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SCOPE OF PRACTICE GUIDELINES FOR REHABILITATION PROFESSIONALS WORKING WITH INDIVIDUALS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE DISORDERS.

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Overview

During the past several decades, it has been increasingly recognized that individuals with co-occurring mental health and substance disorders are a population associated with poorer outcomes and higher costs in multiple domains throughout the service delivery system. In addition, it has been further recognized that the prevalence of co-morbidity in any setting is sufficiently great that we have to consider dual diagnosis to be an expectation, not an exception, in just about every program. For individuals with severe and persistent mental illnesses who are often the recipients of psychiatric rehabilitation interventions, epidemiologic data indicate that approximately 50% of those individuals have a lifetime substance use disorder, and approximately 25-30% have a current disorder. Moreover, the more that we are addressing individuals with higher levels of acuity and instability, the higher the prevalence of co-morbidity is likely to be.

Given that these individuals represent a high need, high volume, and high cost population, one would think that they would have become a priority for system level attention. In fact, the opposite is more likely to be the case. These individuals are experienced as "misfits" at every level of the service system in both the US and Canada. At the system level, these are individuals who have dared 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. Programs are often similarly designed, so that those of us who work providing rehabilitation services to real people in real programs often might feel we have to contort our clients to fit our programs, or our programs to fit our clients. Finally, these individuals are often experienced as misfits at the level of the attitudes, skills, and scope of practice of all types of clinicians, including rehabilitation professionals, who may feel there is a mismatch between what the clients need and what they know or are trained to do.

Historically, therefore, individuals with co-occurring disorders have not been well served in mental health, substance abuse, or rehabilitation settings and systems. Efforts to "refer" these clients from rehabilitation settings to specialized co-occurring disorder programs or to parallel substance abuse counseling have been consistently challenged by the lack of additional resources to support "specialized care" for such a high volume population, the difficulties of co-ordinating parallel mental health rehabilitation and substance abuse services for complex clients, and the simple fact that clients in rehabilitation services may not choose to go anywhere else to receive care. Over time, it has been increasingly apparent that a much broader systems approach is required.

Furthermore, over the past several decades, there has been increasing research on the development of successful treatment approaches for individuals with co-occurring disorders. In the past decade, this research has progressed from only looking at special

programs, to beginning to explore the specific intervention strategies within special programs, in an effort to establish a range of research supported approaches that can be applied in all programs, by all clinicians, in an entire system of care. (Minkoff,1998, Mueser et al, 2003, CSAT, 2005).

Building on these findings, Minkoff (2000) and Minkoff & Cline (2004, 2005) have elaborated the Comprehensive, Continuous, Integrated System of Care approach for system design and transformation. Within this framework, all programs, and all clinicians (including rehabilitation specialists) become co-occurring disorder capable, meaning that the whole system is designed so that each component has an organized set of instructions to provide properly matched interventions to its existing case load of co-occurring clients, within the context of its existing mission and role. The service matching is defined by a set of evidence based principles of treatment (Minkoff & Cline, 2004) that are placed in the context of an integrated model of service delivery that has a common language and treatment philosophy that makes sense from the perspective of either mental health or addictions. Each principle is tied to specific intervention strategies that can be applied by any clinician with any population in any setting. Taken together, the principles organize a set of practice guidelines for assessment, treatment, rehabilitation, and psychopharmacology (posted at www.bhrm.org) Finally, the principles outline the job of each component program and clinician in the CCISC. This model has been applied to system development projects in over 35 states and 4 Canadian provinces.

The component clinical practices defined by the principles have great relevance for psychiatric rehabilitation practitioners. They emphasize a welcoming, person-centered, hopeful, and recovery-oriented perspective for complex individuals. They support the importance of accurate identification of strengths and problems in multiple life domains. Most importantly, they build on evidence based practice findings that define the ongoing treatment of individuals with co-occurring disorders within the context of empathic, hopeful, **integrated**, strength-based, community-based learning relationships, in which individuals with complex problems are assisted to identify hopeful goals, to work their way through stages of change in order to make better choices related to the achievement of these goals, and to incrementally develop and practice the skills they need (including disorder management skills for each disorder) to implement those choices in each and every life domain. (Mueser et al 2003, Roberts et al, 1999) This approach is very consistent with psychiatric rehabilitation philosophy, and emphasizes that the development of dual diagnosis capability within the field of psychiatric rehabilitation is philosophically consistent, mainly requiring the integration of existing rehabilitation approaches to incorporate attention to substance related choices, decisions, skills, and disorder management within the framework of existing psychiatric rehabilitation activities.

One issue that emerges rather quickly in attempting to implement this approach in an entire system of care, is that singly licensed and trained practitioners (whether addiciton counselors, mental health clinicians, or rehabilitation specialists) have never had any instruction regarding a legitimate scope of practice (within acceptable professional standards for each discipline) regarding the treatment of individuals with co-morbidity. Most licensure and certification boards never address this issue, or simply say

that a practitioner encountering a complex individual should “screen and refer”, which is counter to the evidence based practice of integrated care.

In order to address this issue, Minkoff and Cline have worked with focus groups of clinicians (originally in New Mexico in 2002) to identify and refine rational scopes of practice for working with individuals with co-occurring disorders for singly licensed mental health or substance abuse clincians who work in behavioral health settings.. Interestingly, the two scopes of practice generated by the separate focus groups of mental health and substance abuse clinicians were almost identical, mirror images of one another. The original documentation of two scopes, one for addiction counselors and one for licensed mental health clinicians, was reported in a Technical Assistance document prepared for SAMHSA (Cline & Minkoff, 2002). Subsequently, the specific scope of practice for addiction counselors was published in Counselor Magazine (Minkoff & Cline, 2003). Since that time, the scopes of practice have been adapted for use in a number of state and provincial systems in the US and Canada. The purpose of this article is to extend the original work to describe the co-occurring scope of practice for rehabilitation professionals (which also may be applied to mental health clinicians in general).

The elements of the scope of practice are as follows:

Psychiatric Rehabilitation Specialists (and other mental health clinicians) working with individuals with co-occurring substance use disorders can, and should, be able to do at least the following activities:

1. **Welcome the client into an empathic, hopeful, strength-based, and integrated relationship, with a vision of dual recovery.**
2. **Screen for the presence of co-morbidity, and arrange appropriate follow up evaluation and/or intervention for individuals who screen positively.**
3. **Identify acute risk issues related to substance use (intoxication, withdrawal, etc.) and know how to help the person remain or become safe.**
4. **Obtain an assessment of the co-occurring substance use disorder, and understand the content of the assessment and the recommendations.**
5. **Support adherence to these recommendations with the client.**
6. **Identify stage of change for each problem the client has.**
7. **Engage the client in individual and/or group motivational and/or educational intervention to facilitate making better choices regarding co-morbid substance use in relation to mental illness and to person centered goals.**
8. **Provide specific skills training to assist the client in managing substance use related difficulties. (e.g. Asking for help not to use)**
9. **Provide assistance with managing mental health symptoms or painful feelings without using substances.**
10. **Assist client to advocate with mental health and/or substance providers regarding his co-occurring related needs.**

11. **Collaborate with involved substance disorder providers to insure that the client receives an integrated message.**
12. **Modify skills training for substance use issues to accommodate the client's cognitive or psychiatric impairments.**
13. **Identify methods to reward incremental progress in decisions and skills regarding substance use.**
14. **Provide specific rehabilitation services (e.g vocational rehabilitation, Individualized Placement and Support (Bond et al, 2001)) to individuals with co-occurring disorders, as a means of engaging those who may still be using substances, and as a means of developing hope and capacity to achieve a stable functional outcome.**
15. **Educate the client regarding how to participate in addiction recovery programming, including the appropriateness of taking prescribed medication while participating in 12 step or other addiction recovery self help meetings.**
16. **Assist the client to utilize dual recovery self help meetings when they are appropriate and available.**

These sixteen elements are consistent with those prevously published, but include two newer items (13 and 14) as well. We recommend that rehabilitation programs (and other mental health programs) can use this scope of practice as a starting place to de-mystify what it means to be dual diagnosis capable, and to foster a discussion about this issue. The goal would not be to adopt this as is, but to involve practitioners in adapting the scope of practice to their own progam and practice. As this occurs, this facilitates movement of the whole program to achieve dual diagnosis capabilty within the context of CCISC, and defines a sense of dirction for evolving the roles and skills of psychiatric rehabilitation practitioners working with this complex population.

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