Co-Occurring Disorders
Substance Use Disorders and Mental Illnesses

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NAMI Minnesota champions justice, dignity, and respect for all people affected by mental illnesses. Through education, support, and advocacy we strive to effect positive changes in the mental health system, and increase the public and professional understanding of mental illnesses.
# CO-OCCURRING DISORDERS

Substance Use Disorders and Mental Illnesses

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INTRODUCTION

Substance use disorders (SUD) negatively affect a person’s ability to work, go to school, and have good relationships with friends and family. While it impacts about 7.8 percent of the general population, (SAMSHA, 2018) it is even more common among people who have a mental illness. In fact, almost half of people living with a mental illness also have an addiction to drugs or alcohol. Among some groups, such as young people, the number of individuals with both a substance use disorder and mental illness is even higher.

When someone is living with a substance use disorder and mental illness at the same time, these are called co-occurring disorders. Other terms include comorbidity and dual diagnosis.

People experiencing co-occurring disorders have unique needs. Research and practice have shown that an “integrated” approach to care and treatment is best for individuals with co-occurring disorders. This means that the co-occurring disorders are treated at the same time instead of separately.

Unfortunately, fewer than 10 percent of adults with co-occurring disorders receive treatment for both conditions. Almost half receive no treatment at all for either condition (SAMHSA, 2018). Disparities due to discrimination and the lack of access to treatment contribute to higher rates of co-occurring disorders among diverse populations. Coping with mental illnesses by using substances is a common behavior, and careful culturally informed and responsive approaches to interventions should be taken (SAMHSA, TIP 59).

Currently, there are limited resources available to help individuals and their families understand co-occurring disorders or learn about effective treatments. NAMI Minnesota often hears from families that they didn’t know the signs of substance use for their loved ones with a mental illness.

In addition, families want to know how to support their loved one in recovery and how to find the best treatment programs here in Minnesota. For example, in a recent survey conducted by NAMI Minnesota, respondents reported that they had trouble finding the right type of care for a loved one with co-occurring disorders. In part, this is because there is a disconnect between substance use treatment systems and mental health systems. The systems can be difficult to navigate, challenging to coordinate care, and often don’t speak the same language.
This booklet is designed to help individuals and families navigate these and other barriers to find the best care. This booklet will help you:

- Learn the terminology of substance use and co-occurring disorders
- Identify common symptoms of substance use disorders
- Understand the basics around treatment and recovery
- Find and evaluate appropriate treatment options in Minnesota
- Connect to additional resources

Ultimately, we hope that this booklet will improve access to care for individuals with co-occurring disorders by empowering families to better recognize the symptoms of substance use disorder in loved ones with a mental illness and advocate for effective treatment.

**CO-OCCURRING SUBSTANCE USE DISORDERS AND MENTAL ILLNESSES**

**Defining Mental Illnesses and Substance Use Disorders**

Mental illnesses are generally thought of as changes in thinking, mood, and/or behaviors. In the DSM-5, which is the handbook that mental health professionals use to make diagnoses, a mental disorder is defined as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.”

Substance use disorders are considered a mental illness. Like other mental illnesses, it is listed in the DSM-5. The definition of substance use disorders in the DSM-5 is very specific and is provided below. A diagnosis can also identify the specific substance that the individual is using, for example alcohol use disorder, but the criteria will be very similar.

**DEFINITION OF SUBSTANCE USE DISORDER:** A problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following symptoms occurring in a 12-month period:
Substance is often taken in larger amounts or over a longer period of time than was intended
- Persistent desire or unsuccessful efforts to cut down or control substance use
- Great deal of time is spent in activities necessary to obtain the substance, or recover from its effects
- Craving or strong desire to use the substance
- Recurrent use resulting in failure to fulfill major role obligations at work, school, or home
- Continues substance use despite having persistent or recurrent social or interpersonal problems
- Important social, occupational, or recreational activities are given up or reduced because of substance use
- Recurrent substance use in situations that are physically hazardous
- Substance use is continued despite knowledge of a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - A markedly diminished effect with continued use of the same amount of the substance
- Withdrawal, as manifested by either of the following:
  - Characteristic withdrawal syndrome for the substance
  - Use of the substance or closely related substance is taken to relieve or avoid withdrawal

These disorders have commonly been referred to as addiction, alcoholism, chemical dependency, and substance abuse. All of these disorders have different levels of severity.

The National Institute on Drug Abuse defines addiction as “a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences. The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge an addicted person’s self-control and interfere with their ability to resist intense urges to take drugs. These brain changes can be persistent, which is why drug addiction is considered a “relapsing” disease—people in recovery from drug use disorders are at increased risk for returning to drug use even after years of not taking the drug.”

We don’t know all the reasons that people develop a mental illness and/or substance use disorder, but we do know that biology, genetics, environment (high stress, peer pressure, physical and sexual abuse,
early exposure to drugs, poverty), and the stage of brain development play a significant role.

The Relationship Between Mental Illnesses and Substance Use Disorders

Almost half of people living with a mental illness have a co-occurring substance use disorder. That number is far higher than for the general population. Researchers are working to uncover the links between substance use disorder and mental illnesses. Understanding this link is an important key to developing more effective treatments for both substance use disorders and mental illnesses.

Most research right now supports the idea that there is something shared in common between substance use disorders and mental illnesses that leads to the high levels of co-occurrence. This idea of something shared is known as a “common factor.” Here are two possibilities of the common factor:

**OVERLAPPING GENETIC VULNERABILITIES:** Some people’s genes make them more vulnerable to both substance use disorders and mental illnesses or once one appears, they become more vulnerable to the next. For example, some people are born with genes that make them more likely to develop depression and those same genes might make them more likely to develop a substance use disorder.

**OVERLAPPING ENVIRONMENTAL TRIGGERS:** Early exposure to adverse childhood experiences, stress, and trauma (for example, experiencing a natural disaster, witnessing domestic violence, experiencing abuse or neglect, or experiencing neighborhood violence) have been shown to contribute to the development of mental illnesses and substance use disorders. Some groups, like military veterans, may be at an increased risk for co-occurring disorders given high rates of trauma.

It is a common belief that substance use disorders can develop when people “self-medicate” by using drugs or alcohol to mask an underlying mental health condition. For example, using alcohol to help combat insomnia, which is a common symptom in depression. However, there is little scientific evidence to support this cause and effect model. This is important because it affects how substance use disorders are diagnosed in people with mental illnesses and how to design the most effective treatment. For example, an individual with co-occurring disorders may report using alcohol to help cope with insomnia related to depression. If a provider believes that depression causes alcohol use disorder, they might suggest that treating the depression should cure the alcohol use disorder.
disorder. This is not best practice in treating co-occurring disorders. Instead, treatment should include a plan that targets both the alcohol use disorder and depression.

Another common belief is that substance use can cause or trigger the development of mental illnesses. For example, someone might think that a “bad trip” can lead to the development of schizophrenia or that drug use in teenage years caused the development of another mental illness in your twenties. When substance use causes symptoms that are similar to other mental illnesses but were not observed before the substance use began and stop after substance use ends, this is called a substance-induced disorder.

Additionally, substance intoxication and withdrawal can sometimes produce symptoms that are similar to other mental health diagnoses, but these symptoms are generally short term and will respond to treatment differently than independent co-occurring mental illness. For some people with co-occurring disorders, there are already signs of an existing diagnosis when the substance use disorders develop.

Some drugs are so powerful that they can cause symptoms of a mental illness and trigger the development of a mental illness, such as cannabis-induced psychosis. People who have a family history of serious mental illnesses may find that the use of substances triggers the development of a mental illness.

The differences in how these illnesses respond to treatment is an important reason why researchers and the authors of the DSM-5 have chosen to distinguish between co-occurring disorders, substance-induced disorders, intoxication, and withdrawal. Differential diagnosis is the process of determining which diagnosis (or diagnoses) is most appropriate for an individual given their symptoms at a given moment in time. A good assessment, performed by a professional who has experience with co-occurring disorders, is vital to untangle the timeline of symptoms related to both substance use and mental health diagnoses.

The Language of Substance Use Disorders

The language that we use to talk about substance use disorders has changed over time. This is because the science of the brain, body, behavior, and substance use disorders has shown us that substance use disorders are an illness. Language that frames substance use disorders and other addictive disorders as bad habits, moral failing, weakness, or a spiritual/religious sin can place blame on individuals managing a
medical condition, contribute to negative attitudes and misunderstandings, and ultimately interfere with accessing needed treatment.

Addiction medicine is a relatively new field. There is, currently, no agreement in the greater substance use disorder field about how and why these disorders develop, how to treat them (including medication assisted treatment), and the impact of resiliency and protective factors.

By choosing to use more up-to-date language, we show support and respect to those affected by substance use disorders and spread a more accurate message. Here, we provide basic definitions of the most up-to-date language used to talk about substance use disorders. Many of these definitions come directly from the National Institute on Drug Abuse, and their online glossary of terms and from FamilyRX. We also share some of the other terms that you might hear used to talk about the same concepts.

**ABSTINENCE:** Not using drugs or alcohol. This does not include prescribed psychotropic medications. **OTHER TERMS:** Sober, substance free, clean.

**ADDICTION:** A chronic, relapsing disorder characterized by difficult to control drug seeking despite harmful consequences and long-term changes in the brain. **PREFERRED TERM:** Substance use disorder. **LESS PREFERRED TERMS:** Habit.

**CHEMICAL DEPENDENCY TREATMENT SERVICES:** Therapeutic and treatment services provided to stop a pattern of harmful chemical use. **OTHER TERMS:** Treatment, substance abuse disorder treatment.

**CONTROLLED SUBSTANCE:** Any substance that is regulated by the US government based on potential for abuse, considerations for safety, and dependence.

**DRUG ABUSE:** An older diagnostic term that defined use that is unsafe, use that leads a person to fail to fulfill responsibilities or gets them in legal trouble, or use that continues despite causing persistent interpersonal problems. This term is increasingly avoided by professionals because it can perpetuate negative attitudes. **CURRENT APPROPRIATE TERMS:** Drug use (in the case of illicit substances), drug misuse (in the case of problematic use of legal drugs or prescription medications), and substance use disorders.

**DEPENDENCE:** When regular usage of a substance over time produces symptoms of withdrawal when stopped. Dependence can develop with prescribed medications as well as illicit substances. Dependence does not always lead to substance use disorder.
**DETOXIFICATION:** When the body rids itself of a harmful substance. Often the first step in drug treatment. **OTHER TERMS:** Detox.

**HARM REDUCTION:** Steps or approaches taken to lessen the negative impact of using substances while making positive changes in decisions or behaviors.

**ILlicit:** Illegal.

**OVERDOSE:** When a person takes too much of a harmful substance or mix of substances, overwhelming the body and leading to life-threatening symptoms. **PREFERRED TERM:** Drug poisoning.

**RECOVERY:** The process of moving from illness into wellness. This includes restoring the health of one’s brain, relationships, and overall health. This is achieved by many people.

**RELAPSE:** When the symptoms of illness return after a period of remission or wellness. In substance use disorder relapse is often used to refer to using drugs or alcohol after a period of abstinence. When someone has one episode but immediately returns to sobriety it is often called a “lapse” and not a relapse. **PREFERRED TERM:** Re-occurrence. **OTHER TERMS:** Off the wagon.

**REMISSION:** When the symptoms of an illness or disease are reduced to a level that is no longer considered harmful.

**ROUTE OF ADMINISTRATION:** How someone takes drugs into their body (e.g., eats, smokes, inhales, injects, drinks).

**TOLERANCE:** The need for more of a substance to get the same effect or getting less of an effect from the same amount.

**WITHDRAWAL:** Symptoms that occur when dependence or tolerance to a substance has developed and use is stopped.

*Other terms to think about using differently:*

- “Loving well” instead of “tough love”
- “Pro-dependent” instead of “co-dependent”
- “Protecting” instead of “enabling”
- “Substance free” instead of “clean”
- “Actively using” instead of “dirty”
- “Tested positive” instead of “tested dirty”
- “Ambivalence” instead of “denial”
Signs of Possible Substance Use Problems

Drug and alcohol use exist on a spectrum. Harm can occur to the user when engaging in substance use at any level, depending on many factors. For example, even recreational use of alcohol in quantities that wouldn’t be considered dangerous can lead to an overdose or poisoning when combined with some prescription medications.

Spectrum of Substance Use

Once substance use has become a substance use disorder, research has shown that treatment and support will facilitate recovery. This is because substance use alters the brain, causing chemical and physical changes that make quitting much more complicated than simply saying “no.” The cells responsible for sending these signals are called neurons. Signals are sent between neurons using neurotransmitters. Different substances can change which neurotransmitters are released, the amount, and the neurons’ ability to “receive” the signal.

Over time, these little changes can lead to long lasting alterations in some areas of the brain and contribute to substance use disorders. For example, the basal ganglia is sometimes called the brain’s pleasure center because it produces pleasurable feelings in our body in response to things we like. When the basal ganglia is activated by drugs, it can produce pleasure by releasing large amounts of the neurotransmitter dopamine, but over time that part of the brain adapts to the activation caused by the drug. This can lead to a need for more of the drug to stimulate the basal ganglia and also a reduced ability to experience pleasure from other experiences.

Substance use occurs on a spectrum from total abstinence from all drugs and alcohol, to experimental and social use, prescribed medical use, dependency, and substance use disorders. However, substance use and misuse that is not severe enough for an official diagnosis of substance use disorders might still have harmful effects on the health and wellbeing of your loved one (McLellen, 2017). For example, substance use may worsen symptoms of a co-occurring mental illness and could lead to unknown interactions or side effects with other medications.
That is why it’s important to know the signs of a possible substance use problem so there can be early intervention. Early intervention can help stop the problem from getting worse and help minimize the risk of harm.

The clearest sign that a loved one is using illegal drugs or misusing other substances is their self-disclosure. If your loved one comes to you with concerns about their substance use, take their concerns seriously. They’ve taken an important step in their own recovery and shown that you’re someone they trust. You can show support by affirming their concerns and, if appropriate, helping them to take steps to find accurate information and help, like the information provided in this booklet.

However, they may not always be the first to approach you about substance use concerns. Instead, you might begin to notice changes and wonder whether this is a sign of possible substance use problems or something else, like symptoms related to their mental illness. In other cases, you might see drugs (or alcohol or other substances that are being misused), drug residue, or drug paraphernalia (for example, empty beer bottles, glass pipes, syringes, tie-offs, small baggies, cut up straws) directly and wonder whether this is cause for concern.

The following list from the US Department of Health and Human Services provides examples of some changes that you can look for that might be a signal your loved one may be experiencing substance use problems or a substance use disorder.

**Behavioral changes:**
- Drop in attendance and performance at work or school
- Frequently getting into trouble (fights, accidents, illegal activities)
- Using substances in physically hazardous situations such as while driving or operating a machine
- Engaging in secretive or suspicious behaviors
- Changes in appetite or sleep patterns
- Unexplained change in personality or attitude
- Mood swings, irritability, or angry outbursts
- Periods of unusual hyperactivity, agitation, or giddiness
- Lacking motivation
- Appearing fearful, anxious, or paranoid, for no reason

**Physical changes:**
- Bloodshot eyes and abnormally sized pupils
- Sudden weight loss or weight gain
- Deterioration of physical appearance
- Unusual smells on breath, body, or clothing
- Tremors, slurred speech, or impaired coordination
Social changes:
- Sudden change in friends, favorite hangouts, and hobbies
- Legal problems related to substance use
- Unexplained need for money or financial problems
- Using substances even though it causes problems in relationships

It is important to recognize the long-term effects of poverty; social, cultural, political, and economic oppression; and adverse childhood experiences on people’s functioning and adjustment and their vulnerability to be impacted by substance use.

According the Minnesota Department of Health, there are nine adverse childhood conditions:
- Physical abuse
- Sexual abuse
- Emotional abuse
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use by a household member
- Divorce or separation of a parent
- Domestic violence towards a parent
- Incarceration of a household member

The ACE score is a measure of cumulative exposure to adverse childhood conditions.

How you choose to reach out to your loved one with your concerns is dependent on many factors such as your relationship, the age of your loved one, social and cultural norms around substance use, whether or not you live together, and history of substance use.

Remember that you can’t fix your loved one’s substance use disorder yourself, but you can help connect them with information and provide support.

Also remember to take care of yourself. Don’t blame yourself for your loved one’s substance use disorder. Be sure to learn what you can about treatment and connect with resources to help your mental health and emotional wellbeing.
**MOST COMMONLY MISUSED DRUGS**

**Depressants**

**Alcohol**

Alcohol is one of the most commonly misused substances by both adolescents and adults in the US (SAMHSA). According to the CDC, over 15 million adults over the age of 18 and approximately 630,000 young adults currently live with an alcohol use disorder (AUD) in the US but only nine percent receive treatment. While not everyone who drinks alcohol may have an alcohol use disorder, those who misuse alcohol consistently or struggle to stop drinking are at high risk.

Research has also shown that being intoxicated is highly correlated with impulsivity and risk-taking behaviors. In 2019, alcohol was a factor in over 40 percent of suicide attempts and was classified as a major risk factor for self-harm (Commonwealth Fund Report). **OTHER NAMES:** booze, hooch, juice

**Benzodiazepines**

Benzodiazepines—such as Valium, Xanax, Ativan, or Klonopin—are sedative medications that act on the central nervous system to relax the body, relieve withdrawal symptoms, and treat anxiety and sleep disorders. These medications are prescribed in both short- and long-acting forms and oftentimes create a sedative effect that can be considered pleasant. When improperly used or taken recreationally, benzodiazepines carry a risk of becoming addictive and, in high dosages or mixed with alcohol, can lead to overdose.

Hospital admissions for benzodiazepine misuse have tripled since 1998 (SAMHSA). If your loved one is currently misusing these medications, it is important to talk to a medical professional and have a gradual decrease in use (rather than quitting suddenly) to avoid serious health risks. **OTHER NAMES:** benzos, BZD, blue v, tranks, rohypnol (roofies).

**Opiates**

Opiates—or opioid painkillers—are narcotic medications that are commonly prescribed to manage and treat pain. While some opiates are derived from natural based sources (such as the poppy plant), other synthetic variations can be used to create drugs such as OxyContin, Vicodin, and Fentanyl. These painkillers can also relax the body and create a feeling of euphoria, which can lead people to use them recreationally. Opiates can become very addictive and lead to dependency within a short timeframe.
Heroin is one of the most dangerous opioids and is an illegal substance in the United States. A long-term addiction can occur with a single exposure and lead to withdrawal symptoms that last for weeks or months at a time depending how long heroin is used, the dosage and the person’s body chemistry (SAMHSA). Because prescription opioids and heroin produce similar effects, individuals experiencing an opioid addiction are at risk for switching to heroin as it is often less expensive and can be easier to access. Approximately 80 percent of individuals who used heroin were found to have previously misused prescription opioids (Carlson, Nahhas, Martins, Daniulatyte, 2016).

**OTHER NAMES:** brown sugar, tar, smack, “h.”

**Stimulants**

**Nicotine**

Nicotine is a common additive found in tobacco products such as cigarettes, vaporizers (vapes), or hookahs and works by stimulating the body’s adrenaline system to create a pleasant, energized state. With prolonged use, nicotine can be very addictive and quickly cause withdrawal symptoms, if trying to discontinue use. In America, nicotine addiction is the most prevalent substance use disorders and 44 percent of cigarettes in the United States are consumed by individuals who also live with a mental illness (CDC, 2017).

**Cocaine**

Cocaine is a white powder or crystal that is created from extracts of the coca plant. It works by increasing and enhancing the effects of dopamine in the brain, leading to a state of euphoria and high energy for short periods of time. Cocaine can be snorted in the nose, rubbed into the gums, injected intravenously, or smoked. Oftentimes, individuals will take multiple hits of cocaine within a short timeframe to maintain the effects over longer periods of time.

With repeated use of cocaine, an individual’s brain chemistry will often adapt to needing more dopamine to function in a healthy way. This often causes those using cocaine to need higher doses to feel pleasure over time and can lead to heightened feelings of sadness and emptiness when sober. Prolonged cocaine use can often lead to both worsened physical and mental health as well as accidental overdose. **OTHER TERMS:** blow, bump, crack (crystalized form), coke, snow.
Methamphetamine/Amphetamines

Amphetamines—such as Adderall, Ritalin, Dexadrin, and Concerta—are prescription stimulants that are commonly prescribed for conditions such as attention-deficit hyperactivity disorder (ADHD) and narcolepsy. Methamphetamine is chemically similar to amphetamines and is a powerful, highly addictive stimulant that affects the central nervous system. These drugs can increase one’s alertness and energy by stimulating neurotransmitters in the brain such as dopamine and norepinephrine. While dopamine creates feelings of happiness and pleasure, norepinephrine provides support that help these drugs reach important parts of the body. As a result, these drugs create a “rush” that can be sought after for recreational use. In high concentrations, methamphetamines and amphetamines can lead to overstimulation of the body that leads to high blood pressure, irregular heartbeat, and seizures. Repeated use, even in small doses, can additionally cause feelings of anger, paranoia and induce psychosis. **OTHER NAMES:** crank, chalk, crystal, ice, meth, speed.

Hallucinogens

MDMA (3,4-Methylenedioxyamphetamine)

MDMA—more commonly known as ecstasy or molly—is similar in structure to methamphetamine and creates feelings of euphoria alongside hallucinations lasting two to six hours when consumed. Due to the large rush of stimulating chemicals that flood the brain upon use, many people will experience great highs when using MDMA but also experience a “crash” for many hours to days after and experience prolonged sadness, emptiness, and other depressed feelings.

MDMA can come in pills, capsules, or powders and can sometimes contain additives such as caffeine, ketamine, cocaine, or heroin without the user’s knowledge. MDMA is currently classified as an illegal drug and is not recognized for any medical use. **OTHER NAMES:** X, XTC, E, uppers, clarity.

Dextromethorphan

Dextromethorphan—or DXM—is an opioid-derivative cough suppressant commonly used in over-the-counter cough syrups or cold treatments. While not harmful in standard doses, ingesting large amounts of substances that contain DXM (often referred to as “dexing”) can trigger hallucinations and feelings of detachment from the body, euphoria, and double vision. The abuse of cold medications that contain DXM often means simultaneously ingesting large quantities of other chemicals—such as acetaminophen (a common pain reliever known as Tylenol)—
which are incredibly toxic in high doses. The risks associated with these medications increases when paired with alcohol or other drug use.

**OTHER NAMES:** D, robo, orange crush, poor man’s X.

### Other Substances

**Cannabis**

Cannabis, or marijuana, often refers to a substance made from the buds, leaves, or resin of Cannabis plants. When smoked or ingested, cannabinoids (such as THC) enter the body and are transported almost immediately into the bloodstream and to the brain. THC can mimic the neurotransmitter anandamide to impact mood, memory, coordination, and problem solving. While smoking marijuana often creates effects immediately that last for short periods of time, ingesting food items infused with marijuana oil (known as “edibles”) are often slow-acting and their effects may last for many hours. THC is what makes people “high.”

Unlike many other substances, marijuana can be grown and bred to have a wide variety of physiological effects. While some strains of marijuana may act as sedatives or hallucinogens, others produced for medical purposes can create positive health benefits and treatments without the “mind fog” of recreational strains.

As of 2019, Minnesota is one of 30 plus states that has legalized medicinal use of cannabis for a limited number of health conditions and currently allows cannabinoid (CBD) oils to be sold recreationally. CBD doesn’t make you “high.” Common effects of non-medical marijuana can include feeling hazy and relaxed both physically and mentally, altered senses (such as brighter colors), feeling a removed sense of time, slower thoughts and movement, and slower reaction time.

For some people, marijuana can conversely create feelings of anxiety or paranoia and has been linked to increased risk of hallucinations and delusions (National Academies of Science). The amount of THC in recreational marijuana has tripled over the past few decades, which has triggered concern for its long-term impact on individuals living at risk for psychosis, young adults, and the elderly (Mehmedic, Chandra, Slade et al, 2010).

Smoking THC-rich resins from marijuana plants, called “dabbing,” is also a new area of focus in education efforts. This method of smoking marijuana delivers extremely high concentrations of THC into the bloodstream in short timeframes (sometimes as much as 80 percent THC) and can pose high risks for THC-poisoning and the need for other emergency medical care.
Research suggests that between 10 to 30 percent of individuals using marijuana may develop a cannabis use disorder. People who begin using marijuana before age 18 are four to seven times more likely than adults to develop a marijuana-use disorder (Winters & Lee, 2008). Additionally, studies suggest marijuana use is linked with the development of psychiatric disorders in those with a preexisting genetic or other vulnerability (drugabuse.gov). **OTHER NAMES:** weed, pot, dope, grass, kush, reefer, ganja.

**Prescription Medications**

While many people use medications to treat physical or mental illnesses, the ways that these medications affect our body vary from person to person and—as a result—addictions may happen unexpectedly even at low dosages. When someone becomes addicted to their prescription medications, you may notice amplified changes in behavior or personality or a resistance to stopping their medication usage. They may also run out of pills sooner, attempt to get more frequent refills, or try to get prescriptions from more than one doctor or clinic.

If you are worried that you or a loved one are forming an addiction to prescription medications, it is important to reach out to your doctor as soon as possible. They may be able to change your dosage or try a different prescription altogether.

**Other Addictions**

**Gambling**

Minnesota has many avenues for legal gambling, including casinos. This can be a form of entertainment for some adults, but when someone’s gambling behavior starts to cause problems in their life, this can be a sign of a gambling addiction. Individuals with gambling addictions might have cravings to gamble similar to those experienced by people with other addictions, like alcohol. Also, like with substance use disorders and other addictions, co-occurring mental illness are very common among individuals with gambling disorders.

A gambling disorder or pathological gambling is a pattern of behavior that severely impacts a person’s family, job, or personal life. One of the signs that gambling has become a concern is when a person feels an urgent need to keep gambling or to take even greater risks to reverse a loss. It is estimated that gambling addiction affects between 0.2 percent and 0.3 percent of the general population and can develop over a long period of time. Gambling disorders are more common in people who have anxiety, impulse control, depression, and certain personality disorders.
People with a substance abuse disorder are more likely to have a gambling disorder. Alcohol use disorders are particularly common in people who are diagnosed with a gambling addiction.

**Tobacco and Nicotine**

The rate of smoking among those living with a mental illness is much higher than in the general population. Tobacco is the leading cause of death for individuals living with a mental illness. On average, individuals living with a mental illness die 25 years earlier and nearly two-thirds of those lost years are a result of smoking.

25 percent of the US population live with a mental illness or substance disorder, but smoke about 40 percent of all the cigarettes sold. There are many reasons people living with a mental illness smoke more frequently than any other population. The primary reasons include:

- The tobacco industry targets people living with mental illnesses
- Many mental health providers mistakenly believe smoking is beneficial or not harmful to individuals, or they are uncertain about how to address smoking cessation

Nicotine is what makes tobacco highly addictive. It is one of the most addicting drugs, reaching the brain in eight to ten seconds, faster than heroin or cocaine. Nicotine produces mood altering changes in the brain. Withdrawal symptoms usually go away within two to four weeks, but some symptoms, such as cravings, may never go away completely.

Smoking makes several types of medication including psychiatric medication, less effective. If an individual smokes, they will need a higher dose of psychiatric medication and may result in more severe side effects. Medication levels can vary if a person starts or stops smoking or changes how much they smoke.

Health care providers often believe individuals living with a mental illness need to smoke to help with symptoms of their mental illness. However, smoking often makes these symptoms worse. Withdrawal symptoms also often mirror symptoms of mental illnesses, such as anxiety and insomnia.

While many who smoke say that it decreases their symptoms, a variety of research indicates quitting smoking can lead to improved health outcomes and that it doesn’t interfere with treatment. Smoking cessation is associated with:

- Reduced depression, anxiety, and stress
- Improved positive mood and quality of life
DIAGNOSING CO-OCCURRING DISORDERS

Knowing the signs and symptoms of mental illnesses and substance use disorders can help you to know when to reach out and to find help for yourself or a loved one. In this section we will discuss the instruments, processes, and issues involved in identifying and diagnosing co-occurring disorders.

Screening

Screening is a brief, easy-to-use tool that can be used to make a quick decision about a person’s health. Screening isn’t a diagnosis, it’s a sign that something may—or may not—be wrong. One example of screening is getting your temperature checked at the doctor’s office. A temperature that is too high or too low alerts the clinician that something is wrong—but it doesn’t tell you what’s making you sick or how to make you better. A good clinician will follow up on the screening, ask questions, and suggest additional tests to find out more.

Screening is one way that individuals experiencing possible problems related to mental illness and substance use are identified in the community. Many of the screening tools used are short questionnaires. Results from a screening can be used to make referrals for additional testing and sometimes services. Given how common co-occurring disorders are, screening for substance use disorders for individuals entering mental health services and the reverse, screening for co-occurring mental illness among individuals receiving treatment for substance use disorders, might help people receive more accurate and complete diagnoses. More accurate diagnoses in turn lead to more appropriate treatment and improved outcomes.

Some of the more common screening tools used in Minnesota are described here. Families should be familiar with the names of these screenings so you can request them or know what they are if they are referred to by a provider. You can always ask your provider to explain any tests that you are not familiar with.

**ALCOHOL USE DISORDERS IDENTIFICATION TEST:** AUDIT is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol use, drinking behaviors, and alcohol-related problems.

**TEST (AUDIT) CAGE AID:** CAGE-AID is the Conjoint Screening Questionnaire for Alcohol and Other Drug Use. It is a 4-item screening questionnaire used to screen people ages 10 and older for possible alcohol and drug misuse.
CRAFFT: CRAFFT stands for Car, Relax, Alone, Forget, Friends, Trouble—the key items in an earlier version of the screening. It is a six-item questionnaire that is meant to be administered to adolescents between 12 and 21 years of age in hospitals to check for problems related to alcohol and other substance use.

GAIN SS: GAIN SS is the Global Appraisal of Individual Needs Short Screener and is a 23-item screener for use with people ages 12 and older. The GAIN SS is used to identify potential problems in one or more of four categories: internalizing disorders, externalizing disorders, substance use disorders, and crime/violence.

PHQ-9: The Patient Health Questionnaire (PHQ-9) is a nine-item screening for depression. It has been used with people 12 and older and there are versions for use with younger children as well.

SBIRT: SBIRT is Screening, Brief Intervention, and Referral to Treatment. Rather than a specific screening tool, SBIRT is a system for connecting screening to early intervention services. However, SBIRT includes screening as a first step and you may hear it referred to in connection to screening and screening tools.

NIDA DRUG USE SCREENING TOOL: NIDA identifies risky substance use.

OPIOID RISK TOOL: This is a brief, self-report screening tool designed to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain.

BRIEF SCREENER FOR TOBACCO, ALCOHOL, AND OTHER DRUGS (BSTAD): BSTAD is an online screening tool for adolescents.

Assessment, Diagnosis, and Comprehensive Evaluation

The terms assessments, diagnosis, and comprehensive evaluation have related but distinct meanings. In practice, these terms may be used loosely or interchangeably. The definitions below may not be used by every organization, but to help distinguish between what these different types of processes typically refer to. If you are unsure what your loved one’s provider means, ask them to clarify.

ASSESSMENT: In general, assessment refers to specific tests used to make a diagnosis. Sometimes assessment can refer to one specific test, or a whole group of tests. The results of assessments are used to make a diagnosis.

DIAGNOSIS: Diagnosis refers to the process of identifying a disease or illness. It means a written assessment that documents a clinical and
functional face-to-face evaluation of the client’s mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client’s strengths and resources.

**COMPREHENSIVE EVALUATION:** A comprehensive evaluation is a process that includes assessment of many areas and information from multiple sources. Often a comprehensive evaluation will be written up as a report that includes the reasons why the evaluation was started (the problem or question that brought you in), descriptions of the assessments used and their results, and a detailed diagnosis. The report might also include other diagnoses that were ruled out and why, recommendations for additional assessment, and recommendations for treatment and follow-up. Evaluation reports vary a lot based on the provider. They can be long or short, include written descriptions, and information from lots of different people like nurses, and psychologists, and they can be written in ways that are very easy to read or in very technical language. A provider should always be willing and able to talk through and explain the details of an evaluation report.

*When mental health professionals develop a diagnosis, they need to look at a number of factors including:*

- The person’s current life situation, including their age; current living situation, including household membership and housing status; basic needs status including economic status; education level and employment status; significant personal relationships, including the relationship quality; strengths and resources, including the extent and quality of social networks; belief systems; contextual nonpersonal factors contributing to their presenting concerns; general physical health and relationship to their culture; and current medications
- The description of symptoms, history of mental health treatment, including review of the person’s records; important developmental incidents; maltreatment, trauma, or abuse issues; history of alcohol and drug usage and treatment; health history and family health history, including physical, chemical, and mental health history; and cultural influences and their impact
- The person’s current mental state
- The person’s needs based on their symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs
- Screenings used to determine the person’s substance use, abuse, or dependency
- Clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, the person’s and family participation in assessment and service preferences, and referrals to services
Sometimes, professionals working in a system will refer to one condition or another as an individual’s “primary” diagnosis. This can mean many things, for example:

- The diagnosis that the individual received first in time
- The diagnosis with symptoms that are more severe or not currently in remission/stable
- The condition that is causing the other symptoms (e.g. substance-induced disorders, intoxication, and withdrawal)
- The diagnosis that the provider is providing treatment for

Given the multiple possible meanings of this term, it is important that you clarify what the professional means when they refer to one condition as primary. In co-occurring disorders, research suggests that substance use disorders and the co-occurring mental illness are distinct from one another. This has important implications for treatment, as the best programs treat both conditions at the same time.

Diagnosing co-occurring disorders requires a professional. It is best to find a professional who has an understanding of the interaction between substance use disorders and other mental health diagnoses. Professionals who specialize in co-occurring disorders will be able to understand what is behind the symptoms and behaviors you’re seeing and use that understanding to make the best recommendations for treatment. For example, are the individual’s hallucinations due to methamphetamine use and lack of sleep (due to intoxication or a substance-induced disorder) or a co-occurring mental illness? Additionally, side effects of some psychotropic medications used to treat mental illness can mimic the effects of intoxication on substances.

To receive public funding for substance use disorder treatment, an assessment must be completed which involves being interviewed by an alcohol or drug abuse counselor or county or tribal staff. (This is also known informally as a Rule 25 Assessment.) An interview must be conducted within 20 days of a request and completed within 10 days. The purpose of the assessment is to identify the person’s risks, needs, and strengths, as well as help determine where the person should be placed.

During the interview questions are asked about the person’s current and history of substance use (and other addictions), the effects that substance use is having on that person’s life, previous treatment, risk taking behavior, and the person’s recognition of the need for treatment. The assessment might also include diagnostic tests, review of records (medical, legal, etc.), a physical health check, mental health history and treatment, desire for family involvement, and interviews with other people in the person’s life who might have important information to share. If opioids are involved, additional questions are asked about the risks for
opioid use disorder, treatment options, risk of and recognizing opioid overdose; and the use, availability, and administration of naloxone to respond to opioid overdose.

The Rule 25 assessment should address each of these six dimensions:

- **DIMENSION 1:** Acute intoxication/withdrawal potential; the client’s ability to cope with withdrawal symptoms and current state of intoxication

- **DIMENSION 2:** Biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client’s ability to tolerate any related discomfort. The license holder must determine the impact of continued substance use on the unborn child, if the client is pregnant

- **DIMENSION 3:** Emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others

- **DIMENSION 4:** Readiness for change; the support necessary to keep the client involved in treatment service

- **DIMENSION 5:** Relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems

- **DIMENSION 6:** Recovery environment; whether the areas of the client’s life are supportive of or antagonistic to treatment participation and recovery

This information is used to decide whether the individual needs treatment and if so, what level of care will be the most beneficial. Levels of care include everything from peer support services, nonresidential/outpatient treatment with varying degrees of hours, medication assisted therapy, residential treatment, and hospital-based treatment.

If the assessor finds that the person is in severe withdrawal and is likely to be a danger to themselves or others, has a severe medical problem that requires immediate attention, or has a severe mental health symptoms that place them at risk of harm, the assessor must connect the person to services and treatment immediately.
In this section we will look at the substance use disorder system, the mental health system, and an integrated approach. For any treatment plan, it’s important to identify, focus, and build on the strengths of the individual and their family.

**Substance Use Disorder Treatment**

Minnesota’s substance use disorders treatment system includes a continuum of services designed to help ensure that individuals can access effective treatment for substance use disorder and related problems. These services are delivered through collaboration with counties, tribes, and healthcare providers. To find a licensed provider you can go to the Minnesota Department of Human Services licensing look-up page or to FastTrackermn.org. Please note that some substantive changes to the substance use disorder treatment will be going into effect in late 2021.

Substance use disorders can be managed and treated successfully for many people. Successful treatment or management of substance use disorders means that symptoms are no longer present (in remission) and that the individual is back to the routines of daily life. For most people, this does not mean that their addiction has been “cured.” Like other chronic health conditions such as high blood pressure, most people don’t consider themselves “cured.” Instead, the term “recovery” is often used to describe the ongoing process of managing the symptoms of addiction in the long term.

*Recovery is a process and occurs in phases. These phases are described in many different ways depending on which model of recovery is being used. Generally, these phases include:*

- Abstinence (not using the problem substance) and controlling cravings
- Repair harm to the parts of their lives damaged by addiction
- Ongoing growth, which may include ongoing work to continue to address and heal factors that may underlie addiction, such as trauma (Melemis, 2015)

The process of finding and successfully engaging with recovery supports at any stage is challenging for many people and there are additional considerations in identifying appropriate services for those with co-occurring disorders. Programs that enforce an “abstinence only policy” against all substances should help people stay abstinent from mood altering chemicals but shouldn’t be prohibiting medications that treat mental illnesses or health conditions. A person’s need for psychotropic or other medications should be taken into account when developing the treatment plan.
There is not general agreement about whether some prescribed medications can be responsibly used to manage symptoms of mental illnesses such as sleeping medications, ADHD medications, or anti-anxiety medications. Elimination of responsibly used prescription medications can result in poor treatment outcomes in some cases, but there is always the possibility of misusing these medications. Most programs will have abstinence as a long-term goal.

The treatment plan uses the information from an assessment to identify treatment goals, the strategies and methods that will be used to meet those goals, smaller measurable goals that will need to be met to make it to the treatment goals, a timeline for checking in on progress, and a plan for who is responsible for which parts.

The treatment plan might also include information like crisis plans, harm reduction strategies and relapse/re-occurrence prevention information, and a plan for fading out services over time. The exact contents of the treatment plan will vary based on the service provider and the individual's unique needs.

A comprehensive discharge plan is critical to maintaining recovery. Discharge planning should involve the individual and their family and should be individualized and provide information on the services and supports that will be provided in the community. It should address the social, cultural, and therapeutic need to enhance the person’s health and wellbeing in the community.

**Detoxification or Withdrawal Management**

Detoxification is when the body rids itself of harmful substances. When someone has developed a physical dependence on a substance, such as alcohol or opiates, the process of detoxification can cause painful and sometimes dangerous symptoms of physical withdrawal. Those symptoms can affect the body and mind, for example, muscle pain, sweatiness, shakiness, loss of appetite, nausea, vomiting, nightmares, hallucinations, anxiety, confusion, and seizures. The state of Minnesota oversees detoxification facilities where individuals can complete detoxification with medical support to manage withdrawal symptoms.

Detoxification facilities in Minnesota are licensed and governed under DHS Rule 32 which provides guidance on how those facilities must be run. These facilities are short-term 24-hour for the purposes of withdrawal and stabilization from intoxication. However, most detoxification programs last for three, five, or seven days. Detoxification programs can be located in hospitals, clinics, and other facilities, but must be licensed. There are 16 licensed programs in Minnesota.
Withdrawal management facilities are different and are licensed under Minnesota Statute 245F. They are a licensed program that provides short-term medical services on a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their withdrawal, and facilitating access to substance use disorder treatment as indicated by a comprehensive assessment. They have to meet certain standards around staffing, admissions, comprehensive assessments, care coordination, discharge and stabilization plans, and providing culturally appropriate services. There are currently three facilities in Minneapolis, Duluth, and Granite Falls.

**Treatment**

In Minnesota, there are many options for treatment services related to substance use disorder. Those services are provided through a large network of programs which are operated by the state, counties, tribes, hospitals, certified community behavioral health clinics (CCBHCs), non-profits, and other organizations. All these programs are licensed and monitored by the state.

**PROGRAM TYPES:** There are around 400 different substance use disorder treatment programs in Minnesota right now. Most of those programs are licensed under MN Statute 245G (previously referred to as Rule 31 programs). These programs are designed for adults, adolescents, and families. Children’s Residential Treatment Centers (RTC) are regulated by a different set of rules and statutes. Programs can provide different levels of service intensity, serve specific populations, or provide services in specific locations.

**SERVICE INTENSITY:** In Minnesota, there are programs providing residential, inpatient, and outpatient services. Several of the most common include:

- Inpatient or hospital-based treatment provides 24-hour care including medical services and usually lasts a few days or weeks. Once stabilized, a lower level of care is offered.
- Residential treatment provides people with a safe place to stay in the same location where they receive treatment. It provides 24-hour staffing and a range of intensity of clinical service, ranging from 30, 15 or 5 hours of clinical service per week. The length of stay will depend on the severity of the substance use disorder as well as insurance or ability to pay. Room and board are also provided.
- Outpatient treatment is typically individual or group therapy with sessions in a community-based setting providing mental health and/or medical services, medication-assisted therapies and service coordination/case management.
Medication-assisted treatment (MAT) provides those living with opioid use disorder medications to address cravings. Prescribed medications can be consumed at a clinic or at home.

Treatment services are the actual practices used by programs to treat substance use disorders. Many programs describe their services on their websites, but the best way to learn about the specific services provided by a program is to call or visit and ask. Contact information for all programs can be found on the DHS licensing lookup.

**Residential and nonresidential treatment must include the following:**

- Individual and group counseling
- Client education
- A service to help the client integrate gains made during treatment into daily living and to reduce the client’s reliance on a staff member for support
- A service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client’s individual treatment plan
- Treatment coordination provided one-to-one by a staff member which includes coordinating with significant others to help in treatment planning, coordination and follow-up to medical services, referrals to substance use disorder services and/or mental health services, and referrals to economic assistance, social services, housing, and prenatal care

Residential and nonresidential treatment can also include relationship counseling; therapeutic recreation; stress management and physical well-being; independent living skills; employment or educational services; socialization skills development; room, board, and supervision at the treatment site (residential treatment only); and peer recovery support services.

Peer recovery support services include education; advocacy; mentoring through self-disclosure of personal recovery experiences; attending recovery and other support groups with a client; accompanying the client to appointments that support recovery; assistance accessing resources to obtain housing, employment, education, and advocacy services; and nonclinical recovery support to assist the transition from treatment into the recovery community.
LOCATION-SPECIFIC: The state of Minnesota has licensed substance use disorder treatment programs in jails and adolescent correctional facilities, and throughout the state.

POPULATION-SPECIFIC: Population-specific treatment programs focus on providing services to a specific group of people in order to provide more tailored services, for example, in Minnesota there are programs specifically for females, males, Native Americans, African Americans, Hispanic/Latinx, deaf and hard of hearing individuals, LGBTQIA (lesbian, gay, bisexual, queer, intersex, and asexual) individuals, Hmong, Somali, seniors, adolescents, and co-occurring disorders. There are also special programs that provide comprehensive, women-specific, family-centered services, coordinated case management and recovery coaching for women and their families who are vulnerable and at high risk. These programs provide outreach and engagement, treatment and recovery, ongoing needs assessments, client advocacy, daily living skills, mental and physical health, and parenting. In order for a woman to be eligible to receive services from any of the participating providers, women must be:

- Pregnant or parenting dependent children under age 19
- Enrolled in a substance abuse treatment program, have completed treatment within the past six months, or commit to entering treatment within three months of program enrollment
- Women who are pregnant and actively using alcohol or drugs are also eligible to receive program services, regardless of treatment status

Treatment Options

MEDICATION-ASSISTED TREATMENT: Medication-assisted treatment combines the use of medications with therapies like those described below to treat substance use disorders. These medications can help ease the cravings associated with addiction as well as other symptoms. This can help people to stay in treatment longer, prevent relapse, and provide other positive benefits. While the research supports the use of medication to assist in treatment, there is less research to support its use for individuals with co-occurring disorders.

Special consideration should be given to how these medications and their effects may interact with existing medications and mental illness. Some medications might be used to treat multiple conditions, for example, Buprenorphine (below) is more commonly used to treat depression. Some commonly prescribed medications to treat substance use disorders are:
Methadone for opioids
Buprenorphine for opioids
Naltrexone for opioids and alcohol
Disulfiram for alcohol
Acamprosate for alcohol

Some treatment providers who enforce rules about abstinence during treatment for substance use disorders won’t provide services to clients who are given medications to assist in treatment. Decisions about which treatment options are best for you or your loved one should be based on personal needs, preferences, and safety. There is some research that has shown that, in general, medication-assisted treatment is more effective than abstinence-based treatment (Srivastava, Kahan, & Nader, 2017). There are 16 licensed programs in Minnesota.

**THERAPIES:** Here is a list of therapeutic practices from the National Institute on Drug Abuse that have promising evidence to support their use for individuals with co-occurring disorders. This list is not exhaustive. There are other options that might be a good fit for you or your loved one’s specific needs, circumstances, and risks. Equally important is to make sure to take into account the cultural strengths and factors when determining therapy models.

**COGNITIVE BEHAVIORAL THERAPY (CBT):** CBT is designed to change harmful beliefs and behaviors by unpacking the connections between thoughts, feelings, and behavior. It shows strong efficacy for individuals with substance use disorders. CBT is the most effective psychotherapy for children and adolescents with anxiety and mood disorders.

**DIALECTICAL BEHAVIOR THERAPY (DBT):** DBT is designed specifically to reduce self-harm behaviors including suicidal attempts, thoughts, or urges; cutting; and drug use. It is one of the few treatments effective for individuals who live with borderline personality disorder.

**ASSERTIVE COMMUNITY TREATMENT (ACT):** ACT programs integrate treatments for serious mental illnesses such as schizophrenia and co-occurring substance use disorders. ACT is different from other approaches by having a smaller caseload size, team approach, outreach emphasis, a highly individualized approach, and an assertive approach.

**CONTINGENCY MANAGEMENT (CM) OR MOTIVATIONAL INCENTIVES (MI):** CM/MI is used as an adjunct to treatment. Voucher or prize-based systems reward patients who practice healthy behaviors and reduce unhealthy behaviors, including smoking and drug use. Incentive-based treatments are effective for improving treatment compliance and reducing tobacco and other drug use and can be integrated into behavioral health treatment programs for people with co-occurring disorders.
EXPOSURE THERAPY: Exposure therapy is a treatment for people with some anxiety disorders (phobias and PTSD) that involves repeated exposure to a feared situation, object, traumatic event, or memory. This exposure can be real, visualized, or simulated, and is always contained in a controlled therapeutic environment. The goal is to desensitize patients to the triggering stimuli and help them develop coping mechanisms, eventually reducing or even eliminating symptoms. Several studies suggest that exposure therapy may be helpful for individuals with PTSD and cocaine use disorder. Providers who are trained in treating co-occurring disorders might explore use of exposure therapy especially for people with PTSD and a substance use disorder.

INTEGRATED GROUP THERAPY (IGT): IGT is a treatment developed specifically for patients with bipolar disorder and substance use disorder, designed to address both problems simultaneously. This therapy is largely based on CBT principles and is usually an adjunct to medication. The IGT approach emphasizes helping patients understand the relationship between the two disorders, as well as the link between thoughts and behaviors, and how they contribute to recovery and relapse.

SEEKING SAFETY (SS): Seeking Safety is a present-focused therapy aimed at treating trauma-related problems (including PTSD) and substance use disorders simultaneously. Patients learn behavioral skills for coping with trauma/post-traumatic stress disorder and substance use disorders.

MOBILE MEDICAL APPLICATION: In 2017, the Food and Drug Administration approved the first mobile medical application to help treat substance use disorders. The intention is for patients to use it with outpatient therapy to treat alcohol, cocaine, marijuana, and stimulant use disorders; it is not intended to treat opioid dependence. The device delivers CBT to patients to teach skills that aid in the treatment in substance use disorders and increase retention in outpatient therapy programs. It’s called reSET®.

MULTIDIMENSIONAL FAMILY THERAPY: This type of therapy is available for adolescents and their families. It is designed to improve overall family functioning.

12-STEP FACILITATION THERAPY: This therapy is designed to prepare individuals to understand, accept, and become engaged in Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or similar 12-step programs. Typically, it is individual therapy that takes place over the course of 12 weekly sessions.
Motivational interviewing (MI)

MI is a strategy that uses conversations and questions to help increase motivation to change. MI got its start in alcohol and drug counseling, where counselors recognized that not everyone who came in their door was ready to commit to change by engaging in the treatment process. When the push for change came from the outside or was coercive, for example forced by family, courts, or even the counselor. This often led to confrontation and resistance from the client, not change. Change is hard and MI recognizes that people are at different stages of readiness when thinking about change. Those stages are:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Instead of demanding or forcing change, MI provides different techniques that the counselor can use to help an individual identify their own desires and needs, the barriers that are keeping them from achieving those desires and needs, and a plan for reducing some of those barriers. Some of the techniques of MI include:

- Eliciting change talk
- Rolling with resistance
- Expressing empathy
- Developing discrepancies
- Supporting self-efficacy

MI is a commonly used strategy in substance abuse counseling and one that you’ll most likely come across when seeking appropriate treatment options. It has been shown to be an effective strategy for reducing ambivalence related to problematic substance use and increasing engagement in treatment leading to more successful outcomes. Most importantly is that MI is delivered in/with the spirit of (1) partnership, (2) evocation, (3) acceptance, and (4) compassion.

Harm Reduction

In some cases, you or your loved one may be unable, unwilling, or simply not ready to stop using drugs or alcohol, change substance use habits, or begin treatment for co-occurring disorders. In many cases, relapse will happen. Harm reduction is a philosophy and a set of strategies that is used to minimize harm as best as possible, when engaging in a risky or unsafe behavior like drug use. More broadly, harm reduction is about meeting people where they are at and supporting any step in
the right direction (Logan & Marlatt, 2010). There are many benefits to a harm reduction approach including saved lives, safer drug use, less social isolation, and keeping families together.

Harm reduction offers an alternative to the “tough love” approach that has been popular in the media and among some treatment providers in the past. A harm reduction approach may be a welcome opportunity for individuals who have struggled with feelings of guilt and responsibility and are unsure of how to provide loving support to their loved one. This is because harm reduction does not deny the dangers of substance use. Instead, it acknowledges that this behavior exists in the world and looks to identify ways to minimize the harm. There is no one-size-fits-all approach to harm reduction. The specific strategies you choose to use should be selected based on need and risk. Here is a list of some broad strategies to help illustrate what harm reduction can look like:

- Sterile syringe access and disposal options to reduce risk of infection or transmitting disease when injecting drugs
- Accurate information about how to safely use, for example using sterile water for mixing injectable substances to help reduce risk of overdose and infection
- Learning how to use and carrying Naloxone to prevent overdose
- Removing access to a motor vehicle when intoxicated to reduce risk of driving.
- Not using alone
- Discarding self-harm tools like razor blades
- Individuals with co-occurring substance use disorders and mental illness have much higher rates of HIV and other sexually transmitted infections; regular testing and counseling, along with use of condoms and other appropriate protective barriers can prevent risk of contracting or transmitting infections

There are many harm-reduction resources in Minnesota and nationally. Minnesota law allows pharmacies to sell a limited number of sterile syringes to individuals without a prescription.

**Minnesota’s Mental Health Treatment System**

**Mental Health Treatment**

Minnesota’s mental health treatment system also includes a continuum of services designed to help ensure that individuals can access effective treatment for mental illnesses. These services are delivered through collaboration with nonprofit and profit organizations, counties, tribes, and healthcare providers. To find a licensed provider, go to the Minnesota Department of Human Services licensing look-up page or FastTracker-mn.org. More information about the mental health system can be found
in NAMI Minnesota’s booklets Hope for Recovery and Keeping Families Together.

SAMHSA defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” They go on to list four major dimensions that support recovery, including health, home, purpose, and community.

In the mental health system, a functional assessment is used in case management and looks at:

*Mental health symptoms as presented in the adult’s diagnostic assessment*

- Mental health needs as presented in the adult’s diagnostic assessment
- Use of drugs and alcohol
- Vocational and educational functioning
- Social functioning, including the use of leisure time
- Interpersonal functioning, including relationships with the adult’s family
- Self-care and independent living capacity
- Medical and dental health
- Financial assistance needs
- Housing and transportation needs
- Other needs and problems

In the mental health field, an “individual treatment plan” means a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness.

*Residential providers create an individual program plan which includes:*

- An assessment, including a strength and need list, of the resident in at least the following areas of life: social, medical, legal, family, leisure and recreation, spiritual or religious, psychological, financial, vocational, and educational
- The specific problems to be resolved
- A list of goals in order of priority
- Specific, measurable, and time-limited objectives which relate directly to the goals
Specific methods, strategies, and resources, including medications, to be used by the staff in assisting the resident to accomplish the goals and objectives

The names of community resource personnel, program staff, or other persons designated to assist the resident in implementing the various components of the plan; and notes indicating progress in achieving the goals and objectives

The mental health system in Minnesota is similar to the substance use disorder system. Treatment options include:

- Inpatient or hospital-based treatment is offered to provide 24-hour care including medical services, and usually lasts an average of eight days; the focus is on stabilization.
- Residential treatment takes place in facilities called Intensive Residential Treatment Services (IRTS) and Residential Crisis Stabilization services (RCS), which provide a safe and supervised environment in a community-based residential program setting. IRTS provides stays usually between 30 to 90 days, allowing individuals time to develop skills needed for successful transition to outpatient services and supports in their home communities, whereas RCS is intended for very short-term crisis stabilization of up to 10 days. Services are designed to help with stability, personal and emotional adjustment, self-sufficiency, and skills and strategies for living as independently as possible. Both RCS and IRTS have 24/7 mental health staff and range in size from five to 16 beds. There are 65 licensed programs.
- Children’s residential treatment centers includes RTCs and PRTFs, which are a more intensive residential service.
- Partial hospitalization program (PHP) is provided while living at home and is a time-limited, structured program provided in an outpatient hospital setting or a community mental health center. Partial hospitalization provides person- and family-centered treatment by a multidisciplinary team under the direction of a physician.
- Intensive outpatient program (IOP) involves residing at home in conjunction with 6-9 hours of programming per week. Counseling options vary along with psychiatric services.
- Outpatient is typically individual or group therapy with sessions in a community-based mental health provider and service coordination/case management. This also includes club houses or drop-in centers.

There are also additional community-based services available, such as:

- First Episode Programs for people experiencing their first psychotic episode
Behavioral health homes that coordinate care for people with mental illnesses and other health care issues
CADI Waivers which provide in-home services and supports
Adult Rehabilitation Mental Health Services (ARMHS), Assertive Community Treatment (ACT) and Mental Health Case Management

There are providers who work with specific cultural communities and the mental health system also has peer specialists.

For children, there is day treatment and school-linked mental health programs where mental health professionals are in the schools.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC): CCBHC is an integrated community behavioral health model of care that can improve service quality and accessibility. CCBHCs provide integrated, evidence-based, trauma-informed, recovery-oriented and person-and family-centered care; offer mental health, substance-use disorder (SUD), and primary care screening services; and have established collaborative relationships with other providers and health care systems to ensure coordination of care.

Utilizing a CCBHC is a great option for accessing integrated, coordinated care for co-occurring disorders in Minnesota. More information about CCHBC can be found by calling or visiting the websites of certified providers.

Certified providers include:
- Northern Pines MHC, Brainerd
- Northwestern MHC, Crookston
- Wilder Foundation, Saint Paul
- Ramsey County MHC, Saint Paul
- People Incorporated, Hennepin, Dakota and Ramsey counties
- Western MHC, Marshall
- Zumbro Valley Health Center, Rochester
- Human Development Center, Duluth
- Northland Counseling Center, Grand Rapids
- Wayside House, Minneapolis
- More may be added in the summer of 2020.

Integrated Treatment for Co-occurring Disorders

In general, evidence-based treatments are approaches to care that have been shown to work in practice by clinicians, in research by scientists, and in experience by people. Choosing evidence-based treatments, when they are available and appropriate, can help increase the chances of successful and safe recovery. For this reason, the state of Minnesota promotes providers receiving training in evidence-based treatments.
and practices. Additionally, many insurance companies require the use of evidence-based treatments and practices. There is a process in Minnesota whereby treatment facilities can become certified in IDDT, although few have. Many IRTS facilities and CD treatment facilities provide integrated treatment. CCBHCs, mentioned above, also provide integrated treatment.

**Integrated Treatment**

When someone has been diagnosed with co-occurring disorders, the most-up-to-date research and practice has shown that the best care treats both conditions at the same time. This is called “integrated” treatment. Integrated treatment helps to solve the problem of which issue to address first, because both conditions and their symptoms are considered together. This is important because the relationship between substance use disorders and other mental illnesses are complex. Although integrated treatment is considered the best for co-occurring disorders, individuals with mental illness may face challenges in finding integrated treatment services for many reasons, including a lack of providers who have the training to provide these services and disconnected service systems.

**A Model for Integrated Treatment: IDDT**

The state of Minnesota hopes to improve services for individuals with co-occurring disorders by increasing access to an evidence-based practice called Integrated Dual Diagnosis Treatment (IDDT). IDDT is a comprehensive model of care for adults with mental illness and a co-occurring substance use disorders that has been shown to work.

Outcomes that have been demonstrated in the research show that patients who receive IDDT decrease the duration, frequency, and intensity of symptoms of their substance use disorders and mental illness, have decreased hospitalizations, decreased arrests and incarcerations, less overlap in services, less use of high-cost services, experience longer periods of abstinence from drugs and alcohol, better continuity of care, better relationships, more stable housing, more independence, and higher quality of life.

Currently, IDDT can be hard to find. Some providers may say they are offering IDDT, but only provide some components of the model. If you or your loved one is seeking IDDT treatment, the following components are considered core to the model and can help you to understand what a treatment plan built using IDDT should include. You can ask providers to describe these components of their IDDT programs.
Integrated Assessment

If someone is identified as having a substance use disorder and a mental illness, an integrated assessment must be conducted by a qualified provider. It should include:

- A level of care assessment using a standardized tool, the level of care assessment must document how the needs of the client match the corresponding level of care of integrated treatment determined necessary
- A longitudinal review of the interaction between substance use and psychiatric symptoms and the consequences to the client’s health, relationships, and emotional functioning
- An assessment of a client’s stage of treatment and motivation for change
- Documentation of a client’s relevant strengths and indication of how these may be useful in treatment
- Information from collateral sources about the client when available

A summary of this information will be used to develop an integrated treatment plan. This summary must include:

- A case conceptualization that identifies antecedents, responses toward, and consequences of symptoms and maladaptive behaviors of both disorders and their interaction across key areas of a client’s life functions
- A description of how the client’s symptoms and behaviors associated with one disorder affect or impact the expression of symptoms and severity of the other disorder
- A description of situational factors in which the client’s substance use behavior is typically triggered or is typically absent
- A description of the client’s domains of behavior and symptoms that have been most challenging to recovery or have led to crises
- A description of the factors that contribute to the client’s stability and relapse for both disorders and how the interaction of the disorders affects stability and ability to benefit from treatment
- Consideration of referral for pharmacological treatments

CD residential treatment providers who state they specialize in the treatment of a person with co-occurring disorders must:

- Demonstrate that staff levels are appropriate for treating a client with a co-occurring disorder, and that there are adequate staff members with mental health training
- Have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication
- Have a mental health professional available for staff member supervision and consultation
- Determine group size, structure, and content considering the special needs of a client with a co-occurring disorder
- Have documentation of active interventions to stabilize mental health symptoms present in the individual treatment plans and progress notes
- Have continuing documentation of collaboration with continuing care mental health providers, and involvement of the providers in treatment planning meetings
- Have available program materials adapted to a client with a mental health problem
- Have policies that provide flexibility for a client who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping a client successfully complete treatment
- Have individual psychotherapy and case management available during treatment service

Research has identified these 12 core components of IDDT:

**MULTIDISCIPLINARY TEAM:** This team should include all the professionals who coordinate care in order to provide services that respond to the needs of the whole person, integrating care for their co-occurring disorders as well as providing stabilization in other areas of life. The members of this team might vary but should generally include a team leader, a case manager, a substance abuse specialist (LADC), a therapist, a physician or psychiatrist, a nurse, an employment specialist, a housing specialist, and a criminal justice specialist. Some of these roles may overlap or be filled by the same people and there may be additional people on the team, such as a peer specialist. The multidisciplinary team should meet regularly to collaboratively plan, evaluate progress, and make necessary changes to the treatment plans of the individuals receiving IDDT. They should also meet individually and as a group with the client and their loved ones and relevant service providers, for example parole officers and social workers, to ensure ongoing collaborative communication and progress.

**STAGE-WISE INTERVENTIONS:** Staging is about meeting people where they are and incremental change. IDDT uses a stage approach to change and treatment. The stages of change are pre-contemplation, contemplation, preparation, action, and maintenance. The stages of treatment are engagement, persuasion, active treatment, and relapse prevention. You should hear references to this stage-wise approach when discussing progress through treatment. The stages are seen in the below table.
ACCESS TO COMPREHENSIVE SERVICES: As noted in the description for the multidisciplinary team, IDDT is focused on providing integrated treatment for co-occurring disorders by treating the whole person. IDDT should include access to services that help meet the needs of the person receiving treatment. These services could include things like supportive employment, housing/residential services, family services, and medical services.

TIME-UNLIMITED SERVICES: Relapse is a common part of the recovery process for people with co-occurring disorders. Because of this, services should continue to be made available to clients even after intensive treatment in IDDT is over. Ongoing access to IDDT services, even when symptoms are very low, is important to help support recovery and limit the severity and length of relapses. Additionally, IDDT programs should not discharge clients for not meeting treatment goals, for example not taking psychiatric medications or using drugs and alcohol.

ASSERTIVE OUTREACH: This means meeting with people in places that are comfortable to them. This helps meet people where they are, build relationships, and increase engagement with treatment.

MOTIVATIONAL INTERVIEWING: This is a strategy used to help people make positive changes in their lives. The “stages of change” described above are also an important part of motivational interviewing.

SUBSTANCE ABUSE COUNSELING: This is an umbrella term that applies to counseling (therapy) where an individual learns and develops skills that they need to manage symptoms related to addiction.

GROUP TREATMENT: Any of the treatment/counseling included as a part of the treatment plan could be provided in group if appropriate and available. Group treatment is different from peer-support and self-help groups like Alcoholics Anonymous and other 12 step-based programs, because they are usually led by a therapist. You can ask if and what type of group treatment options are available for people with co-occurring disorders options when evaluating specific programs.

FAMILY PSYCHOEDUCATION: This means that the family (and other important members of the individual’s life) should have access to education to learn more about key topics that will enable them to provide

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<th>STAGE OF CHANGE</th>
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<td>Pre-contemplation</td>
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effective support. Of course, any personal information that is shared should be shared with the consent and involvement of the individual receiving services.

**PARTICIPATION IN ALCOHOL AND DRUG SELF-HELP GROUPS:** Peer support groups are one of the most well-known approaches to substance abuse treatment and include programs like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and many others. These groups provide people in recovery with an important opportunity to receive social support and lessons from the learned experience of others. NAMI Minnesota offers many support groups for families and persons with mental illnesses. The groups are led by trained peer facilitators and are free.

**PHARMACOLOGICAL TREATMENT:** Sometimes, certain medications can be used to support the recovery process. Also called medication-assisted treatment.

**INTERVENTIONS TO PROMOTE HEALTH:** Nurses on the multi-disciplinary team and access to comprehensive services which include health services, for example, treatment for HIV or other physical health conditions that might affect their course of treatment, and include goals relating to promoting better health in the treatment plan.

In addition to the twelve components detailed above, an IDDT program should have additional services available to modify and enhance the treatment plan for people who are not initially having success in their recovery. These are secondary interventions for non-responders. This means that there is no “failure” for the individual receiving treatment in IDDT, just increased service intensity.

Trauma informed care (TIC) is an approach that includes organizational safety, trustworthiness, transparency, cultural sensitivity, collaboration, and empowerment among and between staff and patients. This approach recognizes the role trauma plays in the lives of patients and seeks to shift the clinical perspective from “what’s wrong with you” to “what happened to you” by recognizing and accepting symptoms and difficult behaviors as strategies developed to cope with childhood trauma (SAMHSA).

In Minnesota, IDDT does not replace the existing substance use disorder treatment system. Instead, IDDT is being added as a supplement to existing services. This means that not all individuals who have co-occurring disorders will necessarily have access to IDDT everywhere in the state right now. Fortunately, components of IDDT—like substance use counseling, family psychoeducation, and group treatment—can all be included in a comprehensive integrated treatment plan even if IDDT specifically is not available.
New research, interventions, and adaptations of existing interventions are always on the horizon. For example, the Minnesota Department of Human Services and the Center for Practice Transformation have been working together to pilot an adaptation of IDDT and another evidence-based intervention, called Illness Management and Recovery, as a new intervention called Enhanced Illness Management and Recovery (E-IMR). If initial roll-out of E-IMR is promising, this may be another treatment available for individuals with co-occurring disorders in Minnesota.

**Additional Supports**

**Complementary Therapies**

Complementary therapies, also called complementary health approaches, are practices that come from outside conventional medicine and are used at the same time as more conventional practices. With professional guidance, complementary therapies can be used as part of a “holistic” whole person approach to treatment. A holistic approach focuses on reducing symptoms, like drug use and mental illness symptoms, increasing overall wellness and health.

Complementary therapies can include the use of natural products and the use of mind and body practices. Complementary practices can also include the use of medical and healing practices specific to a particular culture or belief system sometimes called “traditional” medicine. Some complementary therapies are the use of natural products like vitamins, minerals, and herbal supplements, deep breathing, yoga, chiropractic manipulation, meditation, acupuncture, and massage.

Complementary therapies vary in their safety, cost, and evidence of effectiveness. Some complementary therapies can have side effects or adversely interact with medications. While the field of research examining complementary therapies develops, it is important to check with your treatment provider about any complementary approaches you or your loved one are interested in trying.

**Spirituality and Peer Support**

There are other actions that also help people in recovery. Spirituality, including a connection to a faith community, can significantly help people create sober stable relationships. Research has shown that spiritual beliefs and engaging in religious activities increases a person’s quality of life, buffers them against the impact of stress, and helps people recover and maintain their recovery.

Peer support groups such as AA, NA SMART Recovery, Women for Sobriety, Celebrate Recovery, and NAMI Connection can provide support
from people who have “been there” and support people in their recovery. Healthy activities such as nutritious meals, exercise and mindfulness training, yoga, and meditation can also be helpful.

**Continuing Care and Recovery Support**

Following treatment, Minnesota has several options for continued support in ongoing recovery. A Recovery Community Organization is not a licensed program, but must meet certain standards and be certified by the Association of Recovery Community Organizations (ARCO). They provide education about recovery, outreach and peer recovery support services.

**MINNESOTA RECOVERY CONNECTION** is a recovery community organization with a mission of strengthening the recovery community through peer-to-peer support, public education, and advocacy. There you can find resources like peer-based recovery supports, such as coaching, phone support, and social activities. Other RCOs include:

- Minnesota Alternatives, Spring Lake Park, MN
- WEcovery (Formerly Beyond Brink), Mankato
- Continuum Care Center, Saint Paul
- Twin Cities Recovery Project, Minneapolis
- Recovery Alliance Duluth, Duluth
- Recovery Support Network, St. Cloud
- Doc’s Recovery House, Rochester

There are also support groups like Alcoholics Anonymous and Narcotics Anonymous where people share their experiences, strengths and hopes with each other. A full list can be found in the resource section.

On the mental health side, there are drop-in centers and clubhouses that can provide support. NAMI Minnesota offers peer-led support groups; Mental Health Minnesota and Wellness in the Woods run warmlines for people who need to talk and connect.

**Housing**

Many people recovering from co-occurring disorders need more support after completing inpatient treatment to return to work or school or mainstream life while managing their symptoms and potentially new medications.

**PERMANENT SUPPORTIVE HOUSING:** Permanent rental housing affordable to the population served where support services are available to residents. Permanent supportive housing is available to individuals and families with multiple barriers to obtaining and maintaining housing, including those who are homeless or at risk of homelessness and those with mental illnesses, substance abuse disorders, and/or HIV/AIDS.
**RECOVERY HOUSING OR SOBER HOMES:** These homes may be helpful for people who are newly in recovery and trying to avoid relapse. They are typically shared living housing where people cannot use alcohol or illicit drugs and where recovery is promoted. Sober homes can help those recovering from active addiction stay sober by providing support while they resume normal activities such as working or going to school. Some find it helpful to connect with new friends who are also committed to sobriety. These facilities allow for more freedom than inpatient treatment facilities.

In Minnesota, these facilities are not licensed or monitored by the Minnesota Department of Human Services or the Department of Health. These homes are privately operated and vary greatly in staffing and supports available. They also often don’t provide the same kind of tenant protections of a typical rental housing agreement. They should list the type and degree of services provided and should not prohibit the use of needed medications for a mental illness.

There are housing assistance programs such as Bridges Housing vouchers, Section 8 housing and public housing. Check with your county or local area HUD office for more information.

**Education**

Schools are an ideal location for connecting young people to services for co-occurring disorders. Providing mental health services in schools reduces common barriers to accessing community-based services (for example, transportation). Co-locating mental health services in schools helps ensure that more youth have access to the services they need. School-linked services help students with co-occurring disorders stay on track in their learning and towards meeting graduation requirements.

The services provided by different schools and school districts can vary greatly. In this section, we want to provide with some information to find what may work for you or your loved one and help you navigate the process.

**CHEMICAL HEALTH PRE-ASSESSMENT TEAMS AND CHEMICAL ABUSE SPECIALISTS:** Many schools in Minnesota have a school district chemical health preassessment team. These teams help manage referrals about students that may have a concern about substance use. They can help connect students to supports in school as well as in the community. Members of the team typically include someone with special knowledge about substance use and addiction in young people.
SCHOOL DRUG AND ALCOHOL POLICIES: Schools are required to have policies around drug and alcohol use. Some schools may have strict or zero-tolerance policies around possession of drugs and alcohol. They may choose to punish students who bring substances onto school property or who appear intoxicated while in school with suspension and expulsion.

It is important that you know your school’s drug and alcohol policies so that you are able to advocate for what your child needs. A copy of the school’s drug and alcohol policy should be made available to you from the school upon request.

SUBSTANCE USE DISORDER AND SPECIAL EDUCATION: Special education laws help students with disabilities obtain a free and appropriate public education. These laws require schools to provide qualifying students with disabilities the supports they need to access their education, even if those supports are different from what their peers need. Students qualify for special education services by meeting specific criteria. Whether or not they meet these criteria is determined through a process called a special education evaluation.

There are several important things to know about special education and students with substance use disorders. The information provided here is not legal advice, but can help serve as a starting point when advocating for what your loved one needs:

► School districts might delay the evaluation of a student who is currently using substances. This is because some criteria for special education services in Minnesota disqualify students if substance use is thought to be the primary cause of their academic problems. This does not mean that a student with a substance use disorder does not qualify for special education services.

► If a student who received special education services needs to leave school due to their disability, they may qualify for education services in their home, day treatment, or residential placement. These are sometimes referred to as “home-bound services” or “care and treatment.” Residential treatment programs and day programs (where the student is missing school to attend treatment) are required to provide educational services and may have licensed educational staff including school counselors to help provide continuity in education while young people are in treatment.

RECOVERY HIGH SCHOOLS AND COLLEGIATE RECOVERY PROGRAMS:
Minnesota has several recovery schools and collegiate recovery programs. These are also sometimes called “sober schools” or “CRPs.”

Recovery high schools are accredited high schools that specialize in serving students in recovery. These schools can be private or public and
may or may not be accredited or approved by the Minnesota Department of Education. The schools that are approved by the Department of Education are required to meet certain educational standards. These schools can vary greatly. Some of the differences include how you enroll in the school, whether the school is private or public, rules about sobriety, the classes offered, and the mental health services provided.

Collegiate recovery programs are college-based recovery support programs designed to provide recovery, academic, and community support to college students.

**TREATMENT PROVIDERS**

In Minnesota, the treatment systems for individuals with substance use disorders and for other mental illnesses are somewhat separate. Individuals with co-occurring disorders may receive services in either or both systems, or through a program that combines treatment for both disorders.

If your loved one is a young person, there are also important service differences between the children’s mental health system and the adult mental health systems. Individuals with co-occurring disorders may also access services through the school system, the criminal justice system, or the child welfare system.

Coordination and communication between systems can be challenging to manage. Sometimes, your loved one will be able to access a case manager or care coordinator who can help them to manage and navigate these various systems. In other cases, they may need an advocate, like you, to help them navigate these systems. Regardless of which system or systems your loved enters, a good integrated treatment plan brings together evidence-based services to treat both mental illness and substance use.

**Finding Treatment Providers in Minnesota**

There are several ways to find treatment providers. One is to look at the health plan and see who is in network. Using out-of-network providers typically means higher co-payments.

The online tool called FastTracker (https://fasttrackermn.org/) connects you to separate systems of services, reflecting the separate silos of services for mental health and substance use disorders more broadly. As a user, you will have to pick the best “door” to enter.
Types of Professionals

The individuals who provide services vary across systems and have different licenses, skills, and privileges. This section is intended to provide a brief explanation of who some of these professionals are:

**PSYCHIATRIST:** A physician who is trained in psychiatry. Can prescribe medications. May give tests to diagnose patients, conducts therapy, and plan patient care.

**PSYCHOLOGIST:** Gives tests to diagnose the patient and conducts therapy sessions. A psychologist also plans patient care.

**THERAPIST:** A professional who conducts individual, group, or family therapy. The therapist can be a psychologist (Ph.D.), Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Clinical Counselor (LPCC), or Marriage and Family Therapist (MFT).

**LICENSED ALCOHOL AND DRUG COUNSELOR (LADC):** This counselor provides specialized services related to substance use disorder recovery. They provide therapy and can conduct assessments and evaluations. Alcohol and drug counselors are licensed by the Board of Behavioral Health and Therapy and often called LADCs.

**SOCIAL WORKER:** Identifies the patient’s social service and therapeutic needs. The social worker helps connect the patient with community resources and makes referrals for services. This person works with the patient, their family, and other individuals to help make sure the patient gets what they need.

**CARE COORDINATOR:** Similar to a case manager, see below.

**CASE MANAGER:** Coordinates medical, mental health, family, employment, criminal justice, housing, and finances concurrently to improve treatment outcomes. Care coordination is a treatment service involving the deliberate, collaborative planning of substance use disorder services with the client and other professionals involved in the client’s care.

**PEER SUPPORT:** Peer support services can be provided before, during, and after substance use disorder treatment to help individuals connect with resources that support recovery. Peers are considered individuals who are willing to share their personal recovery experience, and often engage quickly with individuals to offer reassurance, reduce fears,
answer questions, support motivation and convey hope. In Minnesota, official peer supports are trained, certified, and supervised.

Mental health professionals are licensed in Minnesota and require master’s degrees or higher and a certain number of hours of supervision in the field. Mental health professionals include psychiatrists, psychiatric nurse practitioners, clinical nurse specialists, licensed independent clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and licensed psychologists.

Licensed alcohol and drug counselors (LADC) typically have a bachelor’s degree and supervision in the field. People who are not licensed as LADCs can work in the substance use disorder treatment programs under certain circumstances, related to having a college degree in certain concentrations (such a social work) with classroom instruction in key topic and supervised work in the field.

**Questions to Ask When Evaluating a Program**

Remember, you can ask as many questions as you need to and ask for a second, third, or more opinion before settling on a treatment program. You can do this by contacting the programs you’re interested in. If your loved one currently receiving services, you can also speak with their current provider about recommendations and referrals. Further, if you are unhappy with a program or a provider, you can ask questions, request changes, or choose to discontinue services.

Because there are so many different approaches, types of treatment, and other factors, it’s important to ask questions about the program before your loved one is admitted. Here are a few examples of useful questions to ask:

**What services do you provide?**

- Look for access to comprehensive services that address the whole person. The program should address both substance use disorders and mental illnesses.
- Ask about continuing services and how participants are prepared to plan for relapse and to continue with their recovery process after treatment has ended.
- Ask about how they support other areas of life, such as ensuring students don’t fall behind in school, or helping individuals who are experiencing homelessness access stable housing.
What strategies/practices do you use to keep participants engaged in treatment?
- In general, individuals with co-occurring disorders have more severe symptoms and are more likely to relapse than individuals with only a mental illness.
- Programs should have active engagement strategies that can meet clients at all levels of readiness “where they are at.”
- Programs that have strict, “one strike you’re out” policy or don’t use secondary strategies to re-engage participants after relapse may be less successful at treating individuals with co-occurring disorders.

What are your program’s policies about abstinence/sobriety?
- Ask specifically about the medications your loved one is currently prescribed and using to manage health conditions that are not related to the substance use disorders.
- Individuals who are prescribed medications that they do not misuse and need access to manage their mental health (for example, sleeping medications, ADHD medications, anti-anxiety medications) need programs that appropriately allow their use.

What are some reasons that services might be discontinued?
- Look for programs that have a plan to re-engage participants if they leave services or relapse.
- When evaluating treatment programs, you may come across the term “failure rate.” This language is sometimes used to talk about the success of a program or provider. Failure rate refers to the number of people who don’t complete treatment. Failure rates are not appropriate language to talk about the recovery process of individuals with co-occurring disorders. For some individuals, relapse may be part of their learning and recovery process. Returning to treatment multiple times may not be a failure.

Other Factors to Examine and Assess
- One need (for example, substance use disorder) is not considered “primary” or more important that the other co-occurring mental illness
- Any door policy to accessing services; co-occurring disorders are screened for and planned for from intake
- Active engagement strategies to support individuals at all levels of readiness for participation in treatment
- No “best” set of treatments for individuals with co-occurring disorders; each person’s treatment plan should be developed to meet their unique needs
Service providers experienced in treating co-occurring disorders, not just addiction or other mental illness

- Abstinence rules that don’t require individuals to discontinue use of psychiatric medications used to manage co-occurring mental illness
- Case coordination including supports to manage payment and disclosures across systems, for example criminal justice, mental health services, substance use service, child welfare, and education
- Relapse is seen as opportunity to re-engage participants and not treated as a treatment “failure”
- Completion of treatment is not seen as the “end” of services
- Active planning for ongoing recovery support

**FAMILY SUPPORT**

The family role in supporting a person with co-occurring disorders is very important. Families often play a primary role in recognizing that there is a problem, ensure an accurate diagnosis motivating the person to seek help, navigating the treatment system to find the best fit and help the person sustain gains in recovery. It can be a significant emotional, time and financial commitment, but research shows that family involvement improves outcomes.

In addition to helping access treatment and providing information to the treatment team, families can also help in other ways by:

- Encouraging treatment participation
- Providing emotional support and encouragement
- Participating in family education, joining family support groups
- Attending individual and family counseling and engaging in self-care
- Assisting with medication management
- Encouraging abstinence
- Helping establish structure and meaning
- Promoting healthy social supports
- Fostering coping skills
- Knowing the signs of relapse

There are different approaches and philosophies regarding how families should approach these situations. A lot of the literature talks about “enabling,” “co-dependence,” or “tough love.” Some of this involves using anger and shaming.

There are new ways to talk about it that are emerging. Families are told to think about what actions can support recovery instead of using. Families need to think about how to use empathy and compassion and
allow for natural consequences and boundary setting. Instead of using the “meanness” that can come out of “tough love” they are recommending thinking about “loving well,” or “healthy love.” The idea is to interact with the person in a respectful and loving manner.

Others are recommending seeing substance use disorder as an illness and not work hard on being right but providing love and support. It’s important that you use an approach that you are comfortable with and that works for you.

**SAMHSA suggests that families:**
- Identify an appropriate time and place
- Consider a private setting with limited distractions, such as at home or on a walk
- Express concerns and be direct; ask how they are feeling and describe the reasons for your concern
- Acknowledge their feelings and listen; listen openly, actively, and without judgement
- Offer to help; provide reassurance that mental and/or substance use disorders are treatable
- Help them locate and connect to treatment services
- Be patient; recognize that helping your loved one doesn’t happen overnight
- Continue reaching out with offers to listen and help.

You might hear about doing an “intervention,” but be aware that this method is not used in the mental health field, it’s expensive and is rarely covered by insurance.

A program called CRAFT (Community Reinforcement and Family Training) is an evidence-based, proven family coaching methodology, which has been extensively studied by the National Institutes of Health and other agencies. It helps families support a loved one who is resistant to treatment and helps with their own stress associated with a loved one with a substance use disorder. The online program can be accessed through https://alliesinrecovery.net/.

**Be sure to research other programs, including:**
- The 20-minute guide, which helps individuals address their loved one’s substance use and learn ways to prevent it (https://the20minuteguide.com/)
- Al-Anon (https://al-anon.org/al-anon-meetings/find-an-al-anon-meeting/)
- Families Anonymous (https://www.familiesanonymous.org/)
- An online program and recovery coaching providing healing medicine for families impacted by substance use and mental health conditions (https://www.family-rx.org/)
Thrive! Family support is an organization that provides family support and education to bring hope and restoration to the families of loved ones struggling with substance abuse or other destructive behaviors by providing resources, support, education, advocacy and healing connections with compassion, understanding, and love (https://www.thrivefamilysupport.org/)

NAMI Minnesota also offers free classes and support groups for families who have a child or adult living with a mental illness or co-occurring disorder

RETURNING TO WORK AND SCHOOL

Returning to work and school after a medical leave for care and treatment can be both exciting and challenging. After the work and progress of treatment, returning might feel like a new beginning and an opportunity to practice new skills in a stable environment, a return to the comfort or fulfillment of your academic, professional, and social world.

However, returning might also feel challenging at times. Supportive employment and education programs can help with this. People with co-occurring disorders need to understand their strengths, their illness and the limitations it causes, and their medication side effects. Knowing these and being able to describe them to others will help them determine the supports they need to succeed in school, work, and their personal life.

Employment

Research shows that people recover from a mental illness more quickly when they have an opportunity to work. People do better if they go to work as soon as they feel ready rather than waiting until all of their symptoms disappear.

VOCATIONAL REHABILITATION SERVICES: Vocational rehabilitation counselors help people with disabilities get the training and support they need to succeed at work. Anyone with a disability that affects whether they can find and keep a job can apply for vocational rehabilitation services. Not everyone will get help, though. There are not enough funds for vocational rehabilitation services for everyone who qualifies, so an order of selection is used. This ensures that those with the greatest need are served first. Others are placed on a waiting list for services. The order of selection is based on the number of “functional limitations” that affect a person’s ability to work. These limitations are
mobility, communication, self-care, self-direction, work tolerance, work skills, and interpersonal skills.

When a person is chosen to receive vocational rehabilitation services, they meet with a counselor who assesses their career goals and determines what training and supports they need to find and keep a job. The counselor and the client create an Individual Plan of Employment (IPE). IPEs can include education, job training, help finding a job, support on the job, and more. Clients who qualify financially may get help paying for education programs, tools or transportation. The client does not pay for vocational rehabilitation.

To seek vocational rehabilitation services, contact your local Minnesota Workforce Center. Experiencing symptoms should not disqualify a person from working. The counselor helps develop the skills needed to succeed at work while experiencing symptoms. Once a job is secured, the counselor should offer support at work for as long as needed. Support can be provided during work, during breaks or outside of work.

**EMPLOYMENT SUPPORT PROGRAMS:** If a person continues to struggle with finding and keeping a job, Extended Employment for People with Serious Mental Illness (EE-SMI) can help. EE-SMI offers individualized support to help people with serious mental illnesses find and keep jobs. Supports offered include job coaching, coordination of support services, job placement and money management. The program also encourages employers to hire people with mental illnesses and helps them make accommodations for employees with serious mental illnesses. The program is a collaboration between the Minnesota Departments of Human Services and Employment and Economic Development. EE-SMI can be accessed through a county mental health case manager or vocational rehabilitation provider.

Research shows that the individual placement and support (IPS) model works well to help people with mental illnesses find and keep jobs. The IPS supported employment model is provided by a team. The team is made up of the client, a rehabilitation counselor, a mental health case manager, mental health provider(s) and an employment specialist. The team may also include substance use specialists, nurses and psychiatrists. The IPS model is available in limited areas in Minnesota, but coverage is expanding. Because IPS is proven to work, it is important to advocate with the state for additional funding for better coverage. It is important to ask the vocational rehabilitation counselor about other available services.

**LEGAL RIGHTS AT WORK:** The Americans with Disabilities Act (ADA) protects people with disabilities from discrimination and gives them
equal access to employment. The ADA defines disability this way: An individual with a disability is a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; OR (2) has a record of such an impairment; OR (3) is regarded as having such an impairment. People do not have to disclose they have a mental illness. Employers cannot legally ask about a disability (including mental illness) when hiring, and prospective employees do not need to say if they have one. If an employer learns about a mental illness, that illness cannot be a reason not to hire someone. Once a job offer has been made, employers may ask more questions about an employee’s ability to perform their job duties, as long as they ask all employees the same questions.

Substance use disorder can be considered a disability under federal disability rights laws. Individuals are protected under these laws if they:

- Have successfully completed a supervised drug rehabilitation program or have otherwise been successfully rehabilitated and are not currently engaged in the illegal use of drugs
- Are participating in a supervised drug rehabilitation program and are currently not engaged in the illegal use of drugs
- Are erroneously regarded as engaging in such use but are not engaging in such use

It is important to note that individuals who currently engage in the “illegal use of drugs” are not protected by disability laws. However, an individual is not to be denied health services, or services provided in connection with drug rehabilitation, vocational rehabilitation programs and services, and other programs and services on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services. People receiving Medication Assisted Treatment (MAT) are included under disability rights laws, because MAT related medications are prescribed and are taken under the supervision of a licensed health care professional and MAT is not the illegal use of drugs.

Employers may not discriminate because of disability. However, employees must be able to do the job with reasonable accommodations. A reasonable accommodation is a change to a workplace or position that allows the employee the same access to the workplace that people without a disability have. If an employee needs and asks for a reasonable accommodation, the employer must provide it. The employee may be required to get a letter from their doctor or treatment team member showing the limitations caused by the disability. The accommodation cannot pose a large burden on the employer. The employer does not need to lower performance standards or remove essential job functions.
Examples of accommodations for an employee with a mental illness include:

For help maintaining stamina:
- Flexible scheduling
- Ability to job share
- Backup employees for when extra breaks are needed

For difficulty concentrating:
- Fewer distractions in the work area
- Big jobs divided into smaller tasks
- Space enclosures or arrangements that enhance privacy
- Additional time to learn new responsibilities
- Use of an iPod or headset
- More frequent but shorter breaks
- Use of an electronic device, such as a Motivaider, that vibrate at timed intervals to help maintain focus

For staying organized and meeting deadlines:
- Calendar to track meeting dates and deadlines
- Daily checklists

For clear communication:
- Written instructions
- Clear, written expectations and what will happen if they are not met
- Regular and frequent meetings for feedback
- Gradual updates of changes that are coming
- A clearly identified person the employee can go to with questions or concerns about the job
- Allowing the presence of a job coach to help with training and reading social cues.

The Job Accommodation Network provides a searchable database of job accommodations that may be helpful. This information can be found online at www.askjan.org.

**FAMILY AND MEDICAL LEAVE AACT (FMLA):** Substance abuse and mental illnesses can qualify as a serious health condition under the FMLA if the conditions for inpatient care and/or continuing treatment are met. FMLA leave may only be taken for treatment for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider.

It is important to note, absence because of an employee’s use of the substance, rather than for treatment, does not qualify for FMLA leave. Treatment for substance use disorder also does not prevent an employer from terminating an employee, if the employer has an established
policy, that has been communicated to all employees, that states an employee may be terminated for substance abuse.

An employee may also take FMLA leave to care for a covered family member who is receiving treatment for substance abuse. The employer may not take action against an employee who is providing care for a covered family member receiving treatment for substance abuse.

**DISCLOSURE AT WORK:** No one is ever required to discuss their mental illness with anyone. However, talking about a challenge (such as short-term memory issues) related to a mental illness to a supervisor and/or human resource professionals, allows employees to get needed accommodations. Each person with a mental illness will decide for themselves whether to disclose a disability and ask for accommodations. There are pluses and minuses to consider. If a person chooses to disclose at work, they do not need to do this before they are hired. It pays to be cautious about disclosure.

Deciding whether to disclose is a very personal decision. Not everyone understands mental illnesses. People may wrongly assume that a person with a mental illness can’t do the job, won’t be reliable, or could be dangerous. Any conversation an employee has about their disability or accommodations is confidential. If they speak to someone in the human resources department, their direct supervisor and coworkers will not be told what the disability is.

At a company that doesn’t have a human resources department, the supervisor may know about the disability because the employee may need to ask them for accommodations. The information is still confidential and cannot be shared with coworkers. People should always consider whether their coworkers need to know about the mental illness. Maintaining privacy is sometimes the best choice. A supported employment counselor can support people in making this decision and help with these conversations.

**Education**

Education also can be an important part of a person’s recovery. If the person was in high school or college, they need to know they can return to their education. It is important to learn to be successful while living with symptoms. The young person may need help selecting and applying for school. They also may need help talking with the school about accommodations, developing study skills and dealing with symptoms that may interfere with success.
INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA): The IDEA is a law that makes available appropriate public education to eligible children with disabilities and ensures special education and related services to those children. An Individualized Educational Program (IEP) under IDEA is designed to meet the child’s unique needs and provide the child with educational benefit, so the child will be prepared for “for employment and independent living” and also provides protections to ensure the child’s right to an education.

SECTION 504: Section 504 of the Rehabilitation Act is a civil rights law that prohibits discrimination on the basis of disability. This law applies to public elementary and secondary schools, among other entities. If the child has a disability but does not need special education services, the child may still receive protections under Section 504. Section 504 requires that school districts provide accommodations to access regular education. This could include more time to take tests, fewer homework assignments, etc.

EDUCATIONAL PRIVACY: The federal Family Educational Rights and Privacy Act (FERPA) allows only the student over the age of 18 to have access to their education records. For this reason, school employees cannot speak with parents about how the young adult is doing. If the student has signed a release, certain information may be given to parents. Minnesota law allows the release of information in the case of safety, medical or mental health emergencies.

Most professors likely will not be comfortable talking with parents about a student’s progress. Parents should ask the college about its policy on sharing mental health safety information. Some schools will share more information in the case of a mental health crisis or hospitalization without the proper release forms than they normally would. This can help families advocate for their student. A common request is to allow an “incomplete” grade for a class being taken when the symptoms began so that the student can finish the class without it harming their grade average.

Becoming familiar with the college handbook—which contains tuition refund policies, exam times, and other critical dates—can help parents understand when a student may need extra support. Parent should share any information that they feel the school should have to keep the student safe. They should let the school know right away any concerns they have about their young adult’s health or safety.
RELAPSE PREVENTION

The process of recovery is not always a straight line from addiction to withdrawal to treatment to ongoing care and recovery support. Often, relapse, which means returning to substance use after a period of abstinence, can put the brakes on the recovery process, leaving the individual feeling like they are back at square one.

Substance use is a chronic illness, which means that it is a complex and long-lasting condition requiring ongoing care and monitoring, even after substance use and symptoms are no longer affecting daily life. Even after many years of recovery and abstinence, some people will relapse. Relapse or re-occurrence can range from a one-time incident of substance use during abstinence (a slip or a lapse) to a full re-occurrence of all of the symptoms of substance use disorders. Unfortunately, more than half of people in treatment for substance abuse disorder relapse. For individuals with co-occurring disorders, relapse rates are even higher.

Relapse does not mean that treatment has failed or that recovery is over. Following relapse, treatment and recovery should resume with a plan in place for a better next time. This could mean a return to abstinence with a new commitment to the recovery process, a return to treatment, accessing peer supports, or something else. However, relapse is not inevitable. Relapse prevention is a set of strategies that can be used to effectively help recognize the signs of relapse early and respond without relapse.

There are many theories and resources related to relapse prevention, some of which are provided at the end of this section. These three key concepts are especially important:

- **RELAPSE, LIKE RECOVERY, IS A PROCESS.** The earlier you spot the signs of relapse, the easier it is to put on the brakes and make changes to support recovery.

- **THE STAGES OF RELAPSE ARE EMOTIONAL, MENTAL, AND PHYSICAL.** Physical relapse, where one actually returns to substance use is the last step. Identifying the signs of emotional and mental relapse and using coping strategies can help prevent the occurrence of physical relapse.

- **EACH STAGE OF RECOVERY HAS ITS OWN UNIQUE RISKS OF RELAPSE.** Relapse prevention should take into account where you or your loved one are in the recovery process.

There are strategies to avoid relapse, which include therapy to change negative thinking patterns and create new patterns, lifestyle changes, identification of support networks, relaxation, and developing healthy coping skills. For individuals with co-occurring disorders, the impor-
tance of relapse prevention planning is even more critical given the increased rates of relapse.

One of the reasons individuals with co-occurring disorders are thought to have higher relapse rates are because of the interaction between substance use disorders and the co-occurring mental illnesses. An increase in symptoms or problems in one area can be a trigger for use. The best approach to treatment of co-occurring disorders is an integrated plan that addresses all of the needs of the individual, not just substance use disorders or a co-occurring mental illness.

Below are some strategies for relapse prevention for individuals with co-occurring disorders. Notice that many of the recommendations include consideration of both disorders, reflecting an integrated approach to relapse prevention.

**KNOW YOUR TRIGGERS FOR USING:** Are you more likely to use when you’re not taking your psychiatric medications regularly? When you’re stressed? When the symptoms of your co-occurring disorder are more severe, for example when feeling anxious or unable to sleep? Also consider places and people around whom you feel stronger urges to use.

**MONITOR YOUR FEELINGS AND SYMPTOMS REGULARLY:** Keep a journal of how you feel during the day to track mental health symptoms and relapse cravings.

**LEARN COPING METHODS:** Find coping methods that work for you! Coping methods that are effective can change over time.

**CONTINUE TREATMENT FOR YOUR MENTAL ILLNESS:** Recovery doesn’t stop when you complete treatment. Peer support groups and ongoing therapy are great ways to continue in your recovery process.

**CREATE AN INTEGRATED RELAPSE PLAN:** Be sure that the integrated plan includes:
- Your triggers and how you will respond to them
- Contact information for social supports such as loved ones, your case worker, therapist, etc.
- Coping strategies that work for you

**Involuntary Treatment**

There are a number of situations where the decision to seek services related to substance use disorders or co-occurring mental illness is not voluntary. In these cases, the local government has become involved in a way that requires you or your loved one to participate in treatment.
**CRIMINAL JUSTICE INVOLVEMENT:** specialty courts work closely with prosecutors, public defenders, probation officers, social workers, and other justice system partners to develop a strategy that will allow a justice involved individual to complete a treatment program to reduce the risk of further criminal justice involvement. Across the state, there are specialized treatment courts for veterans, adults with substance use disorders, juveniles with substance use disorders, those who are charged with DUI, mental health courts and others. Treatment court strategies include regular appearances before a judge, intensive supervision by a probation officer, frequent and random drug and alcohol testing, and immediate sanctions and incentives to reward program compliance.

**CHILD PROTECTION:** In Minnesota, parental drug or alcohol abuse is a common reason for out-of-home placement of children involved in child protection. A family’s involvement in the child welfare system can be an opportunity to get connected to integrated, evidenced-based treatment and services to support their path to recovery.

**IN Voluntary COMMITMENT:** In Minnesota, if you live with mental illness or a substance use disorder and are likely to harm yourself or others, you can be civilly committed.

The process typically begins in a hospital, with medical staff filing a petition. A county agency provides further screening and provides the information to the county attorney for a decision on petitioning for commitment. At a hearing, a judge can order the person into a hospital or other treatment program for involuntary treatment. Commitment typically last for six months and can be extended for a year. (See NAMI’s Booklet called *Understanding the Minnesota Civil Commitment Process*.)

**INSURANCE AND TREATMENT COVERAGE**

Understanding your health insurance and treatment coverage or obtaining health insurance is the first place to start when you are seeking care for co-occurring disorders for your loved one. Health insurance—public or private—may pay for many mental health and substance use disorder treatments and services and it is important to learn as much as possible about your health insurance plan or a plan you are considering, to help you make an informed decision about receiving care.

Navigating the insurance system can be very challenging and there are some important laws to be aware of, including that people cannot be denied health insurance coverage because they have a pre-existing health
condition and that children under age 26 can be covered under their parent’s health insurance plan (if “dependent coverage” is available), even if they are not in school.

To help you navigate the complex treatment coverage system, here are some important questions to ask your insurance provider when seeking coverage:

► Does my plan cover mental health and/or substance use disorders benefits? How do I find out for my specific plan?
► Which treatment services require prior authorization (including levels of care (i.e., inpatient, outpatient, intensive outpatient, and partial hospitalization settings, and medications))?
► What documentation do I need to provide for reimbursements?
► What is my deductible and how do any payments I make for addiction treatment, in-network and out of pocket, apply toward that deductible?
► What providers are in my plan’s network?

Finding treatment coverage can be complicated and insurance plans differ in the types of services they cover. Below is a brief overview of the main avenues for obtaining coverage and issues to consider.

**MNsure**

MNsure, Minnesota’s health insurance exchange, is a way to buy private insurance or enroll in public health care programs, including Medical Assistance (MA) and MinnesotaCare. MNsure is available to Minnesota residents and noncitizens lawfully residing in the United States who do not have affordable health insurance through their employer. MNsure is not an insurance provider itself. It is a way to buy health insurance. Insurance plans can be compared side-by-side on MNsure.

Enrollment can be completed online, by phone, or by mail. All plans offered through MNsure are required to cover mental health and substance use disorder treatment in the same way that other health conditions are covered. There are many organizations that have “navigators” to help enroll you or a family member through MNsure. Visit www.mnsure.org for more information.

Even if you do not have health insurance available through your employer you can still purchase health insurance outside of MNsure. However, you will not be able to access tax credits that you may be eligible for to make the insurance more affordable. As with all health insurance options, it is important to learn as much as possible about your coverage (see questions to consider at the beginning of this chapter).
**Public Health Insurance Programs**

If you have limited income, have a disability, and/or are over age 65, you may be eligible for a public health insurance program. Medical Assistance (MA) and MinnesotaCare, are the two public health insurance programs in Minnesota. These programs often cover a greater variety of mental health services than private health insurance plans. To apply for Medical Assistance or MinnesotaCare create an account at www.mnsure.org and fill out the “Application for Health Insurance and Help Paying Costs.”

**Medical Assistance**

MA is often provided through managed care through a MN health plan. They each have their own network of providers and prior authorization rules so you will need to check their websites. In 2019, the legislature passed a law that requires the drug formularies for Medical Assistance fee-for-service and managed care to use the same Preferred Drug List (PDL).

For important medications (such as antipsychotics or antidepressants), anyone transitioning from fee-for-service to managed care would not have a different PDL. However, anyone whose mental health medications are not preferred on the PDL will have to obtain prior authorization in order to access the medication. If you use a medication that is not on the PDL, like a mood-stabilizer, the health plan will continue to use its own standards when determining whether or not to require a prior authorization. MA can cover some medical expenses retroactively—up to three months—from the date of application. It can take 45 days to process an application.

**MinnesotaCare**

MinnesotaCare is a premium-based public health insurance program for low-income working Minnesota residents who do not have access to health insurance through their employer. To be eligible for MinnesotaCare, you must have a family household income at or below 200 percent of the Federal Poverty Guidelines (FPG)—approximately $24,980 per year for a single adult—and not be eligible for Medical Assistance (MA) or private health insurance through your employer. As with MA, the income limit is higher for families with children. There is no asset limit for MinnesotaCare. All mental health services that are covered under MA are also covered under MinnesotaCare. However, other covered services vary according to income and type of household. People with children have a full benefit set, while people without children have a slightly more limited set of coverage for various medical services.
Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services for people age 65 years and older as well as people with disabilities. Medicare has three main parts: Part A is hospital insurance, Part B is medical insurance, and Part D is prescription drug insurance. You can apply by calling 1-800-MEDICARE, going to www.medicare.gov or visiting a Social Security office.

People age 65 years or older are eligible for Medicare if they or their spouse worked at least 10 years in Medicare-covered employment, and they are a citizen or permanent resident of the US.

**People under age 65 years can enroll in Medicare Part A when they:**
- Have a disability (established by the Social Security Administration), and
- Have been entitled to disability benefits under Social Security for 24 months

For Medicare related questions, help choosing a plan or help deciding whether to enroll in Part B or Part D, call the Disability Hub at 1-866-333-2466. You can also call the Centers for Medicare and Medicaid Services at 1-800-MEDICARE or 1-800-633-4227. It is important to note that Medicare has several limitations when it comes to mental health treatment coverage. Medicare is not subject to mental health parity (see next section) and Medicare beneficiaries are currently limited to just 190 days of inpatient psychiatric hospital care in a person’s lifetime. Medicare does not cover the full array of mental health services that are covered under MA. In addition, Medicare only covers mental health treatment provided by the following professionals and only when they are also a Medicare “assigned” provider. Examples include:
- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician Assistant
- Licensed Alcohol and Drug Counselor

Many people with a mental illness are on both Medicare and MA. Please note that MA can’t cover medications; people must use Part D. Medicare doesn’t cover Marriage and Family Therapists or Licensed Professional Clinical Counselors.
Private Insurance

Health insurance provided through your employer will come in one of two ways:

- **EMPLOYER-SPONSORED/FULLY INSURED HEALTH INSURANCE**: A company purchases a health insurance plan and makes that plan available to its employees who usually share the cost in the form of a monthly premium and co-payments. These plans must follow state health insurance laws.

- **SELF-INSURED PLANS**: A company sets aside money to pay employee health costs directly. These plans are usually exempt from state health insurance laws, and do not have to cover mental health and substance abuse treatment but do have to follow federal insurance laws including mental health parity. (See the “Mental Health Parity” section for more information.)

Mental Health Parity

If you have private health insurance, you should be aware of mental health parity. Parity requires health insurance plans to cover treatment for mental health and substance use disorders in the same way as treatment for other health conditions.

There is a federal mental health parity law, as well as a Minnesota law. Unfortunately, these laws typically do not apply to health insurance offered to individuals and through small employers (under 50 employees).

Parity laws do not require a health insurance plan to cover mental health and substance use treatment but do require plans that cover these treatments to cover them in the same way as other health conditions. If a plan has to follow the parity law, it must treat mental health and substance use disorders in the same way as other conditions in three main areas:

- **ARBITRARY TREATMENT LIMITS**: Cannot limit mental health or substance abuse disorder visits if the same limits do not apply to treatment for other conditions.

- **OUT-OF-POCKET COSTS**: Cannot have higher co-pays, deductibles, or maximum out-of-pocket costs for mental health or substance use treatments compared to treatment for other conditions.

- **NON-QUALITATIVE TREATMENT LIMITS**: Must offer same or similar services. For example, if a health insurance plan covers rehabilitative services for physical health conditions, they must also cover rehabilitative mental health or substance use disorder services. Under state law, the Department of Commerce now has the authority to request information from the health plans to determine whether the
plans are using NQTLs more restrictively to limit mental health and substance use disorder benefits.

Federal parity also applies to the criteria used by health insurers to approve or deny mental health or substance use treatment. The standard for “medical necessity determinations”—whether the treatment or supplies are considered by the health plan to be reasonable, necessary, and/or appropriate—must be made available to any current or potential health plan member upon request. The reason for denials of coverage must also be made available upon request.

Federal law bars health plans that offer mental health benefits from setting annual or lifetime limits differently than limits for other medical benefits. Under Minnesota law, health plans licensed by the state cannot have higher co-payments or different limits for mental health or chemical dependency services than other medical services.

Here are some signs your health insurance plan may be violating parity laws:

► You have to pay more or get fewer visits for mental health services than for other kinds of health care
► You have to call and get permission to get mental health care covered, but not for other types of health care
► You have been denied mental health services because they were not considered “medically necessary,” but your plan does not answer your request for the medical necessity criteria they use
► You cannot find any mental health providers in your insurance plan’s network that are taking new patients, but you can for other types of health care
► Your plan will not cover residential mental health or substance use treatment or intensive outpatient care, but they do for other health conditions
► Your plan covers new FDA treatments of other healthcare conditions but not mental illnesses

If your health plan denies coverage for your mental health or substance use disorder treatment, you can appeal it and ask for more information about why your treatment was denied. Should your health plan deny coverage upon review and you believe this violates mental health parity, then you should contact the Minnesota Department of Commerce at 651-539-1600, MN Department of Health or the US Department of Labor at 1-866-487-2365.

To learn more about parity laws, visit www.nami.org/parity, paritytrack.org, parityportal.com, or parityispersonal.org. Those websites will also have resources for filing a complaint.
Culture—a person’s beliefs, norms, values, and language—plays a key role in every aspect of our lives and interacts with other unique personal identity traits, such as our personality, personal history, race, ethnicity, sexuality, gender, and age, to produce particular strengths and needs in treating co-occurring disorders.

Specific groups or populations experience co-occurring disorders at varying rates and there can be differences in access to treatment and the quality of care received and differences in the type of care that is most effective. Certain characteristics of a particular group can make it easier or more difficult to get help. For many groups, there are particular issues to consider when looking for help:

► Poverty level affects mental health status; higher rates of poverty are associated with higher levels of distress
► Discrimination and historical trauma negatively impact mental health
► There is a lack of research on many subpopulations or minority groups, which would provide more guidance on the treatment modalities that have good outcomes
► Lack of insurance or under insurance creates a barrier to accessing care
► There is a lack of culturally informed providers

Being culturally informed means that a provider acknowledges, respects, and integrates the patients’ and families’ cultural values, beliefs, and practices. Unfortunately, research has shown lack of providers from different cultures and a lack of culturally informed professionals in mental health care, which can result in misdiagnosis and inadequate treatment.

Programs tailored to particular racial, cultural, and other group characteristics can help engage clients in their treatment and promote recovery. Studies show the best outcomes occur when treatment includes the core elements of evidence-based practices while also taking into account the cultural concerns of the clients. Effective programs are culturally appropriate, meaning services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.

When researching treatment options, ask questions to get a sense of their level of cultural sensitivity. Providers expect and welcome questions to help them better understand you and what is important to you. Your questions give them important information about you. Here are some questions you could ask:
Have you treated other people from my culture/background?
Have you received training in cultural competence or on my culture’s mental health?
How do you see our cultural backgrounds influencing our communication and my treatment?
How do you plan to integrate my beliefs and practices in my treatment?
Have you received training on trauma?

Understanding the specific needs and strengths of different groups can help you to identify the best treatment options. For example, younger people respond differently to treatments because of brain development, legal status as minors, and their home environment. Family therapies are often recommended for young people with co-occurring disorders because that is the environment they are living in and caregivers can play an important role in supporting recovery. Of course, all of us occupy many categories, for example you may be a veteran and Native American or a youth and LGBTQIA.

Under the chemical dependency statute, a culturally specific program is defined as a substance use disorder treatment service program or subprogram that is recovery-focused and culturally specific when the program:
- Improves service quality to and outcomes of a specific population by advancing health equity to help eliminate health disparities
- Ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to an individual within a specific population’s values, beliefs and practices, health literacy, preferred language, and other communication needs
- A tribally licensed substance use disorder program that is designated as serving a culturally specific population by the applicable tribal government is deemed to satisfy this subdivision

Youth

SPECIAL CONSIDERATIONS: Young people make up a large part of all people diagnosed with co-occurring disorders. In addition, most (70 to 80 percent) young people with a substance use disorder have a co-occurring condition (Kaminer & Winters). That rate is higher than the general population.

TREATMENT IMPLICATIONS: Although co-occurring disorders are extremely common among youth with substance use disorder, the number of service providers who specialize in treating youth is limited.
**Older Adults**

**SPECIAL CONSIDERATIONS:** Abuse of alcohol, drugs, and prescription medications, among adults 60 and older, is one of the fastest growing health problems in the US. This is of particular concern because age-related changes can intensify the impact of substance use. This can contribute to memory loss, worsen other health conditions such as heart disease and diabetes, and increase the risk for hospital admissions and the need for a long-term care facility, like a nursing home.

In addition, older adults tend to take more medications as they age, leading to new and unexpected problems, especially when mixed with alcohol. Finally, older adults with a history of substance use may not understand their new vulnerabilities.

**TREATMENT IMPLICATIONS:** Older adults might be uncomfortable talking openly about mental illness and/or substance abuse and may view a mental illness or substance use disorder as evidence of moral or physical weakness, a character flaw or laziness. They may be reluctant to report needing help because it may cause the family to force an undesired change (for example, move to an assisted living facility).

**Veterans/Military**

**SPECIAL CONSIDERATIONS:** Veterans are twice as likely to die from accidental opioid overdoses as non-veterans, according to a 2011 study of among VA health system patients. Physical wounds and Posttraumatic Stress Disorder (PTSD)—exposure to combat and other life-threatening situations can be very traumatic and cause psychological and physical wounds.

The US Department of Veteran Affairs estimates that one in three veterans seeking help with substance abuse also has PTSD and 70 percent of homeless veterans also experience a substance use disorder.

**TREATMENT IMPLICATIONS:** Chronic pain affects 30 percent of American adults, but affects 60 percent of veterans returning from the Middle East, and more than 50 percent of older veterans in the VA health care system. Battlefield injuries can often result in long-term moderate to severe pain. Chronic pain is sometimes treated with powerful, effective painkillers. Used properly, they can ease suffering and improve quality of life, used improperly they can lead to addiction and sometimes to a reliance on illegal drugs, like heroin.
**Native Americans / American Indians / Alaska Natives**

**SPECIAL CONSIDERATIONS:** Native Americans experience serious psychological distress 1.5 times more than the general population due to the cumulative, multigenerational, and collective experience of emotional and psychological injury. The impact of boarding schools, loss of language and traditions, poverty, and more have resulted in depression, substance use disorders, suicide, and anxiety (including PTSD). Suicide is a major concern. Native Americans use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups.

**TREATMENT IMPLICATIONS:** There are barriers to accessing treatment, including lack of insurance, lack of culturally appropriate services, mistrust of health care providers, shortage of treatment programs on or near the reservations, or lack of culturally appropriate providers in urban areas.

Combining traditional/spiritual healing with other more traditional substance use disorder or mental health treatment leads to better outcomes.

**African Americans**

**SPECIAL CONSIDERATIONS:** Compared with whites with the same symptoms, African Americans are more frequently diagnosed with schizophrenia and less frequently diagnosed with mood disorders. Differences in how African Americans express symptoms of emotional distress and providers lack of awareness of these differences may contribute to misdiagnosis.

The rate of illicit drug use among African Americans is slightly higher than the national average (12.4 percent vs 10.2 percent), but the rate of alcohol use is slightly lower than the national average. Black/African Americans have a high rate of deaths due to opioid overdoses.

Trauma due to discrimination and microaggressions has led to higher rates of poverty and lack of economic investments (redlining, weathering), which has negatively impacted African Americans. Perceptions that substance use disorders are a moral failing or fear of the criminal justice system prevent people from seeking treatment.

**TREATMENT IMPLICATIONS:** Lack of insurance and lack of providers from diverse racial/ethnic backgrounds are barriers to accessing treatment. Finding culturally informed providers is important, as well as providers who have received training in trauma informed treatment. Understanding the importance of religion or faith in recovery is critical. Limited access to buprenorphine treatment is an issue.
Homeless

**SPECIAL CONSIDERATIONS:** For most, if not all, people with co-occurring disorders experiencing homelessness, the impact of substance abuse and mental illness bears a direct relationship to their ability to maintain housing.

The risk of chronic homelessness increases when substance use or a mental illness are present. Barriers to needed services are profound for people without housing and coping with co-occurring disorders. People who are homeless or at risk for homelessness and have a substance use disorder or mental illness are often cut off from social supports and need services ranging from safe and stable housing, food, and financial assistance to medical care, mental health treatment, child care, education, skills development and other preventive services, employment, screening and early intervention, and recovery support.

**TREATMENT IMPLICATIONS:** It is unrealistic to expect that people who are experiencing homelessness will be able to maintain housing if their social and health needs are not met. It is also much more difficult for individuals with substance use and mental disorders to manage their symptoms when they are homeless. Some of the most pressing issues of people who are homeless include:

- Addressing acute and chronic medical conditions (e.g., diabetes, HIV infection, heart and respiratory conditions)
- Untreated or inadequately treated disabilities, such as hearing and/or vision impairment, lack of balance, or mobility impairments
- Recognizing cognitive problems, such as memory deficits, poor attention, and concentration
- Making the transition from jail or prison to the community, which includes adapting survival skills that were functional in prison but are counterproductive outside the criminal justice system
- Dealing with a history of trauma when substance use disorders or unexpected events may trigger flashbacks or other responses that are perceived as inappropriate
- Symptoms of psychological trauma that mimic, exaggerate, or obscure the symptoms of other mental and substance use disorders

There is no “one size fits all” accommodation for the diverse population of people with substance use disorders and/or mental illnesses who are also faced with homelessness. For example, people who are in crisis and transitionally homeless need different services from those who are chronically homeless. Programs for persons with mental or substance use disorders may need to work in close coordination with homelessness programs, especially in early recovery.
Effective programs will address the housing needs (housing first) and will teach people the skills for maintaining housing and will address real-life issues in addition to housing, such as substance abuse treatment, legal and pending criminal justice issues, Supplemental Security Insurance/entitlement applications, issues related to children, healthcare needs, and so on.

Refugees

SPECIAL CONSIDERATIONS: While, statistically, refugees have lower rates of substance abuse compared to American-born individuals, many in this population have suffered intense trauma and may be susceptible to substance abuse as a result. Refugees experience a range of potentially traumatic and other adverse events that increase their risk for alcohol and substance use problems.

Like immigrants, refugees may face cultural, linguistic, or systems barriers to connecting with mainstream substance use treatment programs, which may be compounded by refugees’ unique experiences with exposure to trauma, displacement in refugee camps, and resettlement.

TREATMENT IMPLICATIONS: Trauma informed, culturally relevant models of treatment that are integrated with primary health care and geographically accessible may improve treatment outcomes. Community-based, peer-led programs, 12-step and mutual-help group therapies may provide a bridge to further help-seeking.

LGBTQIA

SPECIAL CONSIDERATIONS: Adults who identify as lesbian, gay, or bisexual have a higher prevalence of substance use and mental illness than adults who identify as heterosexual. The reasons for this include the high rates of bullying in youth, being victims of hate crimes and harassment, and family conflict.

People who are transgender are more likely than those who are cisgender to experience depression, anxiety, and a substance use disorder.

TREATMENT IMPLICATIONS: LGBTQ people with mental illness and substance use disorders need programs and providers who accept them, especially for people who are transgender. The treatment environment should be LGBTQ friendly and accept the person for who they are. People tend to have better outcomes if they are in specialized groups and that treatment addresses homophobia/transphobia, family problems, violence, and social isolation.
**Asian Americans and Pacific Islanders**

**SPECIAL CONSIDERATIONS:** Studies have shown that Asian Americans or Pacific Islanders are less likely than people of other racial and ethnic groups to need alcohol or illicit drug use treatment, but this is changing, especially for those born in this country. Socioeconomic issues and acculturation pressures play a role.

**TREATMENT IMPLICATIONS:** Treatment is most successful for dealing with stress when it incorporates cultural traditions and practices, such as family support, spirituality, and the inclusion of elders.

**Hispanic, Latino, LATINX**

**SPECIAL CONSIDERATIONS:** Substance use disorders are viewed negatively in the Hispanic and Latino community, especially for women. Lack of insurance creates a huge barrier to accessing treatment, along with fear of deportation and lack of providers who are fluent in Spanish.

**TREATMENT IMPLICATIONS:** The involvement of family in treatment is important as is confidentiality. Faith and spirituality are also very important.

**Criminal Justice Populations**

**SPECIAL CONSIDERATIONS:** A significant and growing number of people in the justice system have co-occurring disorders at rates that greatly exceed those found in the general population. These individuals are less likely to enter and successfully complete treatment. They are at greater risk for criminal recidivism and relapse. Few specialized treatment programs exist in jails, prisons, or court and community corrections settings that provide effective mental health and substance use services. Few allow medication assisted treatment.

When released from prison, jail, or residential treatment facilities, people with co-occurring disorders may not have access to the medications that stabilized them prior to release and often experience difficulties engaging in community mental health and drug treatment services.

Other barriers to community integration include lack of affordable housing and transportation, barriers to accessing employment once one has a criminal record, and the termination of income supports and entitlements. Coordinating the diverse medical, mental health, substance use, and supervision needs of these individuals can be a daunting task and often requires the ability to navigate among service systems, institutions, and agencies that have very different missions, values, organizational structures, and resources.
**TREATMENT IMPLICATIONS:** Treatment should address issues of motivation, problem solving, and skill building for resisting drug use and criminal behavior. It is important to include lessons aimed at replacing drug use and criminal activities with constructive activities, as well as aimed at understanding the consequences of one’s behavior.

Treatment and criminal justice personnel should work together on treatment planning—including implementation of screening, placement, drug testing, monitoring, and supervision—as well as on the systematic use of sanctions and rewards.

Research demonstrates that effective treatment and supervision models integrate criminal justice and addiction treatment systems and services. Successful programs in justice settings provide an integrated treatment approach. These programs are typically intensive and highly structured and provide case management and adaptations to clinical services that address the complicated needs of offenders.

**Women**

**SPECIAL CONSIDERATIONS:** It is estimated that between 55 and 99 percent of women in substance abuse treatment have had traumatic experiences. Of these, between 33 and 59 percent have been found to be experiencing current PTSD, yet few substance abuse treatment programs assess for, treat, or educate clients about trauma.

Pregnancy, childbirth, and parenting can aggravate or diminish the symptoms of co-occurring mental illness. Many factors can contribute to a woman experiencing worsening mental illness symptoms:

- hormonal changes, pregnancy;
- Lactation (breastfeeding)
- Medications given during pregnancy or delivery
- Stresses of pregnancy, labor, and delivery
- Adjusting to and bonding with a newborn

In 2019, Minnesota passed a law authorizing children to be co-located with a parent who is receiving treatment from a licensed residential family-based substance use disorder treatment program.

**TREATMENT IMPLICATIONS:** Specialized programs for women with co-occurring disorders have been developed to address pregnancy and childcare issues as well as certain kinds of trauma, violence, and victimization that may best be dealt with in women-only programs. Programs should assess for and address past or present history of domestic violence or sexual abuse, physical health, and pregnancy or parental status.

Women who enter treatment sometimes risk losing public assistance support and custody of their children, making the decision to begin
treatment a difficult one. Women accompanied by their children into treatment can be successful in treatment.

Treatment for substance abuse in women should emphasize the importance of relationships, the link between relationships and substance abuse (many women continue to use with a partner), and the importance of relationships with children as motivators in treatment.

Pregnant women should be made aware of any and all wraparound services to assist them in managing newborn issues—including food, shelter, medical clinics for vaccinations, etc.—as well as programs that can help with developmental or physical issues the infant may experience as a result of alcohol or drug exposure.

*Successful programs for women with children will offer program components that help women reduce the stress associated with parenting and teach parenting skills. For example:*
  - Develop programs for both women and children
  - Provide interventions that focus on trauma and abuse
  - Foster family reintegration and build positive ties with the extended/kinship family
  - Build healthy support networks with shared family goals
  - Make prevention and emotional support programs available for children

**CRISIS PREVENTION**

Loss of a loved one to overdose, especially to opioids, is a topic that we’ve all likely heard about in the news. Sadly, some of us have personal experience. Fortunately, however, most overdoses or drug poisonings do not result in death. Accurate information about overdosing, including knowing the signs of an overdose and how to respond quickly, can help you to prevent long term health consequences and even save a life.

Taking too much of a harmful substance or a mix of substances can result in an overdose. In the case of an overdose, an individual’s body cannot metabolize (process) out the toxins they have ingested quickly enough and is overwhelmed. In other words, the individual is poisoned. This can result in different symptoms depending on the type of substance consumed.

Not all overdoses are caused by intentional misuse of a substance or use of illegal substances. Sometimes substances can be given or taken by accident (by children, for example), through a mistake at the pharmacy, or by simply grabbing the wrong bottle from the cabinet.
Occasionally, one can accidentally take too much of a drug. For example, an extra dose in the evening because of mismeasurement or unintentionally overmedicating when experiencing strong symptoms and taking drugs “as needed,” which can happen with pain or anti-anxiety medications.

Finally, individuals with co-occurring disorders may take medications for multiple conditions, from multiple providers, in multiple systems. Lack of communication and miscommunication across systems can contribute to drug interactions and overmedication that can lead to overdose. For example, prescribed benzodiazepines (such as Xanax and Lorazepam), which are often used to treat anxiety disorders, can lead to an overdose when taken with opioid medications at standard dosages.

**Preventing an Overdose**

To help prevent an overdose, practice harm reduction. In other words, if your loved one is planning to use substances, know the factors that increase risk for overdose and seek to minimize them. To practice harm reduction, be sure to:

- Learn the signs of overdose and overmedication
- Teach others how to recognize and respond to signs of overdose and overmedication
- Ensure medications are taken as prescribed by doctors
- Ensure that new providers who may prescribe are aware of your loved one’s current medications
  - It may be helpful to bring a list with dosages to the appointment; do not expect the medical record or chart to be complete or accurate
- Avoid mixing medications with alcohol or other substances that may cause unknown interactions
- Seek treatment for substance use disorders
- Ensure proper disposal of unused and expired medications
- Know how to use and carry Naloxone if you or a loved one is at risk of overdosing on opioids.

Remember, not all overdoses are due to intentional misuse. If you need step-by-step assistance administering naloxone, call the Minnesota Poison Control System at 1-800-222-1222.

Pharmacists, in collaboration with a registered practitioner, may enter a written protocol to provide naloxone to persons at risk for opioid overdose or who know of someone at risk for opioid overdose. A list of all participating pharmacies is on the Minnesota Department of Health website.
Risk Factors for Overdose

Several factors increase the likelihood of an overdose:
- Mixing drugs, for example opioids and alcohol or Xanax
- Tolerance (needing to take higher doses to get the same effect)
- Depression and opioid use
- Taking doses of prescription pills over 50 morphine milligrams equivalents (MME)
- Long lasting opioids
- Using opioids after a period of abstinence, such as being in the hospital or jail
- Using heroin, fentanyl, and other synthetic opioids
- Quality (the quality of illicit “street drugs” is not often known, but you can test for the presence of fentanyl using fentanyl testing strips, for example)
- Using alone
- Injecting opioids
- Living in a household with opioids
- Age and physical health
- Previous non-fatal overdose

Signs of Overdose

While most overdose deaths are caused by opioids, other substances—such as alcohol and cocaine—can also lead to overdose. Sometimes, individuals may use multiple substances at the same time. Knowing the signs of overdose can help you know when to seek help.

Opioid Overdose

Opioid overdoses happen when there is too much of an opioid in the body. Opioids affect the brain in many ways, including binding with the same part of the brain that controls breathing. Breathing slows down and the person experiencing the overdose is not able to get enough oxygen. Some signs of opioid overdose are:
- Won’t wake up/keeps falling asleep
- Won’t respond (try to wake them up)
- Pinpoint pupils
- Awake, but can’t talk
- Cool or clammy skin
- Face is pale, gray, or ashen
- Body is limp
- Vomiting
- Choking or gurgling noises
Blue-ish or grey-ish nails/lips
- Slow breathing/not breathing
- Slow heartbeat/no heartbeat

**Alcohol Overdose (Alcohol Poisoning)**

Alcohol overdoses happen when there is too much alcohol in the bloodstream. Alcohol affects brain activity and as the amount of alcohol in the blood increases, so does the effect on the brain. When overdose occurs, areas of the brain that control basic life processes—like the heartbeat, breathing, and body temperature—stop working. Symptoms of alcohol overdose can look similar to opioid overdose and might also include confusion, seizures, and dulled responses.

**Other and Unknown Substances**

Overdosing on other substances, such as cocaine and prescription stimulants (for example, methylphenidate or Ritalin) can lead to heart attacks, strokes, seizures, and other serious conditions with long-term consequences. Other symptoms of overdose to look for include:

- Irregular and extremely fast heartbeat
- Chest pain
- Hallucinations
- High body temperature

**Responding to a Suspected Overdose**

An overdose is a life-threatening emergency and requires immediate medical attention. If you suspect an overdose, call 911. Be sure to:

- **Tell the operator:**
  - Your exact location, using as many specific details and as possible (for example, “in the bedroom down the hallway on the fifth floor”)
  - If breathing has slowed or stopped
  - If non-responsive
- **Provide first responders with information.** For example, the substances that the person has used, prescription medications, allergies, and existing medical conditions. If you don’t know the answer to all these questions, that’s ok. Be honest and provide the information you know.
- **Not leave your loved one alone.** Wait with them until medical help arrives.

**PLEASE NOTE:** Police may accompany the ambulance in 911 calls. “Steve’s Law” in Minnesota is intended to protect the person who calls 911, as well as the person who overdosed from being punished...
for possession, use, or sharing of a controlled substance (drugs) or drug paraphernalia. Additionally, a person who receives medical attention for an overdose is immune from prosecution for possession of a controlled substance, even if they are on probation or release.

- If you are concerned about a drug poisoning of any type, call the MINNESOTA POISON CONTROL SYSTEM at 1-800-222-1222. The Poison Center will provide immediate professional assistance for drug overdose to the public and health care providers. The service is available 24/7.

**RECOVERY POSITION:** If you need to leave someone who may be experiencing an overdose alone (for example, you need to get a phone to call 911), you can put them in the recovery position to help make sure they don’t choke on their vomit. The recovery position is illustrated below and consists of repositioning a person on their side with their face turned, supported by their bent knee. More information on the recovery position can also be found at https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/call-for-help/.

Naloxone (Narcan) is a medicine that can reverse an opioid overdose. In Minnesota, you can obtain Naloxone and learn how to use it, if you or a loved one are at risk for an opioid overdose.

Naloxone will *not* help reverse effects of overdoses due to substances other than opioids. Minnesota’s “Good Samaritan Law” protects individuals who administer an opiate antagonist, like Naloxone, in good faith, from any liability.

**What is a Mental Health Crisis?**

A crisis is any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or when they are not able to resolve the situation with skills or the resources available to them.
A mental health crisis may include suicidal thoughts or threats/actions to hurt themselves or others. It can also include not taking care of one’s physical appearance to the point of health concern, not eating or drinking for long periods of time, going outside in cold weather without proper attire, or other concerning behaviors.

**De-Escalation Techniques**

A person experiencing a mental health crisis cannot always clearly communicate their thoughts, feelings, or emotions. They may find it difficult to understand what others are saying. It is important to empathize and connect with the person’s feelings, stay calm, and try to de-escalate the situation while maintaining the personal safety of everyone involved.

*You can help someone experiencing a mental health crisis with de-escalation techniques:*

- Keep stimulation level low: Use a calm and slow voice, avoid touching the person unless you ask for permission, and gently announce actions before initiating them.
- Avoid overreacting: Don’t make judgmental comments, don’t argue or try to reason with the person, and don’t switch the conversation to how you’re feeling.
- Focus on *their* feelings and needs in the moment.
- Don’t trap them: Don’t stand in doorways or exit points and give them space when possible.
- Express support and concern and ask what you can do to help: If you haven’t been able to de-escalate the crisis yourself, you will want to seek additional help from mental health professionals who can assess the person to determine the level of crisis intervention required.

**Mobile Crisis Teams**

Every county in Minnesota has a mental health crisis line and should be available 24/7. All counties have a mobile crisis team and are able to meet the person in the community (for example, at a local school, home, or mental health clinic) when there is no immediate danger. Crisis teams can cope with immediate stressors, help develop a crisis plan, or make referrals to a hospital or additional services such as dual-diagnosis programs for co-occurring disorders.

Crisis teams can also provide stabilization services for as long as necessary. An adult or child does not need to have a mental health diagnosis to receive crisis services and a team will respond regardless of insurance.
status. If the person has insurance, the team will bill insurance if it is available, but individuals will not be charged. The teams can respond to someone experiencing a crisis due to substance use.


**Emergency Services**

*If the situation is life-threatening or if serious property damage is occurring, call 911 and ask for law enforcement assistance as soon as possible.*

When you call 911, tell them someone is experiencing a mental health crisis and explain the nature of the emergency and your relationship to the person in crisis. Tell the law enforcement agency that it is a crisis involving a person with a mental illness and request a police officer trained to work with people with mental illnesses called a Crisis Intervention Team Trained (CIT) officer. If your loved one is currently under the influence or overdosing, it is also important to tell the dispatcher this immediately so that they can also send paramedics to your location to administer Narcan or provide additional life support.

Be sure to tell them—if you know for certain—whether the person has access to guns, knives, or other weapons. When providing information about a person in a mental health crisis, always be very specific about the behaviors you are observing. Instead of saying, “My sister is behaving strangely,” for example, you might say, “My sister hasn’t slept in three days, she has eaten very little in over five days, and she believes that someone is talking to her through her television.”

Report any active psychotic behavior, significant changes (such as not leaving the house, not taking showers), threats to other people, and increases in manic behaviors or agitation (such as pacing or irritability). You need to describe what is going on right now, not what happened a year ago. Be brief, to the point, and stress that the person is not safe in the community.

When the law enforcement officers arrive, provide them with as much relevant and concise information about the person as you can—such as current medication(s) or the location of the last hospitalization(s), if applicable. Lay out the facts efficiently and objectively, and let the officer decide the course of action.
Remember that once 911 has been called and the officers arrive on the scene, you do not control the situation. Depending on the law enforcement officers involved, they may take the person to jail instead of to a hospital emergency room. If the person has been hospitalized in the past, you can request that your loved one be taken back to that hospital for continuity of care.

Law enforcement officers have broad discretion in deciding who to arrest, who to hospitalize, and who to ignore. You can encourage and advocate for the law enforcement officers to view the situation as a mental health crisis. Be clear about what you want to have happen without disrespecting the law enforcement officer’s authority.

If you would like more information on how to recognize and respond to a mental health crisis, see the NAMI Minnesota booklet entitled Mental Health Crisis Planning for Children or Mental Health Crisis Planning for Adults.

If you would like more information about the criminal justice system and what to do in case of arrest, see the NAMI Minnesota booklet entitled Advocating for People with Mental Illnesses in the Minnesota Criminal Justice System.

Suicide Prevention

Individuals with co-occurring disorders are at an increased risk for suicide and overdose.

If you’re concerned that your loved one is at risk for harming themselves here are some resources:
  ► National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
  ► National Suicide and Mental Health Text Line: text MN to 741741
  ► National Suicide Prevention Lifeline online chat: https://suicidepreventionlifeline.org/chat/
  ► Mobile Crisis Teams dial **Crisis from a cell phone

How To Safely Dispose of Drugs and Prescription Medication

If you are planning to dispose of drugs and prescription medications, it is incredibly important to take them to proper disposal locations. In addition to the importance of preventing misuse, proper disposal can prevent environmental contamination. Studies show that medications or drugs flushed down the drain can contaminate lakes and streams and often cannot be fully removed from drinking water. Similarly, drugs
thrown into the trash can still contaminate local soil and end up in waterways.

There are more than 300 medication collection boxes located at law enforcement facilities and pharmacies throughout Minnesota. These sites do not charge a fee for disposal, can be anonymous, and accept all medicines from households including prescription, over-the-counter, illegal drugs, etc. To find a list of disposal locations near you, visit https://doseofreality.mn.gov

If a disposal site is not available, you can call the trash services in your county and see if any incinerate their trash after removal.

**The Minnesota Pollution Control Agency recommends to:**

- Keep prescription medications in their original containers. Cover the patient’s name and prescription number with permanent marker. Over-the-counter medications may be placed in a grocery or other non-transparent bag and placed in the garbage.
- Modify the contents of prescription medications to discourage anyone from taking them. For pills or capsules, add vinegar to the container to dissolve them. Add table salt or flour to liquids.
- Seal and conceal prescription medication containers. Tape the lid shut with duct tape and place the container inside an opaque piece of trash, such as an empty margarine tub. For blister packs, wrap packages containing pills in opaque tape like duct tape.
- Throw the container in the garbage.

**DATA PRIVACY AND DISCLOSURE**

Your loved one has a right to privacy that is protected by law. There are a number of laws and rules—at the national, state, and local levels—that can be applied to medical records and other personal health information. The rules that service professionals and agencies must follow to protect the privacy of the people they serve are sometimes different depending on the system.

**Privacy Laws**

Below is a list of privacy laws that protect personal information that may apply to you or your loved one depending on the service system.

**HIPAA:** HIPAA stands for the Health Insurance Portability and Accountability Act. HIPPA was made to provide legal regulations and protection around few topics, including how private health information is handled and shared by healthcare providers and other organizations,
such as schools or your employer. In general, HIPAA requires that your personal information be kept private and confidential unless you agree to sharing it. Additionally, HIPAA establishes your right to view your own medical records. Health care providers and other organizations can get into legal trouble for violating your privacy and sharing confidential information. HIPAA rights transfer from the parent(s) or guardian(s) to their child at age 18 except in special cases.

PART 2: 42 CFR Part 2, sometimes just called “Part 2” is a law that helps provide privacy protections specifically for people with substance use disorders. This law was passed to help reduce barriers for individuals seeking treatment for substance use disorder to factors such as public attitudes and legal concerns related to substance use. There were major changes to Part 2 as part of the CARES Act in 2020. Information can now be shared for treatment, payment, and health care operations as provided under HIPAA for other health care records.

FERPA: FERPA stands for the Family Educational Rights and Privacy Act. FERPA protects the privacy and confidentiality of educational information and establishes rights for families to access, review, and request to make changes to records. Educational records can include things like grades, attendance history, special education evaluations, Individualized Educational Plans (IEPs), and other special education records.

THE MINNESOTA CONSENT OF MINORS FOR HEALTH CARE STATUTE: This statute allows minor children to consent to medical, mental or other health services. It also allows any person 16 years or older the right to:

- Request informal admission to a treatment facility for observation or treatment of mental illness or chemical dependency
- Receive a diagnostic evaluation
- Receive emergency or short-term acute care

It also means that a child can refuse to accept or sign themselves out of treatment.

Some counties apply the commitment law to teenagers ages 16 and 17. If families need more information on the civil commitment process, they can contact NAMI Minnesota or see the NAMI Minnesota booklet, *Understanding the Civil Commitment Process*. Other counties may allow parents to consent to treatment, use the juvenile courts or even use CHIPS petitions for children ages 16 and 17 who are refusing treatment. Parents generally have access to their minor children’s medical records. However, if the minor legally consents to services listed under the Consent of Minors for Health Care Statute that is not the case.
In that case, parents or guardians do not have access to the records without the minor’s authorization. If a health professional believes that it is in the best interest of the minor, they may inform the minor’s parents of the treatment. A minor who consents to health services is financially responsible for the cost of the services.

**Types of Disclosures**

In healthcare, a “disclosure” is the sharing of personal health-related information. There are several types of disclosures that are allowed.

**VOLUNTARY DISCLOSURE:** Sometimes, you may want your personal health information shared between your different service providers. For example, you may wish for information to be shared between your primary care doctor and your social worker, or with loved ones and caregivers. This is a voluntary disclosure and is allowed.

Typically, you will need to sign a form that explains the terms and limits of what will be shared and with whom to show that you understand and agree to the sharing. You can choose to end this sharing at any time by contacting your providers with your request.

**PERMITTED DISCLOSURE:** Sometimes, the law allows health care professionals to share your private information with people who can help. Health care professionals can share information in these cases without your permission. For example, sharing information with loved ones who can help take care of (or pay for the care of) someone who is unconscious or incapacitated or minor. This includes sharing that an individual has overdosed. Another example includes sharing information that might help prevent a dangerous situation as determined by the health care professional, such as informing family members about a risk to safety posed by ongoing opioid use after discharge. These are permitted, even if they are not voluntary.

**MANDATORY DISCLOSURE:** In some situations, the law requires disclosing or releasing some health information, including information related to substance use disorders. This is called a “mandatory disclosure.” For example, in the course of reporting related to child abuse and neglect, when reporting cause of death, or when following a court order (subpoena). If you have questions or concerns about mandatory disclosures, consultation with a lawyer or special advocate may be necessary.
RESOURCES AND RECOMMENDED READING

National Resources

**ALCOHOLICS ANONYMOUS:** A 12-step support group for people looking for peer support in their efforts to stop consuming alcohol. These meetings do not provide professional support for a substance use disorder (https://aa.org).

**AMERICAN PSYCHIATRIC ASSOCIATION:** The American Psychiatric Association is an organization of psychiatrists working to ensure human and effective treatment for people with mental illnesses, including substance use disorders. The APA provides useful information on what a substance use disorder is, how it can be treated, and where you can access a psychiatrist (https://www.psychiatry.org/patients-families/addiction).

**ASSOCIATION OF RECOVERY IN HIGHER EDUCATION (ARHE):** ARHE provides the education, resources, and community connection necessary to support post-secondary students during their recovery from a substance use disorder (https://collegiaterecovery.org/).

**ASSOCIATION OF RECOVERY SCHOOLS (ARS):** ARS is a national organization that represents recovery schools across the country, including Minnesota. A recovery school is a secondary school designed specifically to meet the needs of students in recovery from a substance use disorder. Teachers and staff will have the additional training and education necessary to support students on their path to recovery. You can learn more about recovery schools, if they are a good fit for your child, and help finding a Minnesota recovery school at https://recoveryschools.org/.

**BAZELON CENTER FOR MENTAL HEALTH LAW:** National organization that advocates for the civil rights, full inclusion, and equality of adults and children with mental illnesses and substance use disorders. The Bazelon center focuses on legal action and public policy (http://www.bazelon.org/).

**CRAFT (COMMUNITY REINFORCEMENT AND FAMILY TRAINING):** CRAFT provides tools and techniques for families and loved ones to engage someone with substance use disorder and encourage them to seek treatment, as well as strategies for managing the stress of having a loved one with a substance use disorder. This program is evidence-based and has been studied by the National Institutes of Health and other agencies. The online program can be accessed through https://alliesinrecovery.net/.

**CO-DEPENDENTS ANONYMOUS:** A 12-step support group for people who self-identify as recovering from co-dependency (https://coda.org/).
DEPRESSION AND BIPOLAR SUPPORT ALLIANCE: A peer-based support organization with a focus on serving people with mood disorders like depression or bipolar disorder. This organization has chapters across the country, develops print resources for members and supporters, and offers 24/7 online support for people with mood disorders. In Minnesota, there is currently one local chapter in Mankato (https://www.dbsalliance.org/).

FAMILIES ANONYMOUS: A 12-step fellowship program for the family and friends of those individuals with drug, alcohol or related mental health issues. Peer support with Families Anonymous can be found across the United States (https://www.familiesanonymous.org/).

FAMILIES RX: An online program and recovery coaching providing healing medicine for families impacted by substance use and mental health conditions (https://www.family-rx.org/).

HARM REDUCTION COALITION: A national organization advocating for public health reform with many resources about harm reduction, including needle exchanges and preventing infectious diseases among intravenous drug users (https://harmreduction.org).

HEROIN ANONYMOUS: A 12-step program that is free and available for anyone who wants to stop using heroin. Anyone can attend these support groups; no medical treatment is offered (https://heroinanonymous.org).

THE KENNEDY FORUM: National advocacy organization to build a better mental health system, including a major focus on mental health parity. These are the state and federal laws around the quality of a private health plan coverage. Under these laws, if a private health plan covers mental health and substance use disorder treatment, then the plan must cover mental health and substance use disorder treatment at the same level that it does other medical and surgical benefits (https://thekennedyforum.org/).

MENTAL HEALTH AMERICA: A nationwide, community-based nonprofit dedicated to meet the needs of people with mental illnesses and co-occurring substance use disorders. Mental Health American provides free online screenings for mental illnesses and/or substance use disorders (http://www.mentalhealthamerica.net/).

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI): NAMI is a non-profit, grassroots organization that provides education, support, and advocacy for people living with mental illnesses and their families, including people with substance use disorders. NAMI National offers support groups, training, a national help line, and other resources (https://www.nami.org or for the Minnesota chapter, namimn.org).
NARCOTICS ANONYMOUS: A 12-step program that is free to attend for anyone who wants to stop using narcotics. These are peer support groups and do not offer professional support for a substance use disorder (https://na.org).

PARTNERSHIP FOR DRUG FREE KIDS: National nonprofit that focuses on supporting youth with substance use disorders and their family. Services include a support-line with parent support specialists, peer support, and advice for navigating the substance use disorder system. To get help text a message to 55753 or go to drugfree.org.

Federal Agencies

MENTALHEALTH.GOV: National Resource for people who want to learn the basics about mental illnesses and substance use disorders. This includes help recognizing the signs of a mental illness and or a substance use disorders, as well as ways to have a conversation with a loved one about these issues (https://www.mentalhealth.gov/).

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH): Leading federal research agency on mental illnesses and substance use disorders. Information about mental illness, research, and treatment. Families and people with substance use disorders can turn to the NIMH for basic information, free brochures and pamphlets, and information about participating in studies on mental health and substance use disorders (https://www.nimh.nih.gov/index.shtml).

NIAAA ALCOHOL TREATMENT NAVIGATOR: The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has developed an online tool to support adults finding alcohol use disorder treatment for themselves or a loved one. This resource does not make referrals for youth or teens. Unlike other referral sources, this website has no commercial sponsors and was developed by a federal agency with expertise in the field (https://alcoholdreatment.niaaa.nih.gov/).

OFFICE OF THE SURGEON GENERAL: Provides the best scientific information about how to improve health and reduce the risk of illness and injury, including treatment for substance use disorders. Important reports have been recently published on opioid use disorders (https://addiction.surgeongeneral.gov/).

SAMSHA TREATMENT LOCATOR: A confidential and anonymous source of information for persons seeking treatment facilities in the United States or US Territories for substance use/addiction and/or mental health problems. SAMSHA is the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services. https://findtreatment.samhsa.gov/locator
**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA):** Lead agency within the US Department of Health and Human Services with a focus on mental health and substance use disorders. SAMHSA can help people with substance use disorders and their family members find a treatment provider, free resources developed specifically for people with substance use disorders or their families, data and statistics about mental illnesses and substance use disorders, and a list of evidence-based treatment practices (www.samhsa.gov).

**Minnesota Agencies and Organizations**

**Minnesota county websites:** Counties have an important role to play in Minnesota's mental health and substance use disorder system. You can engage your county with help finding a case manager, apply for public benefits like disability or MFIP, or learn more about available resources in your community.

County websites are run independently for each county in Minnesota. The information and services available in each county vary greatly. A list of links to all county websites can be found at https://mn.gov/portal/government/local/counties/.

**THE MINNESOTA DEPARTMENT OF EDUCATION (MDE):** The Minnesota Department of Education has many resources for families seeking support and information related to children's mental health and recovery from addiction. The MDE website is https://education.mn.gov/MDE/index.html.

**MINNESOTA DEPARTMENT OF HEALTH (MDH):** The Minnesota Department of Health focuses on preventative measures to reduce the harm of substance use disorders, including needle exchanges, as well as comprehensive information about opioid use disorder and the resources available to Minnesotans.

- Minnesota Syringe Exchange: https://www.health.state.mn.us/people/syringe
- Opioid overdose prevention: https://www.health.state.mn.us/communities/opioids/index.html

**MINNESOTA DEPARTMENT OF HUMAN SERVICES (DHS):** DHS supports counties, tribes, and providers across the state to provide substance use disorders and mental health treatment. You can turn to DHS to get information about accessing treatment, the different treatment services available in Minnesota, and resources that can be useful for people with

**KNOW THE DANGERS.COM:** Resource to learn more about treatment options for someone with substance used disorder with a focus on opioids. This was developed by the state of Minnesota as an “outreach effort shining light on the problem of opioids and synthetic drugs.” The website offers tools for parents, teachers, and other professionals, as well as resources for youth looking for information, support and services

**MINNESOTA OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES (OMHDD):** The OMHDD is an independent state agency that people with developmental disabilities, mental illnesses, or substance use disorders can turn to if they feel like their rights have been violated. For general questions or concerns email the OMHDD (ombudsman.mhdd@state.mn.us); call 651-757-1800, 1-800-657-3506, or MN Relay Service 711; or contact one of the regional staff on the website https://mn.gov/omhdd/.

**Minnesota Resources**

**ASPIREMN:** AspireMN improves the lives of children, youth, and families served by member organizations through support for quality service delivery, leadership development, and policy advocacy (https://www.aspiremn.org/default.aspx).

**COCAINE ANONYMOUS IN MINNESOTA:** The 12-step program in Minnesota is designed for people who wish to stop using cocaine and other mind-altering substances. In-person and online meetings available (https://caminnesota.org).

**MINNESOTA ASSOCIATION FOR CHILDREN’S MENTAL HEALTH (MACMH):** MACMH provides referrals and trainings that build understanding of the multiple systems that serve children and how parents can navigate them effectively. MACMH also trains professionals by presenting current research as evidence-proven techniques that can be put directly into practice (https://www.macmh.org/about/).

**MINNESOTA ASSOCIATION OF SOBER HOMES (MASH):** Trade association of sober home providers in Minnesota. MASH provides a list of sober homes in their organization, what a resident should expect from a MASH-endorsed sober home and a collection of resources in Minnesota.
MENTAL HEALTH MINNESOTA: A non-profit organization that works to help people in their journey toward mental health recovery and wellness through direct service, public policy, education, and outreach. Contact the warmline at 651-288-0400, toll free 877.404.3190, or text “support” to 85511 (www.mentalhealthmn.org).

MID-MINNESOTA LEGAL AID: This agency protects and advocates for the rights of people with mental illnesses and investigate reports of abuse and neglect in public or private facilities that care for or treat people with mental illnesses. (https://mylegalaid.org/).

MINNESOTA ASSOCIATION OF CHARTER SCHOOLS: This is an advocacy organization with information resources about Minnesota charter schools. You can find information about charter schools and links to member schools at https://www.mncharterschools.org/.

MINNESOTA ASSOCIATION OF RESOURCES FOR RECOVERY AND CHEMICAL HEALTH: (MARRCH) is a professional association of addiction treatment professionals and organizations striving to raise awareness about addiction and the power of recovery. They represent more than 75 agencies and more than 2,000 individuals (licensed alcohol and drug counselors, students, other behavioral health professionals) with members in every region of Minnesota (https://www.marrch.org).

MINNESOTA RECOVERY CONNECTION: A recovery community organization with a mission of strengthening the recovery community through peer-to-peer support, public education, and advocacy. Minnesota Recovery Connection maintains a comprehensive list of sober and transitional housing options in Minnesota. This information can be found on their website (https://minnesotarecovery.org/) or by calling 612-584-4158.

NAMI MINNESOTA: Provides education, support, and advocacy. This includes a helpline, free classes, and peer-led support groups, including a support group for people with dual diagnoses. NAMI publishes a number of fact sheets and booklets (such as this) on the mental health system. NAMI Minnesota also operates a helpline for people navigating the mental health system. To contact our helpline, email namihelps@namimn.org or call (651) 645-2948, ext. 117 or 1-888-NAMI-HELPS (www.namimn.org).

PARENT ADVOCACY COALITION FOR EDUCATIONAL RIGHTS (PACER): PACER provides support for families with children with disabilities and special needs and is especially helpful when navigating special education and 504 rights (www.pacer.org).
THE CENTER FOR PRACTICE TRANSFORMATION: This Center’s mission is to inspire, challenge, and transform practitioner skills toward exceptional, informed, and effective recovery-oriented care through training, consulting, evaluation, and research (https://practicetransformation.umn.edu/).

STEVE RUMMLER HOPE NETWORK: Nonprofit organization that specializes in providing training, resources, and support for people with chronic pain who are living with a substance use disorder (https://steverummlerhopenetwork.org).

THRIVE FAMILY SUPPORT: Provides support groups for the family members and loved ones of people with substance use disorders. Thrive also provides educational support and can connect you with local resources to better support your loved one with a substance use disorder (https://www.thrivefamilysupport.org/).

WE CAN NAVIGATE: Intensive treatment program for people who are experiencing their first psychotic episode. This is a highly effective treatment program for people with psychosis and will also provide support for a co-occurring substance use disorder. There are currently two providers in Minneapolis, one provider in St. Louis Park, and another provider in Duluth (https://www.wecannavigate.com/).

WELLNESS IN THE WOODS: Nonprofit agency in North Central Minnesota that provides training on mental illnesses, peer support groups, and a warmline for people struggling with the symptoms of their mental illness and or substance use disorder. Contact their warmline at 844-739-0369 or https://www.mnwitw.org/.

Further Reading

NAMI Minnesota’s Guide Keeping Families Together: A Guide to the Children’s Mental Health System provides information about children’s mental health services in Minnesota and how to access them. It can be found on the NAMI Minnesota website (namimn.org) in the resources section or directly.


Family & Friends Handbook by SMART Recovery. This booklet is for people with a loved one with substance use disorder. Uses the SMART Recovery rubric (self-management and recovery training). Learn more...
about this handbook at https://www.smartrecovery.org/smart-recovery-handbook-for-family-friends/.

**Get Your Loved One Sober: Alternatives to Nagging, Pleading, and Threatening** by Robert Meyers and Brenda Wolfe. This resource includes strategies to engage people with substance use disorder who are resistant to seeking treatment. Foundational book for evidence-based strategy called Community Reinforcement and Family Training (CRAFT).

**I'm Not Sick I Don't Need Help** by Xavier Amador. This resource offers advice on how to get someone with a serious mental illness to engage in mental health treatment.

**Praying Our Loved One Home** by Pam Lanhart. Faith-based strategies to support people with a loved one living with substance use disorder.

**Unhooked** by Jason Coombs. Written from the perspective of someone in recovery from a substance use disorder about how to engage a loved one with substance use disorder.

**The 20-minute guide.** Practical guide to support family members or partners address their loved one’s substance use and learn ways to prevent it. https://the20minuteguide.com/

This booklet was funded in large part by Minnesota Department of Human Services (DHS), with support from Janssen Pharmaceuticals, Inc

If you have suggestions for additions or changes, please email us at namihelps@namimn.org.

Thanks to Hannah Fairman, Sophia Frank, Tim Walsh, MA, LP, DPA, Saul Selby, MA, LADC, Neerja Singh, Ph.D., LICSW, LADC, and Jonathan Lofgren, Ph.D., LADC, for their assistance in developing and reviewing this booklet.

July 2020
**Letting Go**

- To let go doesn’t mean to stop caring; it means I can’t do it for someone else.
- To let go is not to cut myself off; it is the realization that I can’t control another.
- To let go is not to enable, but to allow learning from natural consequences.
- To let go is to admit powerlessness, which means the outcome is not in my hands.
- To let go is not to try to change or blame another; I can only change myself.
- To let go is not to care for, but to care about.
- To let go is not to fix, but to be supportive.
- To let go is not to judge, but to allow another to be a human being.
- To let go is not to be in the middle arranging outcomes, but to allow others to affect their own outcomes.
- To let go is not to be protective; it is to permit another to face reality.
- To let go is not to deny, but to accept.
- To let go is not to nag, scold, or argue, but to search out my own shortcomings and to correct them.
- To let go is not to adjust everything to my desires, but to take each day as it comes and to cherish the moment.
- To let go is not to criticize and regulate anyone, but to try to become what I dream I can be.
- To let go is not to regret the past, but to grow and live for the future.
- To let go is to fear less and love more.

NAMI Minnesota champions justice, dignity, and respect for all people affected by mental illnesses. Through education, support, and advocacy we strive to effect positive changes in the mental health system, and increase the public and professional understanding of mental illnesses.
Co-Occurring Disorders
Substance Use Disorders and Mental Illnesses

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