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CHANGING THE WORLD:

Establishing Guidelines for Scope of Practice for Addiction Counselors Treating Individuals with Co-occurring Psychiatric and Substance Disorders

The past several decades have witnessed increasing recognition of the high prevalence of individuals with co-occurring psychiatric and substance disorders (ICOPSD) presenting for treatment in both the mental health system and the substance disorder system. The emergence of this population relates to several major trends, including deinstitutionalization of individuals with severe and persistently disabling mental illnesses (e.g., schizophrenia), increased availability of more psychopathologically dangerous substances (e.g., methamphetamine, ecstasy), and increased recognition of the widespread prevalence of non-psychotic biologically based mental illnesses (e.g., depression, panic disorder, ADHD) in the general population, and even more so in populations of people with substance disorder.

Not surprisingly, ICOPSD represent a population that is experienced as “difficult to treat” by both mental health treaters and addiction treaters. For one thing, individuals with more than one problem are likely to “do worse” than people with only one problem, and in fact extensive research indicates that ICOPSD have poorer outcomes in multiple domains. Specifically, they are more likely to relapse and readmitted, treatment resistant and non-compliant, self-destructive and violent, medically involved, criminally involved, impoverished, homeless, traumatized, and victims or perpetrators of abuse. In addition, in systems of care with poor resources, ICOPSD are strikingly overrepresented among the highest utilizers of those resources; 70-85% of high cost clients in public or private systems are found to have co-occurring disorders. Furthermore, these high cost, poor outcome clients are generally experienced as “system misfits” at every level of the service system. At the systems level, they are individuals who dare to have more than one disorder in systems of care that are designed as if everyone had one disorder only or only one disorder at a time. At the program level, programs within those systems have been similarly designed, so that those of us who work with real people in real programs are constantly finding that we need to either contort our clients to fit our programs or contort our programs to fit our clients. Frequently, we find that program regulations and standards provide little guidance for providing successful treatment; it’s not so much that regulations may actually prevent dual diagnosis treatment – rather, the regulations are written as if there is no such thing, so that every intervention for a person with co-occurring disorder has to be invented outside of standard program structures. Consequently, at the clinical practice level, there are no routine policies for addiction counselors (or mental health counselors) to provide screening, assessment, treatment

planning, progress note documentation, and discharge planning for ICOPSD, nor is there clear guidance as to what the scope of practice for a singly licensed addiction counselor should be when he or she encounters such an individual in his or her daily work. Finally, at the clinician competency level, these individuals tend to be misfits related to our skills as clinicians, since most counselors have been trained in either mental health OR addiction, but not both, so that we encounter someone with a co-occurring disorder, we immediately experience a misfit between what they need and what we know.

To complicate the situation further, new epidemiologic data, utilizing more sensitive methodology for detecting psychiatric and substance disorders, has begun to make it dramatically clear that ICOPSD are much more common than we once thought. The Epidemiologic Catchment Area survey discovered, for example, that 62% of people with bipolar disorder and 55% of people with schizophrenia had a lifetime substance disorder (not including caffeine or nicotine). Conversely, the more recent National Comorbidity Survey found that 59.9% of individuals with substance disorder met lifetime criteria for any psychiatric disorder. As a consequence of this data, one principle has become abundantly clear:

Dual diagnosis is an expectation, not an exception.

The amazing thing about this principle is not so much that we are beginning to observe this in our clinical work, as more and more addicted individuals present requiring ongoing psychiatric medication, but that our whole system of care has been designed as if this principle is not true, guaranteeing that our efforts to help these individuals will be as difficult, costly, and inefficient as possible.

As a result, leadership in both the mental health system and the addiction system is slowly beginning to recognize that we will never address the magnitude of the problem of these high volume, high problem, high cost individuals by setting up a few isolated programs. Rather, we need interventions on the systems level to begin to mobilize all the resources of the system to be proactively designed to address comorbidity. This process of “integrated systems planning” does NOT involve merging or blending all the mental health and addiction funding into one indefinable lump: quite the contrary. Integrated systems planning preserves categorical funding streams that support the value of high quality addiction treatment and high quality mental health treatment. However, because dual diagnosis is an expectation, each single funding stream (whether via program contract or billable service code) is planned to promote attention to co-occurring disorders wherever that money is spent. Consequently, all programs become dual diagnosis programs, not in that they become dramatically different from what they already are, so much that each program is designed to meet formal criteria for dual diagnosis capability (DDC) for the ICOPSD already being seen in that setting, as part of its basic program design. In fact, the most recent version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC 2R), released in April, 2001, recommends that every addiction program be expected to meet DDC criteria. The same expectation has been applied to mental health programs, and in some states (e.g., Oregon) DDC criteria are being incorporated into state regulations. Further, DDC criteria for program design extend to clinical practice and clinician competency as well: DDC programs are expected to have specific procedures to support appropriate clinical practice

and measurable clinician competencies to address ICOPSD in that service setting. For example, a treatment plan for an individual with alcohol dependence and major depression in a standard addiction treatment program would be expected to list each diagnosis as a problem, with specific goals and objectives for each. The goal for an individual with reasonable stable major depression would be to develop skills to maintain stability of mood disorder while participating in addiction recovery efforts. Objectives would include maintaining medication compliance, learning skills for addressing medication issues in 12 step programs, and demonstrating techniques for managing mood symptoms without using alcohol.

Within the context of the changing world of dual diagnosis capable programs, many addiction counselors have expressed concerns that their roles and functions will be increasingly marginalized. This is emphatically not true. One of the key principles of successful treatment intervention for ICOPSD in all service settings is that good treatment derives from empathic, hopeful, integrated treatment relationships, in which a primary clinician or clinical team takes responsibility for helping the client to integrate treatment recommendations for multiple disorders in any treatment setting, rather than leaving the client to integrate these recommendations on his or her own. Within addiction treatment settings, addiction counselors are the most logical individuals to perform this service, particularly if they have access to mental health and psychiatric consultation to assist them in understanding mental health diagnoses and treatment recommendations. Many counselors are eager to expand their roles in this way, believing that good counselors already do this routinely as part of their jobs. However, there is concern that such activity might not be permissible under the scope of practice defined by state licensure authorities. As with most parts of the service system, state licensure regulations have been designed with little acknowledgement of the high prevalence of co-occurring disorders in addiction treatment settings. As a result, counselors have little guidance concerning their appropriate scope of practice should be with ICOPSD.

In the past year, as more and more systems have begun to address these issues at the systems level, clearer definition of appropriate scope of practice has begun to emerge. In New Mexico, for example, a statewide Co-occurring Disorders Service Enhancement Initiative (CDSEI) sponsored by the state Department of Health Behavioral Health Services Division (BHSD) included recommendations for licensed addiction counselors to assume a primary treatment role with ICOPSD in a variety of service settings. When licensure concerns were expressed, addiction counselors were encouraged by BHSD to help the state define for the licensure board (which had not previously considered this issue) what the appropriate scope of practice for singly licensed counselors should be. As a result of this effort, 16 separate items were identified as part of the expected scope of practice for addiction counselors, and a similar 16 items were identified for mental health counselors. The 16 items are listed below:

New Mexico
Co-Occurring Disorders Services Enhancement Initiative
Region 2 Behavioral Health Providers, Inc.

Appropriate Scope of Practice for LADACs

1. Demonstrate welcoming, empathic, hopeful attitudes, conveying a philosophy of dual recovery
2. Screen for presence of co-occurring disorders
3. Assess acute mental health risk (e.g., suicidality) and arrange appropriate intervention
4. Refer for mental health assessment or obtain existing recent assessment information
5. Be aware of mental health diagnosis and mental health treatment recommendations
6. Support mental illness medication compliance and treatment adherence
7. Identify and document stage of change for each disorder
8. For clients who are not motivated to change, engage in individual, group and/or system (family, court) strategies for motivational enhancement
9. For clients who are trying to change, review their activities to reduce use and provide suggestions for how to do better using relapse prevention techniques
10. Help client identify painful feelings and mental health symptoms and how to manage these without using
11. Help client advocate/educate with mental health providers regarding managing mental illness
12. Help client advocate/educate with mental health providers regarding his/her addictions and addiction treatments
13. Communicate and collaborate with mental health providers
14. Educate client regarding dealing with 12-step meetings (re: meds for example)
15. Demonstrate awareness of how mental illness interferes with learning substance abuse recovery skills and how to modify substance abuse interventions to simplify skill acquisition
16. Promote access to dual recovery meetings

NOT within scope of practice

- Advertise as a mental health counselor
- Establish or rescind a mental health diagnosis
- Provide psychotherapy for PTSD or other psychiatric disorders
- Prescribe or recommend medications for mental illness

This document has been subsequently brought to the licensure board by BHSD, and is currently in the process of being incorporated into existing licensure definitions.

This initiative in New Mexico has important implications for counselors in other states. As more and more systems of care begin to formally address co-occurring disorders, access to tools that define scope of practice for various categories of clinicians can help to more clearly define the role of those clinicians in providing appropriate treatment. By indicating clearly the contributions that can be made by addiction counselors, these tools help to guarantee counselors a valuable “place at the table” in the changing world.