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Professional Competence and Co-Occurring Disorders

By Robert B. Hordan, M.A., LCADC

There are multiple ethical issues that clinicians must navigate in the course of providing psychological and rehabilitative services. Such responsibility requires ongoing decision-making, process review, and adept clinical judgment. Moreover, adjunctive supervision and consultation promotes proficiency and clinical account-ability. Likewise, continuous critical self-evaluation helps identify professional strengths and liabilities and specific occupational competencies.

The process of professional maturation should result in the development of a clinical style and expertise based on "best practices" employed in the context of "guiding & organizational principles". For example, a therapist's professional attitude towards drug consumption in general and drug relapse in particular, can have a decisive affect on expectations and the course of treatment. Obviously, other more complex and difficult value-laden opinions and decisions will affect the overall efficacy of treatment. This article reviews a multitude of knowledge and skill-based issues.

Therapists are ethically bound to practice within their areas of competency and bear the professional responsibility to enhance their knowledge, skills and specialty in the course of treating their clients. These efforts should result in an integration of diverse skills. However, the degree and extent to which this responsibility is assumed or avoided is not easily measured. This issue becomes ever more complicated when providing rehabilitation counseling to persons with drug abuse and mental health co-occurring disorders (COD).

Many counseling decisions are based on past training, supervision, and traditional state-of–the-art approaches to clinical problems; however, there is an implicit obligation to become familiar with innovative techniques and scientific advances. As such, though some clinical decision-making may be summary and routine, a motivational and/or direct approach, as compared to classical client-centered techniques, is more often the rule when working with COD persons.

Professional Competence, continued on page 5

Ethical Decision-Making and Clinical Judgment

By Michael A. Gillette, Ph.D.

Providing professional counseling services to individuals with mental health and substance abuse co-occurring disorders (COD) can be challenging in a multitude of ways. Legal and clinical concerns are often complicated and co-mingled by the fact that persons with COD have varying degrees of general and specific capacities for making decisions on a variety of different types of personal issues. Some of these decisions are made based on personal needs, values and preferences that are in conflict with what may be considered good judgment.

For example, COD clients may indicate an interest in dealing with their mental health problems but refuse substance abuse services. Conversely, they may be willing to subject themselves to a strict regimen of substance abuse treatment services but refuse to accept any similar course of treatment for their mental illness. These tendencies to select treatment options "a-la-carte" can create significant ethical challenges for clinicians. This is especially true when clinicians recommend specific treatment options and/or advocate for mandatory interventions. However well intended, this form of recommended advocacy is "paternalistic intervention".

Ethical Decision-Making, continued p.2

INSIDE:

Ethical Decision-Making, continued from page 1

Paternalism can be defined as interfering with a client's liberty of choice and/or action but is clinically motivated for the client's own best interest or welfare. This dilemma is a recurrent scenario in the field of clinical ethics. Although we may restrict a person's liberty for a variety of reasons, paternalism applies only to those situations in which the intervention is justified on the basis of benefit to the client.

For example, we act paternalistically when we intervene to stop an incapacitated person from committing suicide, secondary to a mental illness, because we are acting for their benefit. While there are other scenarios that involve mixed motives, this article is concerned with the ethical justifications for paternalistic interventions.

The following case study offers several examples of issues related to paternalism:

Ms. X is a 65-year-old patient who carries an AXIS I diagnosis of delusional disorder. Reports indicate that she has lived in her mini-van for the past ten years. Ms. X showers at the YWCA, cooks on a camp stove, and while she does move the van from place to place, she parks at night in particular locations that are well light. Recently, Ms. X was committed to a mental health facility but is stable now and approaching discharge readiness. She indicates a desire to return to her mini-van but staff members are concerned that this placement might be unsafe. Ms. X suffers from fixed delusions that cause her to believe that the mini-van is her best placement option. An ethics consult was requested to determine the ethical implications of either supporting her choice to move back into her van or for a paternalistic intervention.

An intervention to prevent Ms. X from returning to her previous living situation would most likely be based on paternalistic reasoning. However, before we begin the process of evaluating the ethical implications of Ms. X's case, it would be useful to review the process by which clinical, ethical decisions are normally made and defended.

The method of practical, ethical decision-making involves a process of comparison and contrast between a given difficult case and non-controversial analogies. In other words, in order to determine the appropriate response to Ms. X's case, we should start by cataloguing our clinical experiences and recall situations where paternalistic intervention was acceptable or unacceptable.

By examining these previous cases, we will accomplish three important things. First, we will determine our "default assumptions" regarding paternalism. Second, we will identify the characteristics that determine the "limits of our default assumptions". And finally, we will examine the current case and the relative nature of the case along a continuum of ethical responses.

When it comes to paternalistic interventions, comparisons to known values and clear examples can yield ethical clarity. The moral conflict rests in the tension and differences between the values of "respect-for-autonomy" and "commitment-to-beneficence".

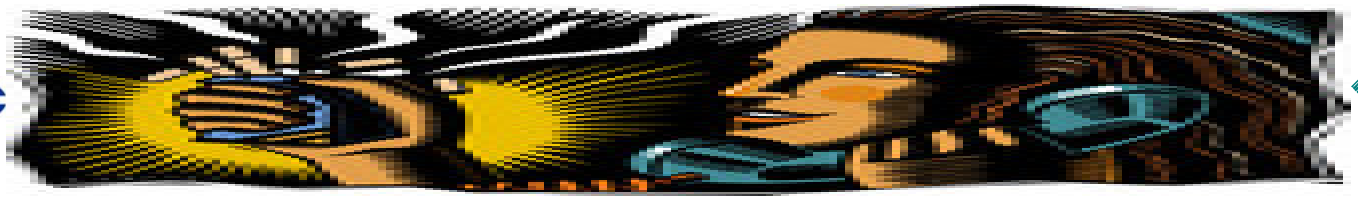
[...ethical decision-making involves a process of comparison and contrast between a given difficult case and non-controversial analogies.]

Our society places great emphasis on an individual's right to make self-directing decisions while, at the same time, helping those in need. Therefore, sometimes we can generate benevolent outcomes by restricting autonomy (suicide prevention); and sometimes we can demonstrate respect-for-autonomy by allowing people to make unsafe and unwise decisions (treatment refusal). Balancing these two basic values is a necessary skill in the clinical world of mental health services.

By examining a variety of different cases, some of which present ethically justified paternalism and some of which do not, we find that the moral issue can be reduced to four characteristics. Ethically justified paternalism requires all four characteristics, arranged in order of priority based on the strength of our moral intuitions. Paternalistic intervention is justified only when:

1. the client lacks capacity for autonomous choice regarding the relevant issue,
2. there is a clear indication for intervention,
3. the intervention is the least restrictive alternative that is reasonably available and meets the client's needs, and
4. benefits of the intervention outweigh the harms.

Ethical-Decision Making, continued on bottom of page 4



Nicotine Addiction and Co-Occurring Disorders

By Robert B. Hordan, M.A., LCADC

Persons with mental health & substance abuse co-occurring disorders (COD) are at greater risk for a variety of medical disorders (1). Some of these medical health problems are directly related to the consumption of alcohol and other drugs (AOD). One primary medical condition often associated with COD is caused by tobacco smoking behavior. Though there is significant recognition of the personal & social costs directly related to smoking behavior, there is limited commitment given to the development of tobacco cessation within COD integrated treatment.

The phenomenon of tobacco consumption has a historical, cultural and medical heritage. The addictive nature of nicotine is well established & the negative health consequences of tobacco use are well published. Despite a decades decrease in smoking behavior, over 60 million Americans currently use tobacco though it is well known that smoking tobacco has a debilitating effect on the physical health of most nicotine consumers. Tobacco smoking causes diseases to the circulatory & respiratory systems and is the single most important factor associated with premature and preventable deaths.

The medical profession is not fully trained to address addictive disorders in their various forms. Ironically, for some mental health providers, smoking tobacco is viewed as a psychologically pacifying drug and not a substance with serious imminent or residual behavioral consequences. attention.

[…nicotine maintains an implicit link in the chain of addiction with Alcohol and other Drugs.]

This is especially true in the context of COD services, whereas there are multiple other chronic disorders in need of immediate clinical attention.

As such, many clinics do not attempt to motivate or challenge clients about their continued use of tobacco. However, failure to provide harm-reduction services may implicitly undermine AOD related treatment objectives. For example, nicotine is a gateway drug intimately related and often used in conjunction with other drugs of abuse. Evidence shows that alcohol use is frequently associated with tobacco consumption and there is a high co-morbidity between alcohol & nicotine dependence as well as a shared genetic vulnerability. Therefore, continued smoking can act as a "cue" or "trigger" that contributes to relapsing behavior in that, for many poly-drug abusers, nicotine maintains an implicit link in the chain of addiction with AOD.

The psychopharmacological action of nicotine has a paradoxical effect on human behavior. Though nicotine is a short-term neuro-stimulant that acts on specific receptor sites in the brain, the behavioral outcome is experienced as a generalized sedating effect. During the last decade, manufactures have increased the nicotine delivery levels per cigarette. Further, tobacco smokers are exposed to over 4,000 other chemicals and the negative consequences associated with even the passive-inhalation of these chemicals cannot be minimized.

Similarly, marijuana smoke has carcinogenic properties and marijuana consumption is a cancer promoter.

Overall, the primary health concern & eventual outcome associated with continuous smoking behavior is chronic obstructive pulmonary disease (COPD). As compared to the general population, research shows that clients with mental illness have higher rates of smoking and an increased mortality from COPD (2). In an outpatient setting, 70% of adult methadone maintenance admissions reported smoking in the last 30-days; and when asked, 47% of these smokers requested tobacco cessation assistance (3).

During the last decade, there has been well-designed anti-smoking campaigns and health care legislation that significantly limit environmental exposure to tobacco smoke. New and specific cognitive and behavioral as well as pharmacological treatments are available. As such, smoking cessation programs abound, yet the difficulties associated with abstinence are well known (4). Mark Twain is credited with the saying: "Quittin' smokin' is easy, I've done it hundreds of times."

Interestingly, JCAHO standards acknowledge that an assessment of a client's history of tobacco use contributes to the development of a credible & integrated treatment plan. These JCAHO accreditation behavioral health standards suggest an educational, counseling and/or referral-based system to address this chemical addiction. Importantly, many of the cognitive-behavioral techniques of smoking cessation teach clients practical strategies for dealing with the cessation of AOD and other lifestyle management problems.

Nicotine Addiction, continued top of p. 4

Nicotine Addiction, continued from page 3

Some rehabilitation programs have embedded or referral-based tobacco cessation initiatives and policies in their clinical curricula with some significant success. However, without a definitive clinical agenda and means of advocating cessation treatment, the health problems associated with tobacco cannot receive adequate attention (5). The challenge associated with developing an integrated approach to nicotine addiction should be part of the professional commitment to providing "best practices" in rehabilitation services.

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Ethical-Decision Making, continued from page 2

The first (1) requirement is based on the fact that autonomous individuals have a right, all other things being equal, to maintain their freedom so long as they do not pose a threat to others. Our society is rife with examples of respected unwise decisions.

The second (2) requirement is based on the view that the burden of proof rests on the person seeking to restrict freedom. Freedom does not need justification; restriction of freedom does. Therefore, the person acting paternalistically must have an affirmative reason for doing so.

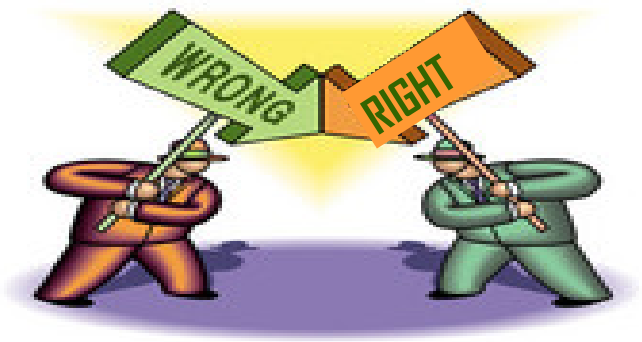
The third (3) requirement extends the second by recognizing that each incremental increase in the invasion of freedom will necessitate a correlative increase in justification. The least restrictive alternative that achieves the indicated goals is ethically safer than a needlessly restrictive alternative. And finally (4), even in cases where the first three requirements are met, our intervention must not do more harm than good.

Therefore, the question is: "Is it ethical to paternalistically intervene and restrict Ms. X from moving back to her mini-van?" The Answer is: a resounding, "It depends."

There may be known or pending circumstances in which great risk would accrue if Ms. X moved back into her mini-van as her permanent residence and, therefore, paternalism maybe ethically permissible.

There may also be instances where, even if Ms. X has diminished capacity, the risks associated with this placement are minor and paternalistic intervention is not justified. As such, as with all ethical questions in clinical cases, the answer will not be uniform across all circumstances and for all situations.

The true value of any ethical evaluation is in developing a process for analysis and not relying on foregone conclusions based on a pre-determined set of opinions or formula. This step-by-step process is the true theme behind all ethical decision-making.



Professional Competence, continued from Page 1

The goals of psychological treatment should be in the best interest of the client. Most important is that clients assume ownership for their problems and related disorders. This propriety applies to the client as well as the treatment provider, though the treatment provider assumes a greater responsibility for promoting specific recommendations and interventions. These treatment provider responsibilities are proportionate and complementary to the professional skills and competency of each treatment provider, whereas a lack of knowledge and skills can have serious unattended consequences.

The professional responsibilities of providing COD services are compounding. This is in part due to the complexities and progressive nature of these disorders that have predictable and unpredictable outcomes. The Medical Model acknowledges the chronic and progressive disease-like consequences of these disorders; however, the Mental Health Recovery Model accounts for many of the primary psychological factors that affect the nature and outcome of these multi-dimensional disorders. Also, life-span developmental principles looms large in the field of COD because of the early-onset and persistent symptoms associated with many drug abuse and mental disorders. Familiarity with these principles and models help us clinically conceptualize and offer context to the client's mental status, diagnosis, and stage of recovery.

Many COD persons have extended histories of addictions, distress, dependences and related brain-behavior dysfunctions. Therefore, comprehensive assessments and continuing, periodic, qualitative reassessments are recommended.

Failure to assess for the vicissitudes of post-traumatic stress, compulsions, impulse control and chronic medical conditions undermines the quality of these clinical reviews.

A life-style assessment that questions the client's reasoning behind their expressed ideas and behavior often reveals serviceable information. As such, a clinician's (sub) cultural competencies will play a significant role in understanding and effectuating any lifestyle and therapeutic changes.

[…responsibilities are proportionate and complementary to the professional skills and competency of each treatment provider.]

Familiarity with the clinical manifestations of various medical aliments such as HIV, Hepatitis B & C, hypertension and diabetes is a requirement; and knowledge about psychopharmacological medications and the ability to monitor drug interactions, side effects and the efficacy of these interventions is critical. Regarding these and other psychophysiological conditions, the status and course of the disorders and treatments need to be monitored and not ignored.

The assessment of danger-to-self and/or others is ubiquitous and requires a review of the client's personal competencies. Dangerousness can result from either intentional or accidental behavior as well as a variety of self-harm tendencies. This is particularly true with regard to drug consumption and other related high-risk behaviors while under-the-influence. Repeated intoxication can result in mental and physical impairments that are transitory or result in chronic incompetence.

Since drug consumption and relapse should always be suspect, this is a continuous responsibility.

The "right-to-treatment-on-demand" and the "right-to-refuse-treatment" are important factors that create context and expectations in negotiating workable treatment plans. However, due to their disabilities and impairments, many clients may not know what is in the their own best interests. Further, the cost and benefits of professional consultation, pharmacological intervention, behavioral techniques and other rehabilitative practices should be evaluated against the informed consent and the willingness of each individual client to participate in these methods.

The success of coerced treatment has also been studied in the context of criminal justice and judicial interventions. Research has shown that many outcomes for mandated treatment are similar to the results of voluntary drug abuse & mental health treatment. This suggests that the mandated client may "acquire" a readiness-to-change that is characteristically similar to clients' who are intrinsically motivated. Most "treatment drug courts" promote an opportunity-for-rehabilitation that encourages compliance and attempts to foster a non-adversarial relationship. As such, psychological services associated with compulsory treatment are legitimate, humanistic and sanctioned as ethical. In practical terms, there are lessons-to-be-learned from such direct interventions.

A critical factor in gauging effectiveness of treatment is the timeliness of the interventions.

Professional Competence, continued p. 6

Professional Competence, continued from page 5

Delayed or postponing services can have unforeseen and confounding consequences and represent neglect or protracted negligence. Since COD persons often require multiple, integrated types of services that need to be introduced in a parallel and/or sequential fashion, many interventions have time-sensitive objectives. As such, establishing time-tables for these initiatives is critical and basic to a well-constructed treatment plan. Importantly, COD treatment planning should be based on empirical research as compared to outdated strategies, pseudo-science and myths about treatment and the recovery process.

The principle of "harm-reduction" suggests that a therapeutic approach that reduces or diminishes rather that resolves drug or mental health problems is sufficient. Similarly, the promotion of Moderation Management versus Abstinence-based Anonymous groups is also controversial. Harm-reduction techniques can empower a client by establishing a succession of events that shows incremental changes in experience and behavior. However, such permissive strategies can also undermine long-term rehabilitation goals.

The ability to make referrals and advocate a net-work of services is an additional specialty skill.

This requires an ability effectively maintain an ongoing dialogue with a multidisciplinary team and appreciate the measure of other specialties. This is especially true when treating co-morbid medical and psychiatric conditions, whereas, the diagnosis of neuro-psychiatric impairments necessitates an inter-disciplinary approach. In fact, collaboration across disciplines is the basis to providing effective integrated treatment services.

In addition to "knowledge and skills", the professional "attitudes and values" of the clinician towards many of the above issues are important factors that defines competence. Collectively, these factors contribute to the attainment of basic, intermediate or advanced clinical competencies in the specialty of COD. The integration, mastery and refinement of these practices define "clinical competency", and is best achieved by means of an extended commitment to professional development and merited clinical practice.

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To become a member of the Co-Occurring Disorders Committee, please contact Tiffany Kelsey at (703) 228-5216.
To submit articles, resources, or other information on co-occurring disorders, please contact Robert B. Hordan at (301) 883-3505.

Metropolitan Washington Council of Governments
777 North Capitol Street, NE, Suite 200
Washington, DC 20002
www.mwcog.org/hspps

Tiffany Kelsey, Arlington County, ***Committee Chair***
Robert B. Hordan, Prince Georges County, ***Writer & Editor***
Lauren Udwari, ***COG Staff***