance abuse program, you don't have to abide by the Rights of Recipients.

REALITY: ***FALSE*****–Rights of Recipients apply to persons who are receiving mental health services in an agency setting.**

APPENDIX 1
DOCUMENTS

AC-OK Screen for Co-Occurring Disorders
(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

First Name: _____**Last Name**: _____

Gender: _____ **Date of Birth:** _____ **Date of Screening:** _____

During the past year:

1. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? ☐ Yes ☐ No
2. Have you experienced thoughts of harming yourself? ☐ Yes ☐ No
3. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts? ☐ Yes ☐ No
4. Have you attempted suicide? ☐ Yes ☐ No
5. Have you had periods of time where you felt that you could not trust family or friends? ☐ Yes ☐ No
6. Have you been prescribed medication for any psychological or emotional problem? ☐ Yes ☐ No
7. Have you experienced hallucinations (heard or seen things others do not hear or see)? ☐ Yes ☐ No

Mental Health **Questions 1-7** **Total Yes Answers:** _____

8. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone? ☐ Yes ☐ No
9. Have you experienced a traumatic event and since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life? ☐ Yes ☐ No

Trauma **Questions 8-9** **Total Yes Answers:** _____

10. Have you been preoccupied with drinking alcohol and/or using other drugs? ☐ Yes ☐ No
11. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using? ☐ Yes ☐ No
12. Do you, at times, drink alcohol and/or use other drugs more than you intended? ☐ Yes ☐ No
13. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less? ☐ Yes ☐ No
14. Do you, at times, drink alcohol and/or use other drugs to alter the way you feel? ☐ Yes ☐ No
15. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't? ☐ Yes ☐ No

Substance Abuse **Questions 10-15** **Total Yes Answers:** _____

Provider Signature: _____

AC-OK Adolescent Screen

(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

First Name: _____Last Name: _____

Gender: ____ Date of Birth: _____ Last grade completed: ____ Date of Screening: _____

During the past year have you:

1.	Felt really sad, lonely, hopeless; stopped enjoying things, wanted to eat more or less, had problems sleeping, or doing what you need to at home or at school.?	☐ Yes ☐ No
2.	Heard voices or seen things that others don't hear or see?	☐ Yes ☐ No
3.	Burned or cut yourself?	☐ Yes ☐ No
4.	Been prescribed medication for your feelings?	☐ Yes ☐ No
5.	Tried to kill yourself?	☐ Yes ☐ No
6.	Had thoughts about hurting yourself or wanting to die?	☐ Yes ☐ No

Mental Health Questions 1- 6 Total Yes Answers: _____

7.	Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over?	☐ Yes ☐ No
8.	Have you ever been afraid of your parent, caretaker or a family member?	☐ Yes ☐ No
9.	Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone?	☐ Yes ☐ No

Trauma Questions 7-9 Total Yes Answers: _____

10.	Been in trouble with the law, school, or parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use?	☐ Yes ☐ No
11.	Drunk alcohol or used other drugs to change the way you feel?	☐ Yes ☐ No
12.	Drunk alcohol or used other drugs more than you meant to?	☐ Yes ☐ No
13.	Changed your friends or planned your free time to include drinking alcohol or using other drugs?	☐ Yes ☐ No
14.	Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using?	☐ Yes ☐ No
15.	Tried to stop drinking alcohol or using other drugs, but couldn't?	☐ Yes ☐ No

Substance Abuse Questions 10-15 Total Yes Answers_____

Provider Signature: _____

Sample Assessment #1

Client Name: _____ **Date:**_____
Soc Sec #_____ **DOB:**_____
Client's Legal Status: _____
Legal Guardian Name:_____ **Phone:**_____
Relationship to Client:_____
Emergency Contact:_____
Phone Number:_____ **Relationship to you:** _____

1. What brings you to this agency?

_____

2. What would you like to accomplish?

_____

3. What resources and strengths do you have that will help you accomplish your goals?

_____

I. Current Living Situation

A. Where are you living?_____

_____

B. Are you having any difficulties with your living situation?

_____

II. Finances

A. Current Income:_____ ___Wages ___SSI ___SSDI ___VA Benefits ___Other

____ Food Stamps ___ Medicaid ___Medicare ___Payee

B. Recent Changes:_____

III. Physical Health

A. Is there anything about your health that worries you?_____
B. Primary Care Provider:_____
C. Date of Last Physical:_____
D. Allergies to Medications, Food or the environment?_____
E. Nutritional Needs: _____
F. Medications (route / dosage/schedule) (start and end dates) (prescribing Physician):

_____

_____

_____

Non-Prescription Medications and Medications not listed: _____
_____

G. Physical and environmental barriers that may impede ability to obtain services: _____
_____

H. Need for cognitive or neurological assessment? _____
_____
_____

IV. Educational/Vocational

A. Previous Education/Training (highest grade completed- college/trade, employment and military history: _____
_____

B. School Performance/Military Discharge _____
_____

C. Current and Last position held: _____

D. What are your interests in the areas of work or education? _____
_____

V. Legal

A. On Probation: _____ Probation Officer:_____

B. Pending Charges:_____

C. Legal History:_____
_____
_____
_____
_____

D. Were you under the influence of alcohol or drugs at the time you committed this offense(s)?
_____
_____
_____

E. How many crimes in your life were committed while under the influence of substances or in order to buy substances? _____
_____
_____

VI: Social System

A. Client's current family composition:_____

B. Current support/social relationship(s):

_____

_____

_____

C. Significant Relationship History:_____

_____

D. Are you involved with an ethnic/cultural or religious/spiritual community? _____

_____

E. Social/ Environmental/ Recreational/Hobbies/ Interests Needs:_____

_____

VII. Family History

Name or initials/ Ages	Type of relationship: Supportive or not/contact or not	Health Hx including mental health and addictive disorders
Parents:		
Grandparents:		
Extended Family:		
Siblings:		
Children:		
Family Relationships:		

Current significant relationship (Quality of relationship/Does partner struggle with mental health and/or addictive disorders?) _____

_____

VIII: Personal History

A. Developmental History

Where were you born and where did you grow up? _____

_____

Family composition, birth order: _____

_____

Divorces, separations, loss, deaths:_____

Family Strengths and/or weaknesses:_____

1. Childhood (Schools, friends, family, significant events):_____

_____

2. Adolescence (School, social events, family, friends, significant events)_____
_____
_____

3. Adulthood (Education, Vocation, Relationships, Marriage, children, significant events)
_____
_____

B. History of Trauma, Violence, Abuse, Neglect

Has anyone ever hurt you, tried to control you by threatening or tried to restrict your freedom? Yes _____ No _____

How?_____

Have you ever hurt anyone, damaged property, tried to control someone by threatening or restricting his or her freedom or thought about it? Yes _____ No_____

How?_____

Have you ever hurt yourself or thought about it? Yes _____ No_____

How?_____

Have you ever hurt or thought about hurting an animal? Yes _____ No _____

How?_____

Current concerns, thoughts, plans, intentions in any of the above? _____
_____

Have you ever witnessed a violent crime or tragic accident? Yes _____ No _____
_____

Have you ever been involved in an accident or been traumatized physically, emotionally or sexually? Yes_____ No_____
_____
_____

C. Functioning and Coping Patterns

Can you remember a time in your life when things were going well for you? _____
_____

What was going on at that time?
_____

What has changed?

_____

_____

D. Current Overall Functioning

Appetite: No change____ Decrease ____ Increase____ Other _____
Restricted ____ Binging/Purging ____

Weight: Stable ____ Increase ____ Decrease ____ Other _____

Elimination: No Change ____ Alteration _____

Alteration, explain:_____

Average # Sleep Hrs: [ ] ____ Trouble staying asleep ____Sleeping less

____ Sleep/Rest problems ____ Early Awake ____Sleeping more

____ Disturbed Sleep ____ Nightmares ____Uses sleep aids

____ Trouble Falling asleep ____ Night sweats Sleep aid: _____

Hygiene: Good _____ Poor _____ Changed _____

Energy:	Increased____	Decreased____	No Change____
Interest:	Increased____	Decreased____	No Change____
Sex:	Increased____	Decreased____	No Change____
Socialization:	Increased____	Decreased____	No Change____
Decision-Making:	Easy_____	Slowed_____	Change_____
Thinking:	Easy_____	Slowed_____	Change_____

E. Psychiatric/ Mental Health History

1. Have you ever received a mental health diagnosis in the past?

Describe: _____

Have you ever attempted suicide?_____

How many times? _____ How did you attempt? _____

Last attempt? _____ Has anyone you know ever attempted suicide? Y / N

Who?_____ When? _____

How?_____ Comments _____

2. What mental health services have you received? (Counseling, crisis services, hospitalizations, medications, friends, church) _____
_____

3. What Mental Health services were for you? _____

4. What part of the treatment was helpful? _____

5. Is there something you learned in treatment that helps you today? _____

_____

5. What was not helpful? _____

6. Do you find your symptoms are affected by the seasons? _____
_____

7. When was the first time you remember being impacted by your symptoms?
Please describe: _____
_____

F. Substance Abuse/Dependence

How has the use of cigarettes, alcohol or drugs affected how you handle things?_____
_____

What substance(s) have you or do you struggle with?_____

SUBSTANCE	Age of first use	Date of last use	Route of Admin	Pattern: How much/often?
Alcohol				
Heroin				
Methadone				
Other Opiates				
Barbiturates				
Other sed/hyp/tranq				
Cocaine				
Amphetamines				
Cannabis				
Hallucinogens				
Inhalants				
Caffeine				
Nicotine				
Other				

Have you experienced "black-outs" as a result of substance intoxication? ____Yes ____No

Have you experienced physical withdrawal from substances? ____Yes ____No

Have you experienced seizures during physical withdrawal? ____Yes ____No

Have you overdosed on drugs? ____Yes ____No

Have you attempted to cut down or cease use in the past? ____Yes ____No

Have others annoyed you when asking you about your drinking or substance use? ____Yes ____No

Have you ever felt guilty about your substance use? ____Yes ____No

Have you ever had an "eye-opener" or used first thing in the morning due to a hangover or withdrawal? ____Yes ____No

Have you ever been to detox? Where? How many times? _____

_____

How do you feel your substance use impacts your mental health?_____

_____

Are you or have you ever been involved in any current substance abuse treatment? (Outpatient, Residential, Intensive Outpatient, DSAT, Inpatient, Partial, DEEP) Where and when?

_____

_____

_____

Which treatment was most helpful?_____

What specifically was helpful and what do you still use as a tool of support?_____

_____

What was not helpful?_____

Describe your longest period of sobriety _____

_____

How did you stay sober?_____

Did you notice a difference in your mental health when you were using and when you were sober? What was the difference? _____

_____

How has your use and/or history of your use impacted your family and your relationships?

_____

_____

Have you ever been involved with a self-help/12-step program/Dual Recovery Anonymous? Was it helpful?

_____

Other Addictive Behaviors (gambling, sex, relationships, shopping, stealing, food, lying, violence, risky behaviors):

_____

Client's Self-Assessment:

Do you have a problem with alcohol or drugs interfering in your life?_____

Are you concerned about your substance use or addictive behaviors? _____

Do you have concerns that your mental health is impacting the quality of your life (depression, anxiety, anger, inability to focus)?_____

How confident are you about making changes in your drugs/alcohol use or in maintaining the changes you have already made? _____

How confident are you about making changes in your life to improve your mental health?

_____

Do you think changing your current level of drug or alcohol use is possible?

_____

Do you think it is possible to make changes to improve your mental health?

_____

How are you coping in your life today? (10 means the best you've ever been)

_____

Do you think you need to make changes? _____

What is your motivation for seeking assistance now? _____

_____

What do you think might happen if you don't change (consequences)?_____

_____

What do you think is the first step you can do to begin change in your life?

_____

IX. Mental Status

Appearance:

Stated age:_____ Younger____ Older_____ Appropriate____ Inappropriate____
Unkempt_____ Neat____ Disheveled____ Other_____

Behavior/Attention:

Cooperative ____ Sleepy/lethargic ____ Unremarkable ____ Passive ____ Guarded ____
Distracted ____ Suspicious ____ Restless/Agitated ____ Uncooperative ___ Hostile ___
Sober ___ Focused____ Withdrawn____ Bored____ Engaged____ Tearful___ Hyperactive ___
Defiant___ Oppositional___ Hostile___ Lethargic___ Anxious____ Able to follow directions___

Clothing: Appropriate _____ Inappropriate _____
Describe:_____

Eye Contact:

Good ___ Intermittent ____ Little ____ None _____

Motor Activity:

Avoids eye contact _____ Makes eye contact_____ Passive_____ Posturing _____
Restless _____ Responsive _____ Slowed_____ Spontaneous_____
Tics_____ Tremors_____ WNL_____ Other_____

Attention:

Alert/Attentive_____ Apathetic_____ Distracted____ Drowsy ____ Hyper-vigilant_____
Other_____

Describe:_____

Affect (observed):

Appropriate/Congruent _____ Full range _____ Blunted _____ Broad _____ Labile_____
Constricted_____ Flat_____ Grandiose_____ Inappropriate/Incongruent_____

Mood (by report):

Anxious ____ Dysphoric ____ Elevated____ Euphoric____ Euthymic (WNL)_____
Angry____ Agitated____ Sad___ Normal_____ Irritable ____

Speech (rate, flow, volume):

Difficult to interrupt _____ Hesitant____ Loud____ Pressured ____ Rambling_____
Rapid____ Slow____ Soft___ Slurred____ Normal____ WNL_____

Describe:_____

Stream of thought/Association:

Unremarkable _____ Logical _____ Blocking _____ Relevant _____
Flight of Ideas _____ Goal-Directed _____ Coherent _____ Circumstantial _____ Incoherent _____ Tangential _____ Evasive _____
Looseness of Assoc._____ Distraction _____

Thought Process (by report):

Obsessional _____ Projection ____ Ruminative____ Thought insertion ____
Other _____

Thought Content:

Appropriate ____ Bizarre Ideation ____ Delusional ____ Grandiose ____ Homicidal ____
Ideas of reference ____Depersonalization _____ Obsessive/Compulsiveness _____
Paranoid____ Poverty____ Somatic____ Suicidal____ WNL____ Other_____

Hallucinations/ Delusions:

Delusions: Somatic_____ Persecutory _____

Hallucinations: Auditory _____ Visual _____ Olfactory ____ Tactile ____
Other: _____

Intellectual Functioning:

Above Average ____ Average ____ Below Average _____
Learning-Disabled ____ Street Smart ____

X. Orientation

Confused ____ Disorientated ____ Person____ Place ____ Time____ Other____

Memory (by report):

Impaired-Recent ____ Impaired-Remote ____ Intact-Recent ____ Intact-Remote ____

Insight:

Absent ____ Externalizes____ Full____ Limited____ Internalizes____
Other_____

Judgment:

Fair ____ Good ____ Poor ____

XI. Summary of Services Needed

Housing ____ Legal ____ Trauma History ____ Financial Resources ____
Support System ____ Mental Health_____ Health Needs____ Family____
Substance Abuse ____ Co-occurring Services_____ Voc/Education ____
Personal ____ Crisis Support ____

Describe any unmet needs: _____
_____

XII. Summary of Clients Strengths and Barriers

Strengths:_____
Barriers:_____

Presenting Stage of Change: (for each problem)
Pre-contemplation Contemplation Preparation Action Maintenance Relapse

Client's motivation_____

Presenting Clinical Issues/ Problem list (What's important for client, interaction between substance use & mental health when applicable):

_____
_____
_____
_____
_____
_____
_____
_____

Clinical Formulation:

Assessment Summary by ASAM Dimension

Alcohol Intoxication and/or withdrawal potential	__Very high-risk	__High-risk	___Moderate risk	__Low
Biomedical conditions and complications	__Very high-risk	__High-risk	___Moderate risk	__Low
Emotional, behavioral conditions/complications	__Very high-risk	__High-risk	___Moderate risk	__Low
Readiness to change	__Very high-risk	__High-risk	___Moderate risk	__Low
Relapse, cont. use or cont. problem potential	__Very high-risk	__High-risk	___Moderate risk	__Low
Recovery Environment	__Very high-risk	__High-risk	___Moderate risk	__Low

Clinical Summary / Formulation
(Brief integration of assessment and next steps based on all info gathered):

_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Diagnosis:

AXIS I _____**by**_____

AXIS II _____**by**_____

AXIS III _____**by**_____

AXIS IV _____**by**_____

AXIS V _____**by**_____

Recommended Level of Care / Treatment recommendations / Time available / Plan Summary

_____
_____
_____
_____
_____
_____

_____ _____

Clinician **Credentials** **Date**

_____ _____

Supervisor **Credentials** **Date**

Annual Update: _____ _____
Clinician Date

Update Notes

_____
_____
_____
_____
_____
_____

_____ _____
Clinician **Credentials** **Date**

Agency: _____

Address: _____

Phone: _____

Sample Assessment #2

Client Name: _____ Date: _____

Clinician: _____

What is motivating you to come to treatment? _____

_____

_____

Tell me about the most recent time that things were going well for you. What were you doing? What was your substance use like? _____

_____

_____

_____

What was your emotional health like during that time? _____

_____

_____

Give me an idea of what has happened since then: _____

_____

What does substance use do for you? _____

_____

_____

What problems does it cause? _____

_____

_____

Are there any things you would like to change? _____

_____

Do you see any strengths that you have that will help you with your change? _____

_____

Problem:	Staying the same	Changing
Advantages		
Disadvantages		

Substance Use in the past 12 months

Please indicate use:	1,2,3	Specifics	Method of Administration	Amount	Age of first use	Age of Problem use	Last Use
Alcohol							
Marijuana							
Cocaine							
Amphetamine							
Sedative							
Hallucinogen							
Inhalant							
Opiate							
Rx Meds:							
Other:							
Comments:							

***Primary use in past 30 days?** ❑Once ❑2-3 days a month ❑once per week ❑2-3 days per week ❑4-6 days per week ❑daily
***Secondary use in past 30 days?** ❑Once ❑2-3 days a month ❑once per week ❑2-3 days per week ❑4-6 days per week ❑daily
***Tertiary use in the past 30 days?** ❑Once ❑2-3 days a month ❑once per week ❑2-3 days per week ❑4-6 days per week ❑daily

When did your problems with substances begin? _____

_____

***Indicate the reason for non use in the last 30 days:** ❑Incarcerated ❑Inpatient Tx ❑Other:_____
***Have you ever used IV?** ❑Y ❑N
*** If yes, indicate last IV use?** ❑ within the last 6 mos, ❑ within the last 5 yrs, ❑ 5+ years ago
***If you have used needles, have you shared them in the past year?** ❑ Y ❑ N

Trauma History

Have you ever experienced trauma or abuse? ❑ Y ❑ N ❑ physical ❑ emotional ❑ verbal ❑ sexual
Currently? ❑ Y ❑ N

Other Trauma:_____

***Have you ever experienced domestic violence?** ☐Y ☐N **Currently?** ☐Y ☐N **Describe:**_____

_____

***Have you ever initiated violence with a domestic partner?** ☐Y ☐N

Do you have a family history of mental illness? ☐Y ☐N **Describe:** _____

_____

Do you have a family history of substance abuse? ☐Y ☐N **Describe:** _____

_____

Do you have any people who provide you with support?_____

_____

Do you currently have a: ***(please list name, agency, address and phone number)***

☐ Psychiatrist: _____

☐ Therapist_____

☐ Case Manager_____

☐ Substance Abuse Counselor_____

Mental Health

Does the client have a history of Mental Health Diagnoses? ❑No ❑Yes

❑Depression ❑Anxiety ❑PTSD ❑Bipolar ❑Borderline Personality Disorder
❑ADHD ❑OCD ❑ Social Anxiety

❑Other:_____

❑Other:_____

Do you have an Individualized Support Plan (for "community support services")? ❑No ❑Yes If yes, status?_____

Do you wish to see any changes in your mental health? ❑No ❑Yes_____

_____

_____

Are you experiencing any symptoms currently? ❑No ❑Yes_____

_____

_____

How are they affecting your functioning?_____

_____

_____

Do you see your mental health and your substance use being connected? ❑No ❑Yes_____

_____

_____

What was your substance use like when you were diagnosed with MH? _____

_____

_____

Has the client had any Outpatient Mental Health Treatment in the past year? ❑No ❑Yes

What type:

❑ 1:1- Where:_____

❑ Psychiatrist visits- Where:_____

Risk Assessment-Suicide

Current SI

❑None (move on to HX of attempts)
❑Passive Thoughts
❑Active Thoughts
Duration:_____
Frequency:_____
❑Persistent
❑Obsessive

Are you able to control your suicidal thoughts? ❑ No ❑Yes
Has the ct made preparations for death? ❑ No ❑Yes
Are there command hallucinations present? ❑ No ❑Yes
History of Suicide Attempts ❑No (move onto Self Harm)
❑ Recent (past 12 mos)
❑ Method:_____
Was Medical Care Needed? ❑ No ❑Yes
❑Remote History (more than 12 mos ago)
❑None
❑Single Attempt:_____
❑Multiple Attempts:_____
Medical Care Needed? ❑No ❑Yes

Severity of attempts

❑Actions imply gestures v/s intent
❑Dangerous/ not lethal/ ct believed it was
❑Dangerous/ potentially lethal
❑Would have been lethal without intervention

Suicidal Intent

❑ None in the past 24 hours
❑ No intent but not able to contract for safety
❑ What is intent related to? Please describe in notes

Suicidal Plan

❑ No Concrete Plan
❑ Plan with no means
❑ Plan with Means:_____

Impulsivity

❑ No elevated risk factors present (move on to thoughts)
❑ Feels compelled or driven at times
❑ Cannot hold onto money
❑ Feels a loss of control at times
❑ Gets involved in fights
❑ Acts without reflections on consequences
❑ Has a "bad temper"
❑ Fired from a job
❑ Contact with law enforcement

Thoughts regarding the future

❑ Ct has faith in solutions/ resolution (move on to demographics)
❑ Ct is indifferent to the future, feels ambivalent
❑ Ct feels no hope for the future

Demographic risk factors

❑ None (move on to Self Harm)
❑ Lives alone ❑Widowed/ separated
❑ Native American

Self Harm (*i.e.*, cutting, burning, picking)

❑ No History (move on to deterrents if ct has indicated present or Hx of SI)
❑ Ideation
❑ Yes:_____

Deterrents to Suicide

❑ Loved ones:
❑ Spiritual Faith
❑ Hope for the Future
❑ Other:_____

*****Risk Potential:**

❑ Low/ No Elevation
- Ct denies current SI, no indicators are evident

❑ Moderate
- There is SI without Intent

❑ High
- Strong Ideation with Intent

Notes Box _____

Risk Assessment- Homicide

Does the client feel homicidal or violent currently? ❑No ❑Yes
(If no, answer only ** questions)
****Has the client ever physically attacked someone?** ❑No ❑Yes
❑Provocation
❑No Provocation
Was there serious Injury?
❑No
❑Yes
❑ stopped by a third party?
Has ct reportedly threatened to harm someone?
❑No
❑Yes- see comments
Has the ct threatened to harm someone in the presence of this interviewer?
❑No
❑Yes, see comments
Does ct Entertain thoughts of violence?
❑No
❑Yes, see comments
Does ct have access to weapons?
❑No
❑Yes, see comments
Has ct taken steps to secure means to harm someone?
❑No
❑Yes, see comments
Does the client report command hallucinations?
❑No
❑Yes, see comments
Mental Status concerns
❑Persecutory Delusions
❑Intense Jealousy
❑Ruminating
❑Reports Mounting Tension
❑Physical Outburst
❑Poor Impulse control related to aggression
Reckless use of a weapon?
❑No
❑Yes, see comments
Destruction of Property?
❑No
❑Yes, see comments
History of stalking or harassing others?
❑No
❑Yes, see comments
Thoughts about Violence:
❑Ego Dystonic- Uncomfortable with Violence
❑Ego Systonic- Considers violence a reasonable conflict resolution strategy
Risk Factors
❑History of Paranoid Schizophrenia
❑Recent ETOH or Drug abuse
❑Seizure Disorder
❑Quarreling with someone
❑Intense Jealousy
❑Habitual Rage Response
❑Childhood fire setting/ cruelty to animals
❑Violence in Family of origin

**Risk Potential for Violence

- ❑ **No elevations -** denies current violent or Homicidal Ideation, no indicators evident
- ❑ **Moderate -** Violent/Homicidal Ideation without intent
- ❑ **High -** Strong Ideation with intent
- ❑ **Emergency Situation** ❑No ❑Yes

Mental Status by Observation unless otherwise noted

APPEARANCE ❑Clean ❑Appropriate ❑Disheveled ❑Soiled ❑Malodorous ❑Other

MOTOR ACTIVITY ❑Normal ❑Slow ❑Restless ❑Abnormal Gait ❑Tardive Movements

SPEECH ❑Clear ❑Soft ❑Loud ❑Slowed ❑Slurred ❑Pressured ❑Rapid ❑Hyperverbal ❑Mute ❑Other:_____

BEHAVIOR ❑Cooperative ❑Agitated ❑Threatening ❑Restless ❑Withdrawn ❑Suspicious ❑Other

EYE CONTACT ❑Yes ❑No

AFFECT ❑Appropriate ❑Flat ❑Depressed ❑Sad ❑Angry ❑Afraid ❑Ashamed

MOOD BY REPORT ❑Depressed ❑Sad ❑Anxious ❑Angry ❑Afraid ❑Ashamed ❑Refused

THOUGHT PROCESS ❑Logical ❑Disorganized ❑Blocking ❑Loose ❑Concrete ❑Tangential ❑Racing ❑Confused ❑Flight of Ideas ❑Circumstantial ❑Paranoid:_____ ❑Grandiose:_____ ❑Delusional:_____

PERCEPTION ❑No distortion ❑Hallucinations: ❑Auditory ❑Visual ❑Tactile ❑Olfactory

CONSCIOUSNESS LEVEL ❑Normal ❑Vigilant ❑Lethargic ❑Stupor

CONCENTRATION ❑Normal ❑Moderate Impairment ❑Severe ❑Impairment

ORIENTATION ❑Normal ❑Abnormal to: Person Place Time

MEMORY ❑Intact ❑Impaired ❑Immediate ❑S-T ❑L-T

INTELLECTUAL FUNCTIONING
General Knowledge ❑Within Normal Limits ❑Abnormal ❑Unable to Assess
Receptive /Expressive Language ❑Within Normal Limits ❑Abnormal ❑Unable to Assess

JUDGEMENT ❑Intact ❑Impaired as evidenced by:_____
_____
_____

INSIGHT ❑good ❑average ❑minimal

NOTES BOX_____
_____
_____

CLINICAL SUMMARY

CURRENT Specific Psychosocial/Environmental Problems ASAM Dimensions 5 and 6, Axis IV
Please check all that apply:

Problems with Primary support group:
__Death of a family member
__Health problems in the family
__Disruption of family by separation, divorce, estrangement
__Removal from the home
__Sexual, emotional physical abuse
__Discord with Siblings
__Birth of a Sibling
__Acting out children
__Significant other substance abuser/ using partner or dealer
__Significant other threatened by recovery
__Absence of a positive primary social support system
__Threatened removal of a child by the state

Problems Related to the Social Environment
__Death or loss of a friend
__Inadequate social support
__Living alone
__Difficulty with acculturation
__Discrimination
__Adjustment to lifestyle transition
__Social support system made up of other users
__Absence of positive social support system
__Living with active addict or dealer
__Rampant drug use/ sale in neighborhood/work/school
__Pressure to use by others
__Employer not supportive of recovery
__Upcoming military deployment

Educational Problems
__Illiteracy, academic problems
__Discord with teachers, classmates
__Inadequate school environment
__Absence of High School Diploma or GED

Housing Problems
_Homeless
__Inadequate housing/Unsafe housing/ neighborhood
__Discord with neighbors or landlord
__Substance availability in housing
__Substance use rampant in housing
__Inadequate income for housing

Economic Problems
__Extreme poverty, inadequate finances
__Insufficient welfare support
__Dealing drugs is primary was to make money
__Money is owed to dealers
__Unable to acquire psych meds due to inadequate finances

Problems with access to healthcare services
__Inadequate healthcare services
__Transportation to healthcare unavailable
__Inadequate/absent healthcare insurance
__Recent loss of healthcare benefits

Occupational Problems
__Unemployment, threat of ob loss
__Stressful work schedule or difficult work conditions
__job dissatisfaction or conflict with boss or coworkers
__Job change
__Lack of vocational skills or lack of job opportunity
__Lack of experience acquiring/ maintaining employment
__Inadequate transportation
__Lack of childcare
__Job skills assoc w/substances
(bartenders, opiate addicts who are doctors)

Problems related to interaction with the legal system
__Arrest
__Incarceration
__Victim of a crime
__Upcoming trial
__Threat of incarceration for past crimes
__On probation/parole

Other Psychosocial/ Environmental problems
__Exposure to disasters, war
__Discord with non family caregiver such as physician, counselor
__Unavailability of social service agencies

Stages of Change:

Issue 1_____	❑Pre-contemplative	❑Contemplative	❑Preparation	❑Action	❑Maintenance
Issue 2_____	❑Pre-contemplative	❑Contemplative	❑Preparation	❑Action	❑Maintenance
Issue 3_____	❑Pre-contemplative	❑Contemplative	❑Preparation	❑Action	❑Maintenance

Multiaxial Assessment

CODE	DESCRIPTION
I.	_____
	_____
	_____
	_____
II.	_____
III.	_____
IV.	_____
	_____

***V. GAF:** _____

SUMMARY

LOC Recommendation: ❑OP group ❑OP 1:1 ❑IOP ❑Short Term Res ❑Long Term Res ❑Referred to a higher LOC

❑Other:

***Does client agree to above Recommendation?** ❑Yes ❑No

Where has client been referred for higher LOC?

Plan:

Staff Signature: **Date:**

Supervisor Signature: **Date:**

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Sample Assessment #3 (includes child-focused questions)

Physical Location of Appt: ☐ Sweetser Affiliate Office ☐ School ☐ Client's Home ☐ ER ☐ Jail ☐ Other:

Date of Assessment: **Time Spent:**

Age of Client at time of assessment (in years):

Data Sources (check all that apply):	**Present at Session:**
☐ Self	☐
☐ Parent	☐
☐ Guardian (if other than parent)	☐
☐ DHHS worker	☐
☐ Case Manager	☐
☐ Psychiatrist	☐
☐ Clinician	☐
☐ PO/JCCO	☐
☐ Primary Care Physician/Nurse	☐
☐ Records	
☐ Relative/Kin	☐
☐ Other :	☐
☐ Local Education Agency (LEA)	☐

Other / Remarks:

REASON FOR SEEKING SERVICE: (check all that apply):

☐ Substance Abuse	☐ Mental Health	☐ Co-Occurring Disorder
☐ Family difficulties	☐ Health concerns	☐ Relational difficulties
☐ Work difficulties	☐ School Difficulties	☐ Other

Briefly summarize reason for seeking services at this time: **(Mandatory)**

Is this affecting your life in any of the following areas? (check all that apply):

☐ Relationships with family	☐ Relationships with friends or peers	
☐ Home life	☐ School/Work	☐ Self Care
☐ Community	☐ Other:	

Briefly summarize how this is affecting client's life: **(Mandatory)**

Family/Friends perception of client's needs:
☐ N/A

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

LIVING SITUATION

Where are you currently residing:

- ☐ On own
- ☐ With parents
- ☐ Spouse / Partner
- ☐ With other relatives
- ☐ Friend's home
- ☐ Foster Care
- ☐ Jail (name of facility)
- ☐ Hospital (name of facility)
- ☐ Group Home (name facility)
- ☐ Homeless
- ☐ Other (identify where)

How long have you been residing there?

Other / Remarks:

What type of housing do you live in?

- ☐ Own house/apt
- ☐ Friends' house/apt
- ☐ Shelter
- ☐ Relatives' house/apt
- ☐ Other:

How long have you been residing there?

MENTAL HEALTH ISSUES

Anniversary of Significant Losses	Yes ☐	No ☐	Describe:
Depression:	Yes ☐	No ☐	Describe:
Anxiety:	Yes ☐	No ☐	Describe:
Mood Disorders:	Yes ☐	No ☐	Describe:
Psychosis:	Yes ☐	No ☐	Describe:
Suicidal Ideation:	Yes ☐	No ☐	Describe:
Self-Injurious Behavior:	Yes ☐	No ☐	Describe:
Suicide Attempts:	Yes ☐	No ☐	Describe:
Homicidal/Assaultive Ideation:	Yes ☐	No ☐	Describe:
Homicidal/Assaultive Behavior:	Yes ☐	No ☐	Describe:
Weapons used:	Yes ☐	No ☐	Type of weapon(s):
Other Mental Health Issues:	Yes ☐	No ☐	Remarks:

Current Diagnoses (as reported by client): Information not available: ☐

Past Diagnoses (as reported by client): Information not available: ☐

Comments/Other remarks:

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

TREATMENT / PLACEMENT HISTORY

Has the client received mental health or substance abuse treatment services in the past 3 years?
Yes ☐ No ☐ If yes, please complete the following:

Name of Agency	***Name of Clinician***	***Treatment Setting******	***Other / Remarks***	***Dates***	***Treatment Status******	***Reason***

*** Treatment Setting:

Community Based	Hospitalization – Medical	Intensive In-Home Services
Crisis Stabilization	Hospitalization – Psychiatric	Outpatient
Foster Care	Incarceration/Hold for Court	Peer Center
Substance Abuse	Other	Residential Placement

*** Treatment Status: Current Past

DEVELOPMENTAL HISTORY (Child only)

☐ Information not available. Please Explain:
Walking met w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
(12 mo. – walking w/assistance, by 18 mo. – walking alone)
Talking met w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
(12-15 mo. saying 2-3 words, 2 yrs. saying 2-3 word sentences…)
Toilet Training met w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
(3 yrs. – using toilet with help, by 4 yrs. – using toilet alone)
Cognitive Functioning w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
Did mother experience complications during pregnancy: Yes ☐ No ☐ Unknown ☐ If Yes:

Complications during labor and/or delivery: Yes ☐ No ☐ Unknown ☐ If Yes:

BEHAVIORAL HISTORY

Cruelty to Animals Yes ☐ No ☐ If Yes:
Fire-setting Yes ☐ No ☐ If Yes:
Physical aggression by child toward adult Yes ☐ No ☐ If Yes:
Physical aggression by adult toward child Yes ☐ No ☐ If Yes:
Physical aggression by child toward peers/siblings Yes ☐ No ☐ If Yes:
Property Destruction Yes ☐ No ☐ If Yes:
Running Away Yes ☐ No ☐ If Yes:
Verbally Abusive Yes ☐ No ☐ If Yes:
Use of Intimidation (bullying, posturing) Yes ☐ No ☐ If Yes:
Addictive behaviors other than substance abuse (gambling, sexual compulsivity, spending, etc.)
Yes ☐ No ☐ If Yes:

Client Name:	DOB:	Client No:
Clinician:	Provider No:	

TRAUMA HISTORY

Has the client experienced any abuse/violence (check all that apply):

- ☐ No self report of abuse/violence
- ☐ Community Violence
- ☐ Domestic Violence/Abuse
- ☐ Other
- ☐ Elder Abuse
- ☐ Emotional Abuse
- ☐ Physical Abuse
- ☐ Physical Neglect
- ☐ Sexual Abuse/Molestation
- ☐ Witness to Violence

If there is a Hx of trauma, is this causing difficulties in your life? Describe:
Other / Remarks:

SEXUAL HISTORY

Sexual Orientation (check all that apply):

- ☐ Asexual
- ☐ Bisexual
- ☐ Heterosexual
- ☐ Gay/Lesbian
- ☐ Questioning Sexuality
- ☐ Unknown
- ☐ Other:

Gender Identity:

- ☐ Female
- ☐ Transgender – male>female
- ☐ Inter-sexed
- ☐ Male
- ☐ Unknown
- ☐ Questioning gender identity
- ☐ Transgender – female>male
- ☐ Other:

Is your sexual orientation or gender identity causing difficulties in your life:
Other / Remarks:
Is the client exhibiting any of the following sexualized behaviors (check all that apply):

- ☐ Provocative Behaviors (sexualized dress)
- ☐ Prostitution
- ☐ Exposing Self
- ☐ Verbal abuse w/sexual overtones
- ☐ No reports of sexualized behaviors
- ☐ Promiscuous Behaviors
- ☐ Engaged in inappropriate online activity
- ☐ Masturbates in public or frequently
- ☐ Sexually coercive to others
- ☐ Other

If any of the above are checked, are these behaviors causing difficulties in your life:
Other / Remarks:

EDUCATIONAL HISTORY

☐ Information not available. Please Explain:
Highest grade completed:
Highest diploma or degree earned:
☐ HS Diploma ☐ GED ☐ Assoc. Degree ☐ Bachelor's Degree ☐ Master' Degree
☐ Doctorate ☐ Other: ☐ N/A
Describe your interests/strengths at school:
Participation in extracurricular activities (sports/clubs):
Awards/Merits/Recognitions:
Future educational goals:
History of receiving special education services: Yes ☐ No ☐ Remarks:
History of learning disabilities: Yes ☐ No ☐ Remarks:

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

School experiences: (check all that apply)

☐ Academic success ☐ Honor student ☐ No school problems
☐ Academic difficulties ☐ Attendance issues ☐ Dropped Out ☐ Truancy
☐ Suspensions/Expulsions ☐ Relational difficulties ☐ Retention (held back)
☐ Behavioral difficulties ☐ Transportation issues ☐ Other

Other / Remarks:

EMPLOYMENT HISTORY:

Are you currently employed: Yes ☐ No ☐
If Yes: Where and for how long:
Are you satisfied with your job: Yes ☐ No ☐
If no: Why not:
If No: Reason:
☐ Disabled ☐ Homemaker ☐ Retired ☐ Student
☐ Residing in an institution ☐ Other:
Other / Remarks:
Number of jobs in last 5 years:
Are you interested in being employed: Yes ☐ No ☐
Are you concerned about losing benefits: Yes ☐ No ☐
History of vocational rehabilitation involvement? Yes ☐ No ☐
History of vocational training involvement? Yes ☐ No ☐
History of Volunteer work? Yes ☐ No ☐
If Yes, where and for how long:
Comments on past/current skills/interest:
Military Service: Yes ☐ No ☐
If Yes: Current ☐ Past ☐
Branch:
☐ Navy ☐ Army ☐ Coast Guard ☐ Air Force ☐ Marines
Type of Discharge:
☐ Honorable ☐ General (under honorable conditions)
☐ Other than honorable ☐ Bad Conduct ☐ Dishonorable
Date of Discharge:

LEGAL HISTORY

Current legal involvement:
☐ None ☐ Charges Pending ☐ Conditional Release ☐ Detention
☐ Parole ☐ Probation ☐ Other
Other / Remarks:

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

History of legal charges: Yes ☐ No ☐
Legal description of last charge (*e.g.*, OUI, Breaking and Entering):
Date of last legal charge:
Convictions: Yes ☐ No ☐ Describe:
Incarcerations: Yes ☐ No ☐ Describe:
Child Protective Services Involvement: Yes ☐ No ☐
Past or Present:
Reason:
Child Support Enforcement Involvement: Yes ☐ No ☐ Describe:
Other current legal issues (divorce, custody issue) Yes ☐ No ☐ Describe:

SOCIAL INFORMATION

Participation in Meaningful Activities (Check/define all that apply):
☐ None Identified ☐ Religious/Spiritual ☐ Community ☐ Cultural/Ethnic
☐ Recreational ☐ Other
Other / Remarks:
Strengths/Capabilities:
Community Supports/Self Help Groups (check all that apply):
☐ AA ☐ NA ☐ Friend / Peer ☐ Neighbor ☐ Parent
☐ Provider ☐ Sibling ☐ Relative ☐ Other ☐ No community supports

Other / Remarks:
Limitations or challenges in client's life: (check all that apply):
☐ Cultural/Ethnic ☐ Financial ☐ Health ☐ Transportation ☐ Other
Other / Remarks:

HEALTH HISTORY

Information not available: ☐ Remarks:
Current & historical Medical issues:

History of Chronic Pain: Yes ☐ No ☐ Describe:
History of Head Injury: Yes ☐ No ☐ Describe:

Date of last physical exam: N/A:
Name of physician who completed last exam: N/A:
Address and phone number of Physician:
Date of last dental exam: N/A:
Name of dentist who completed last exam: N/A:
Healthcare services (medical & alternative) individual identifies as needed but unable to access:
None ☐
Identified Healthcare Services:

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Eating: ☐ Normal ☐ Healthy Diet ☐ Recent Decrease
☐ Weight Gain ☐ Weight Loss ☐ Recent Increase
☐ Pica ☐ Binging ☐ Anorexia
☐ Unusual Eating Habits

Sleeping Patterns:
☐ No Difficulty ☐ Disturbed ☐ Falling Asleep ☐ Staying Asleep
☐ Early Awakening ☐ Nightmares ☐ Uses Sleep Aides

Average hours of sleep per night:

MEDICATION HISTORY

Is the client currently taking any medication (prescribed or OTC) or supplements? Yes ☐ No ☐

Name of Medication	***Daily Dosage***	***Prescribing Physician***	***Medication Type******	***Purpose of Medication***	***Medication Status******	***Compliance******	***Adverse Reactions***	***Length Taken***

*** Medication Type:	None Over the Counter (OTC)	Herbal/Natural	Medical	Psychiatric
*** Medication Status:	Current	Past		
*** Compliance:	Yes	No	Sometimes	Unknown

If medication has been stopped or changed, what is/was the reason?

ALLERGIES

Is there any Medical, Food or Environmental Allergy history to report? Yes ☐ No ☐

Allergy	***Status******	***Treatment Needs***

*** Status: Past Present

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

SUBSTANCE USE/ABUSE

SUBSTANCE: Source of information: ☐Client report ☐Documentation ☐Other:_____

Please indicate use:	**Past**	**Present**	**Amount**	**Frequency**	**Age of first use**	**Last Use**
Caffeine	☐	☐				
Nicotine	☐	☐				
Alcohol	☐	☐				
Marijuana	☐	☐				
Cocaine	☐	☐				
Amphetamine	☐	☐				
Sedative	☐	☐				
Hallucinogen	☐	☐				
Inhalant	☐	☐				
Opiate	☐	☐				
Prescription meds	☐	☐				
Over-the-counter	☐	☐				
Other:	☐	☐				

- What is/was the client's primary substance of choice? _____
- What is/was the client's secondary substance of choice? _____

Comments:

Complete for each significant substance used as indicated above.

	Substance:		***Substance:***		***Substance:***		***Substance:***	
Indicators of Dependence	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Increased Tolerance	☐	☐	☐	☐	☐	☐	☐	☐
☐ Withdrawal Symptoms *(shakes, tremors, vomiting, severe anxiety or panic, intense craving, severe headaches)*	☐	☐	☐	☐	☐	☐	☐	☐
☐ Loss of control of amount	☐	☐	☐	☐	☐	☐	☐	☐
☐ Persistent desire/effort to reduce or control use	☐	☐	☐	☐	☐	☐	☐	☐
☐ Considerable time spent obtaining, using or recovering	☐	☐	☐	☐	☐	☐	☐	☐
☐ Reduced importance of significant activities	☐	☐	☐	☐	☐	☐	☐	☐
☐ Continued use in spite of problems caused by use.	☐	☐	☐	☐	☐	☐	☐	☐

Client Name:	DOB:	Client No:
Clinician:	Provider No:	

If three of the above indicators are not met, continue by assessing the following:

Indicators of Substance Abuse *(Only complete when the criteria for dependence have not been met)*	Current	Past	Current	Past	Current	Past	Current	Past
☐ Recurrent use in physically hazardous situations	☐	☐	☐	☐	☐	☐	☐	☐
☐ Recurrent substance-related legal problems	☐	☐	☐	☐	☐	☐	☐	☐
☐ Continued use despite persistent or recurrent social/ relationship problems	☐	☐	☐	☐	☐	☐	☐	☐
Comment on additional SA concerns:								

Has your use of drugs or alcohol interfered with
Work: Yes ☐ No ☐ School: Yes ☐ No ☐
Relationships: Yes ☐ No ☐ Other: Yes ☐ No ☐
Summarize how it interferes: **(Mandatory)**
Have you ever experienced any of the following:
Blackouts (times when you could not recall what happened while drinking or drugging):
Yes ☐ No ☐ If Yes when & how often:
Seizures: Yes ☐ No ☐ If Yes when & how often:
Has anyone ever asked you to stop drinking or using drugs? Yes ☐ No ☐
Have you ever received treatment for alcohol or drug abuse: Yes ☐ No ☐
(enter facility information on Treatment History page)
Have you ever tried to quit or decrease substance use? Yes ☐ No ☐
If yes, describe support received and barriers to recovery:

During relapse periods, describe what was happening with the client's relationships (spouse, partner, children, parents), work/school, money, mental health issues:
Family history of substance abuse? ☐ Yes ☐ No
If yes, describe (who & how did this affect you):

PATTERN OF CO-OCCURRING SUBSTANCE ABUSE AND MENTAL ISSUES:

Does the client think there is an interaction between his/her mental health issues and substance use?
☐Yes ☐ No ☐ NA If yes, describe:
If any criminal history, does the client feel that his/her mental health and/or substance use influence his/her criminal behavior?
☐Yes ☐ No ☐ NA If yes, describe:
Client Stage of Change: (For Co-occurring Disorders, complete both below)
MH Disorder: ☐Pre-contemplative ☐Contemplative ☐Preparation ☐Action ☐Maintenance
SA Disorder: ☐Pre-contemplative ☐Contemplative ☐Preparation ☐Action ☐Maintenance

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Client meets Level of Care:

☐ **Level I** Outpatient	☐ **Level II** IOP or Partial Hospitalization Program	☐ **Level III. 3, 5, 7** Clinically Managed or Medically Monitored Inpatient Tx or detox	☐ **Level IV** Medically Managed Inpatient Tx

Child Screening (under 12)

Do you wish that someone in your family would stop drinking beer or wine or using drugs? Yes ☐ No ☐
Do you ever worry about the ways that people in your family behave when they use alcohol or drugs? Yes ☐ No ☐
Have you ever taken a drink of beer or wine, or used a medicine or other pill or substance that made you feel different than normal? Yes ☐ No ☐
Have you ever taken medicine that didn't belong to you? Yes ☐ No ☐
Have you ever smoked a cigarette? Yes ☐ No ☐

FAMILY HISTORY

Pertinent family history:
Identify family activities/interests:
Describe your parenting methods: (supervision, discipline): ☐*N/A*
Identify family supports:

Other Family Concerns

Alcohol Abuse: Yes ☐ No ☐ If Yes, describe:
Drug Abuse: Yes ☐ No ☐ If Yes, describe:
Domestic Violence/Abuse: Yes ☐ No ☐ If Yes, describe:
Financial Concerns: Yes ☐ No ☐ If Yes, describe:
Legal Issues: Yes ☐ No ☐ If Yes, Who: What:
Military Service: Yes ☐ No ☐ If Yes, describe:
Mental Health Issues: Yes ☐ No ☐ If Yes, describe:
If Yes, were medications used to treat the illness:

Significant Losses: Yes ☐ No ☐ If Yes, describe:
Addictive behaviors other than substance abuse (gambling, sexual compulsivity, spending etc.)
Yes ☐ No ☐ If Yes, describe:
Trauma: Yes ☐ No ☐ If Yes, describe:
Health Concerns for Family Members:
Yes ☐ No ☐ If Yes: Who: What:

MENTAL STATUS

Orientation: ☐ x3 ☐ Not to Person ☐ Not to Place ☐ Not to Time

Dress: ☐ Appropriate ☐ Inappropriate ☐ Unkempt ☐ Other

Appearance: ☐ As Stated Age ☐ Younger ☐ Older ☐ Other

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Manner: ☐ Cooperative ☐ Uncooperative ☐ Guarded ☐ Agitated ☐ Withdrawn ☐ Combative ☐ Other

Attention: ☐ Attentive ☐ Distractible ☐ Confused ☐ Hyperactive ☐ Selective ☐ Short Attention Span ☐ Other

Eye Contact: ☐ Good ☐ Fair ☐ Poor

Speech: ☐ Slow ☐ Normal ☐ Rapid ☐ Pressured ☐ Mute/Absent ☐ Loud ☐ Mumbled ☐ Soft

Mood ☐ Happy ☐ High Energy ☐ Elated ☐ Stable ☐ Fearful ☐ Anxious ☐ Irritable ☐ Angry ☐ Hopeless ☐ Depressed ☐ Other ☐ Low Energy

Affect: ☐ Appropriate ☐ Inappropriate ☐ Restrictive ☐ Labile ☐ Blunted ☐ Flat ☐ Panic ☐ Anxious ☐ Fearful ☐ Congruent w/Mood ☐ Incongruent w/Mood

Motor / Activity Level: ☐ Age-appropriate ☐ Slow ☐ Passive ☐ Tics ☐ Restless ☐ Combative ☐ Silly ☐ Other

Dangerousness: ☐ Suicidal Ideation with ☐ Intent ☐ Plan ☐ Hx of Attempts
☐ Homicidal Ideation with ☐ Intent ☐ Plan ☐ Hx. of Assault
☐ Access to Intended Victim ☐ Yes ☐ No
☐ Access to Means (specify –guns, pills, etc.) ☐ Yes ☐ No
☐ Fire-setting ☐ Animal Abuse ☐ Cutting Behavior
☐ None

Further information regarding dangerousness:

Judgment: ☐ Age-Appropriate ☐ Impaired ☐ Impulsive

Apparent Intellectual Level: ☐ Age-Appropriate ☐ Possible Impairment

Memory: ☐ Intact ☐ Impaired ☐ Remote ☐ Recent

Insight: ☐ Age-Appropriate ☐ Partial ☐ Absent

Thought Content: ☐ Age-Appropriate ☐ Delusions (type)

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Thought Process:

☐ Normal ☐ Concrete ☐ Logical
☐ Relevant ☐ Goal-Directed ☐ Tangential
☐ Abstract ☐ Circumstantial ☐ Racing
☐ Looseness ☐ Impaired Concentration
☐ Paranoid ☐ Other

Impulse Control: ☐ Good ☐ Average ☐ Limited ☐ Poor

Perceptual Distortions: ☐ Denies
Delusions: ☐ Persecutory ☐ Grandiose ☐ Other
Hallucinations: ☐ Visual ☐ Auditory ☐ Tactile ☐ Olfactory ☐ Command

Service Recommendations:
☐ Outpatient Mental Health Treatment ☐ Outpatient Substance Abuse Treatment
☐ Outpatient Co-Occurring Disorders Treatment ☐ Outpatient Medication Management
☐ Referral to other agency: name agency & service recommended:

Potential Need for Crisis Intervention Services: ☐ High ☐ Medium ☐ Low
Describe:

SUMMARY:
Brief clinical formulations/summary to include the following: *(Presenting Problems, Presenting Symptoms, Functional Status, Potential Barriers to Treatment, Client's strengths and supports, Co-occurring issues, Treatment History and Statement of medical necessity/LOC for Recommendations):*

Sweetser Affiliate Program
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

DIAGNOSIS

Diagnosis: (Please use Comment area for any addition information on Dx)

Axis I	**DSM Code**	**Description**	**Severity**	**R/O**
				Yes No
				Yes No

Axis II	**DSM Code**	**Description**	**Severity**	**R/O**
				Yes No
				Yes No

Axis III ***Health concerns***	**ICD 9 Code** (if known)	**Description**	**Severity**	**Diagnosis given by:**

Axis IV	**Category**	**Specific area of difficulty**

Axis V	**GAF Score**	**Type**

_____ _____

Staff Signature & credentials Date

_____

Staff Name (Please Print)

APPENDIX 2

REFERENCES AND RESOURCES

REFERENCES

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Walker, J. S., Bruns, E. J., VanDenBerg, J. D., Rast, J., Osher, T. W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.
(Resource for definition of "strengths-based.")

RESOURCES

The Addiction Technology Transfer Center Network
www.ATTCnetwork.org

American Association of Community Psychiatrists
www.communitypsychiatry.org

The Co-occurring Collaborative Serving Maine (CCSME)
Lists many other co-occurring links and includes information on training and continuing education resources
www.ccsme.org

Drug and Alcohol Services Information System (DASIS)
National Survey of Substance Abuse Treatment Services
http://wwwdasis.samhsa.gov/dasis2/index.htm

Faces and Voices of Recovery
The National website of the recovery community
www.facesandvoicesofrecovery.org

Judge David L. Bazelon Center for Mental Health Law
http://www.bazelon.org/

Maine Department of Health and Human Services
Co-Occurring State Integration Initiative (COSII)
http://www.maine.gov/dhhs/cosii/index.shtml

Maine Department of Health and Human Services
Office of Adult Mental Health Recovery for ME Initiative
www.maine.gov/dhhs/mh/recovery/index.shtml

Many Roads to Recovery **– a publication of the COSII Consumer Input Committee**
http://www.maine.gov/dhhs/cosii/recovery.shtml

National Institute on Alcohol Abuse and Alcoholism
(National Institutes of Health)
www.NIAAA.nih.gov

The National Institute on Drug Abuse
(National Institutes of Health)
www.NIDA.nih.gov

National Institute of Mental Health (NIMH)
(National Institutes of Health)
www.NIMH.nih.gov

The National Survey on Drug Use and Alcohol (NSDUH)
Formerly the National Household Survey on Drug Abuse (NHSDA)
www.oas.samhsa.gov/nhsda.htm

NIATx
(Formerly Network for the Improvement of Addiction Treatment)
www.niatx.net

The United States Department of Health and Human Services, Substance Abuse & Mental Health Services Administration (SAMHSA)
www.samhsa.gov

The SAMHSA Co-occurring Center for Excellence
***Soon to become the* Co-occurring Disorders Initiative**
http://coce.samhsa.gov

Shery Mead's website
www.mentalhealthpeers.com

ZiaPartners – The website of Ken Minkoff & Chris Cline.
Contains many examples of forms, policies and co-occurring change projects
www.ziapartners.com

The following sites provide information about stages of recovery and relapse prevention:

The Addiction Web Site of Terence T. Gorski
www.tgorski.com

Gorski-CENAPS, Certified Relapse Prevention Specialists
www.cenaps.com

Gorski-CENAPS, Relapse Prevention Therapy Workbook
www.relapse.org