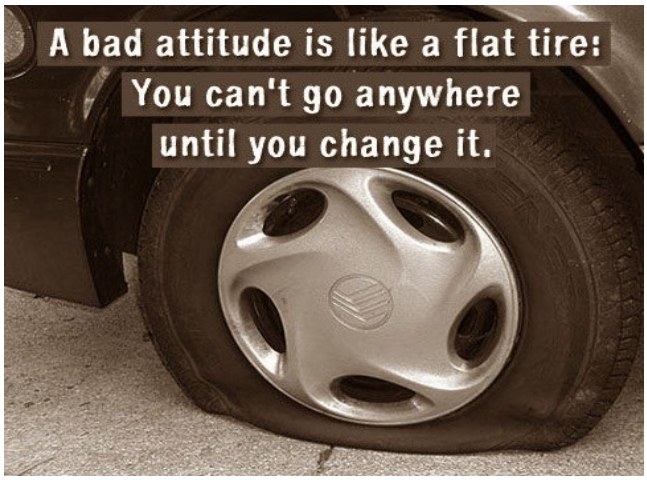
Integrating Coexisting Issues by Treating Substance Use and Mental Health Together

One of the biggest mistakes that could be made in either the substance use or mental health fields is to completely separate these two issues. Fortunately, there has been significant research and advancement with regard to the need to integrate the two fields of substance use and mental health. The interplay between mental health and substance use is such a critical part of the overall change process. Substance use affects mental health and mental health effects substance use in a variety of ways which can differ from person to person and situation to situation. Sometimes it is impossible to tell which issue is primary, while other times it may seem obvious which came first. Regardless, to ignore one issue while just focusing on the other would be the same as shifting weight from one side of a seesaw to another; As one side gets better, the other side, if ignored can get worse. Treating both mental health and substance use simultaneously therefore, is the best way to prevent this "see-saw" effect which can be an obstacle to progress. Treating mental health and substance use together, at the same time, in the same setting, is the basis of integrated treatment for co-occurring disorders and coexisting issues*.

(*If you have not done so already, click the following link to read "Intro to Coexisting Issues")

One of the most critical factors in determining the answer to the age old "*which came first, the chicken or the egg*" scenario with regard to mental health and substance use is *time*. For example, there are those people who get help for their substance use issues but also present with a coexisting mental health issue, and as they stop abusing substances, the mental health issue seems to go away as progress is made. In that scenario, if the mental health issue continues to be alleviated when progress is made with substance use goals over time then it is likely that substance use was the primary issue. The converse is true when an individual with both mental health and substance use issues seeks mental health treatment and then the use of substances consequently stops with time. In that case then mental health was clearly the primary issue. However, to assume that everyone will have similar results is merely wishful thinking as more often than not, when coexisting mental health and substance use issues are present, much more is involved. There was a past day when some substance use professionals maintained the commonly-held false belief that all mental health issues will improve as a direct result of sobriety over time, so then sobriety was erroneously seen as the only solution ever needed. The opposite mistaken viewpoint was often true in the mental health field in the past when some mental health professionals believed that substance use could be ignored by instead treating only underlying mental health issues which would then trigger a client to eventually stop abusing alcohol or other drugs as a direct result of improved mental health. However, more often than not, time is often not so kind to those who have coexisting substance use and mental health issues when just one side of the proverbial coin is treated while the other side is ignored. The interplay between mental health and substance use is often much more complex and inter-related and there

are many other potential scenarios and outcomes. To treat one issue and ignore the other in either direction could be likened to only changing the tires on one side of a car. Whichever side one chooses to focus on, eventually the car is going to get a flat tire and stop moving. Rather, treating the whole person over time is clearly a necessity



Again, when looking specifically at substance use treatment, there are those people who get help and make excellent progress with their substance use issues; however their coexisting mental health issues do not get better even after progress is made over time. In some cases, coexisting mental health issues can even get worse even after a period of abstinence from substances, especially if there was a degree of self-medication going on. In that case, removing the substance, even if it was being used, can trigger a spike in mental health symptoms because the substance was being used as a means to cope with the present mental health issues and symptoms. Abstinence alone is clearly is not enough in this common scenario. It is these individuals who will need more than just straight "substance use only" treatment. During this prevalent combination of circumstances, extra effort above and beyond just substance use treatment alone is needed. Mental health treatment must be included in the mix in a cooperative and complementary manner. Once again, integrated care for coexisting mental health and substance use issues is the most practical and effective way to approach these issues

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This dilemma involving the need for comprehensive mental health services in addition to substance use treatment has been a huge challenge in the substance use treatment world in the past. To be an effective substance use counselor, it is critical to have an additional array of skills and resources available for helping those with coexisting mental health issues. The outdated mentality of "just don't drink and go to meetings" is not nearly enough advice for most people who use substances, let alone someone who also is clinically depressed, or with severe anxiety, panic attacks, trauma, a mood disorder, psychotic or having any other significant mental health issue affecting their functioning. There is much more involved with regard to successfully managing the change process than simply just learning basic substance use management skills and tools. Managing and treating mental health is equally as important when both issues are present. The days of looking at substance use only in a vacuum, while ignoring mental health and hoping it gets better on its own should be long over by now. Integrated mental health/substance use treatment really is the only reasonable answer, however this requires a lot more from counselors and other treatment providers, which we shall discuss further

Integrating Mental Health and Substance Use:

We have established the fact that it is essential to work on both substance use issues and coexisting mental health issues both simultaneously and interactively due to their inter-related nature. How exactly to do that is another issue. There are many types of mental health issues, disorders and symptoms, and there are many types of treatment. Fortunately there has been a lot of progress made in this area of integrated treatment over the past two decades. (For more in-depth information and research on this topic produced by the United States Substance Use and Mental Health Services Administration, go to www.samhsa.gov and search "integrated treatment" as well as "co-occurring disorders". There are a lot of worthwhile free publications and reviewable research documents available for download regarding integrated treatment for co-occurring mental health and substance use disorders).

The following are some critical principles that guide the process of integrated substance use and mental health using the Escalator method:

Motivation and Insight - As stressed repeatedly in the Escalator model for substance use treatment, **motivation** and **insight** are the two most critical factors for successful progress as well for mental health issues. There are many effective methods and evidence-based skills and strategies we can share with our clients for coping with the vast array of coexisting mental health issues. Still, just like with substance use, all the best skills in the world are useless if the person who needs those skills does not have the insight to believe the skills are needed or if there is little or no motivation present to use them. Providing coping skills to someone with no motivation and insight would be like handing a plane ticket for a vacation to a person who doesn't want to go anywhere to a place he or she knows nothing about. Even with the free trip offer, that person is most likely not going to even get on the plane. Therefore, motivation and insight building remain the best starting points for mental health issues in addition to substance use concerns. A lot of the tools and suggestions in this publication and also on the www.takingtheescalator.com website, both can and should be used for mental health issues in addition to substance use. When it comes down to it, with all problems that are substance use and mental health related, it all starts with recognizing a need for help (insight) and then developing a desire to want to do something about changing for the better (motivation). These two critical factors, motivation and insight, are at the core of any issue that requires inspiration for positive change which truly encompasses the entire array of coexisting substance use and mental health issues. In summary, whatever aspects of mental health seem to be added to the mix when working with a substance abusing client, focusing on the role that insight and motivation play in the change

process for both mental health and substance use is equally as important and is at the foundation of the Escalator methodology.

To clarify, consider the common mental health issue of depression as an example. To instruct a clinically depressed client to just "think happy thoughts and everything will get better" would be the same as telling an addicted client to "Just stop using and you'll be fine" These simplistic responses illustrate the need to consider insight and motivation as outlined in the Escalator method. Again considering an individual with depression, it is essential to assess that individual's insight into his depression. This person may appear to be highly depressed to family, friends and everyone else who knows him but the client may tell you as their counselor that he does not even think he is depressed. In that case, working on insight would be indicated before moving forward. Similarly, if this client recognized that he was depressed but then told you, his counselor, that he had no desire to change anything about his life, then clearly working with him on motivation would be essential. No matter what the coexisting mental health issue or disorder involved may be, just as you have learned with substance use issues, always look at the problem through the pivotal lense of insight and motivation building for inspiration and positive change. Motivation and insight drive change for coexisting issues.

Introduce CBT when clients are ready - Once a client has the needed insight and motivation to really get started working on mental health issues some of the best methods for getting better are skills-based. Cognitive Behavioral Therapy (CBT) is an excellent way to address the skills needed for the change process as reviewed at the outset of this book. (If you need a refresher, go to the http://www.takingtheescalator.com/about site and again review "Cognitive Behavioral Therapy)

Therefore CBT is a fundamental aspect of the Escalator method particularly when there is a degree of insight and motivation present and an active readiness to change on behalf of our clients. In the last few decades there have been many new methods and techniques for treating a wide variety of mental health issues. However, when you break down the best and most practical, skill-building methods, they are commonly based on Cognitive Behavioral Therapy due to CBT's practicality and proven effectiveness with clients who are ready to change.

Therefore, depending upon the types of coexisting mental health issues and disorders that you may treating in your practice, it is important as a counselor to continually develop a wide understanding of various mental health coping skills for the population you serve. If you are less experienced and that prospect seems daunting or overwhelming, remember that the key to overcoming those feelings is to focus on *quality over quantity* when it comes to CBT skills for coexisting mental health issues. Consider anxiety as an example. If you are a newer counselor working with a lot of clients who say that they suffer from anxiety, rather than try to quickly learn everything there is to know about anxiety and get yourself confused and overwhelmed, instead focus on learning to firmly understand just a handful of practical anxiety coping skills that you can teach and practice with your clients. In this example, a counselor who can recite an entire textbook's worth of background information about anxiety is probably less useful to the anxious client than someone who can proficiently teach basic relaxation skills, positive self-talk, grounding, and cognitive reframing, as simple, teachable, and useable coping skills for the anxious client. In time your counseling skill set and "tool box" will grow for a variety of mental health issues, but to get started remember that it is not how much you know but how well you know it, so working on mastery of a few basic CBT skills can carry you a long way toward building momentum in your experience and expertise as a counselor working with coexisting issues in treatment. Also remember, whenever you learn a new skill well enough to teach it, you can use that skill in future counseling sessions repeatedly for the rest of your career.

Implement integrated substance use/mental health "Check-Ins" - If mental health and substance use are to be worked on and treated simultaneously in an integrated manner, then it is essential to "check-in" with both of these issues regularly with our clients. A check-in does not need to be long or elaborate, rather it can be brief and to the point. A good check-in is essentially a basic status report with regard to progress (or lack of progress) with both substance use and co-existing mental health issues and symptoms as well as any other relevant treatment, case management and safety concerns. Check-ins should occur at least once per week if not more, preferably at least once per session. It is usually best to do a check-in during the first part of a session when performing individual or group therapy. One error that some counselors make when doing check-ins is focusing on making check-ins too long. In a group for example, a check-in only needs to be about 5-10 minutes per person in a large group, give or take, depending upon the size and type of group. The primary reason for getting in the habit of doing check-ins in both group and individual therapy, especially earlier in session, is because check-ins are a way of making sure that all of the necessary treatment goals, progress measures, case management needs and risk factors are reviewed and addressed as needed. Doing a check-in early in session could be view similarly to the way a pilot does a "systems check" of his airplane's instruments before attempting to fly the plane. Most counselors have had the experience of what can often happen when we fail to remember to do a check-in for a session. The client may spend the entire session talking about other topics but then on occasion (often when you least expect it) close the session by telling you on his or her way out the door that he/she relapsed or is suicidal or had some other major situation occur. That type of information you want to do your best to review early in the session so it can be addressed while there is still time. Doing a check in early in session helps prevent the stressful situation of having to deal with a crisis with little time left. With adolescents, when family is present and participating in therapy it is a good practice to also check-in with the caregiver early in the session. Again, many counselors have had the experience of failing to check-in with an available parent about an adolescent followed by a session where the adolescent then states that everything is going great. Then, in this example, the parent may later tell you at the end of the session that something major happened during the past week, which the adolescent failed to mention, but it is again too late to address in depth due to time constraints. Therefore I always instruct counselors, new and old, to make early check-ins routine in your sessions. Elements of an

appropriate check-in can include a brief, non-confrontational survey of some of the following basic issues and points:

- As obvious as this may sound, always make sure to check in and *address the primary issue(s)* at hand which are driving the reason for the client being in treatment. This can play out slightly differently in an individual session when compared with a group therapy session. After some initial icebreaker engaging conversation in an individual session it is helpful to make it a habit to check in and ask "So how are you doing with your _____" (Fill in the blank with presenting problems that apply to the client such as "drug use", "depression", "housing situation" etc.) It is important to make sure not to go a whole session while forgetting to ask about the presenting problems. If a counselor is not careful, especially with a more talkative client, you can find yourself with 5 minutes left in a session not knowing how the client is doing with their main issues, if you forget to directly check in and ask. In a group session, it is good to get into the practice of asking each member to express "Why am I here". That simple question helps get each client talking about his or her presenting issues and as new members enter the group it is helpful for them to know why one another are present in the group. It is also helpful for each client to continually remember the reason why they are in treatment, regardless of whether or not that is externally or internally motivated. Finally, the way the client responds to explaining "Why am I here" can say a lot about his or her insight and motivation. For example, imagine if for weeks in a substance use group a particular client answers the "Why am I here?" question in group with a response such as "Probation is making me come here…" Then one day this same client responds in his check in by saying "The reason I am here is because I drink too much." That shift in the client's response can tell the counselor a lot about a potential positive shift in this client's insight an internal motivation levels as the reason for coming to treatment shifted from an external motivator (Probation) to a more insightful and internally motivated viewpoint, "….I drink too much". Any information gathered about insight and motivation is extremely valuable when using the Escalator method as this can help guide your interventions and approach going forward with the client.

- In a substance use group, check in and *review current level of substance use/use or abstinence.* Keep it brief and to the point, for example: "I drank once last week over the weekend, 10 beers at my cousin's graduation party but nothing the other 6 days" Or, if abstinent or partially abstinent, a *ballpark* figure can be provided "I haven't used anything in at least 6 weeks" or "I haven't used any heroin in 3 weeks but I am still smoking pot about 3 times a week, with my last use yesterday" Honestly is the best policy and should be encouraged, as opposed to clients feeling the need to lie just to sound better. The reason I suggest "ballpark" with regard to expressing clean time is because people who are not using should not be expected to count clean time unless they want to, just like no one should be forced to label themselves as a "addict" or "alcoholic" unless they choose too. To know the exact number of days for a client's last use in not necessary. Often when a client answers "I don't know" to the question about last use (which usually is a bad sign) a good way to follow up would be something like: "You don't know when the last time you used was? Can you at least tell me if you were to make a close guess about your last use, would you count it in Months? Weeks? or Days….or

even Hours? This sample follow up probe is a nonthreatening way toward ascertaining at least a ballpark figure of the client last use of substances

- *Review of current coexisting mental health issues*. When doing individual therapy, this should be based on one's specific mental health symptoms often characteristic of a specific disorder. For example for someone who has Bipolar Disorder it would be relevant to review mood swings, anger outbursts, level of depression and/or mania, sleep issues, etc. Or, for example, if someone was depressed, review how depressed they might have been, for example "How many days out of the past week did you feel depressed" or "On a scale of 1 to 10, how well have you been doing with your depression?" In a group setting it is important to facilitate an atmosphere where clients feel safe discussing their mental health concerns to the degree that they are willing and able too. In a group it is also important to be prepared that some clients will be more open about mental health than others due to issues such as stigma, cultural considerations, guilt/shame, insight/lack of insight, and other factors that may prohibit open expression about mental health. In a substance use group setting, clients may often be much more private and/or sensitive about their specific mental health issues Therefore, in a group where there are issues with comfort level and trust with regard to mental health functioning, a much broader and non-threatening check-in question such as: "So how are you doing since last session, how have you been feeling?" may be the closest you can get in a group with more guarded clients. As a counselor, it is important to learn the balance between carefully and tactfully probing a little when clients are guarded without pushing or prodding for information so as to make someone feel uncomfortable in the group.

- *Medication issues* (where applicable) Are you taking your meds for _____? (Mental health issue). Is the medication helping? Are you using medication assisted treatment for substance use? Are you getting it legally or on the street? Again, the way this may play out in a group is different than in an individual therapy session. When in a one to one session, asking directly about medication is essential. Depending upon the type of group, it is careful to be sensitive to clients' feelings about being on medication as well as the overall level of group cohesion, comfort and mutual acceptance. In a group that has not established a stronger level of trust, it may be better not to ask clients directly about medication in the group setting and reserve that as a private individual conversation. Still the main point is that it is important to check in and remain aware of your client's medication situation particularly when coexisting mental health issues are present. A counselor can get out of the habit of checking in and asking about medication and then find out when it is too late when a client unexpectedly tells you something like "I stopped taking my medication weeks ago!"

Many of the principles related to the change process for substance use can be used just as effectively with coexisting mental health issues. The value of good substance use treatment techniques can be overlooked by people who look at things strictly from a mental health perspective. Also, for clinicians coming from a substance use treatment background, the perspective when looking at substance use should always be broadened to include any coexisting mental health and other issues as well. Just for example, there is a lot of material available about setbacks and relapse in the substance use world. A lot of the same principles about what may influence setbacks and relapse are true for both substance

use and mental health. To illustrate, consider how environmental factors such as negative peers can trigger a substance use setback. The same way that encountering negative people can trigger a setback after a period of abstinence from substance use, encountering negative people can similarly trigger a depressive episode for a client recovering from depression. Therefore the skills needed for coping with setbacks used for substance use are often fully transferrable for addressing coexisting mental health issues with just a few slight modifications. This is true for a wide range of substance use and coexisting mental health issues and disorders. It is therefore important for counselors to learn to flexibly and cleverly use the skills and techniques known in both mental health and substance use treatment interchangeably across both disciplines.

Overall, it is important that when both substance use and mental health issues are present, both issues remain on the clinician's treatment radar throughout the entire change process. To do this, it is important to be able to utilize and creatively adapt various counseling tools reciprocally when addressing these coexisting issues. As we stated at the beginning of this book, attention to coexisting substance use and mental health issues is like an "umbrella" that covers over the entire treatment process. Integrated treatment for coexisting issues is a paradigm that counselors must adapt too in order to treat these interrelated issues efficiently and effectively. This section focused on primarily on mental health and substance use issues in treatment however the same principles discussed here are applicable for integrating all coexisting issues into the treatment of the whole person, (including for example, medical issues, employment, housing, family, etc.) Counselors need to be conscious of not limiting their treatment perspective to the "lens" of their specialty. Substance use specialists need to look beyond just substance use just as mental health experts should not have tunnel vision for mental health. Nor should medical professionals only look at physical health and medical symptomology. Our clients are best served when we assess, observe and provide care with an open mind to the full range of coexisting issues in our effort to treat each unique individual as a whole person and each family as a distinct entity. Therefore helping professionals from the full spectrum of disciplines (addiction, psychiatric, medical, case management, etc.) need to also be prepared to work together in a collaborative, cooperative and integrative manner. This is the future of client care.