Practice Guidelines for Co-occurring Disorders - Adults

Introduction:

A co-occurring disorder (COD) is the presence of both a mental health condition and substance use disorder (SUD). People with co-occurring disorders experience worse health outcomes, higher service utilization, higher costs over time.

1. Due to more severe symptoms in both domains, more hospital readmissions, and medical comorbidity (HIV, hepatitis B and C, high blood pressure, etc. – many of which are preventable).

2. Over the course of a lifetime, the prevalence of CODs can approach 50 percent.

3. People with CODs often end up coordinating their own care, which is often difficult, frustrating, and can result in stigma and prejudice.

4. Untreated and unidentified CODs associated with more difficulties in treatment engagement, the development of a therapeutic alliance, agreement with treatment recommendations, and increased odds for medical illness, suicide, and early mortality (i.e., people with mental health or substance use disorders die, on average, over 20 years sooner than people without either condition).

5. Therefore, COD may be considered a chronic condition for certain populations, so long-term services and continuity of care across programs and time must be available.

   Clinical conceptualization and interventions should vary for different populations, such as children and adolescents, transition-age youth, and older individuals.

Integrated care can make treatment more attractive to individuals in care, increase retention rates, and promote better outcomes.

1. Data exists to suggest that:

   a. People with CODs who engage in services have better mental health and substance use outcomes at six months.

   b. Individuals working with COD-trained clinicians had better mental health outcomes at 18 months than those who participated in mental health-only services.

   c. People with COD who engage in 12-step programs seem to benefit as much or more than individuals with SUDs only.

2. Conceptual models of COD:

a. SAMHSA's "four quadrant model"[1] related to intensity of symptoms.

b. COD care delivery: serial, simultaneous/parallel, coordinated/parallel, and integrated.

c. Center for Integrated Health Solutions: coordinated, co-located, integrated.

Care Delivery[2]

People with diagnoses of both mental health and SUDs should receive concurrent treatment for both. Agencies and their staff should not prioritize treatment for SUDs over mental health disorders or vice versa, unless the individual chooses to address one before the other. This is consistent with the application of motivational interviewing and principles of recovery and harm reduction. Agencies and staff meet individuals where they are at and give them autonomy to shape their treatment and define their recovery goals.

Engagement

1. Single point of entry or "no wrong door."

2. Assertive outreach and retention activities. "Outreach" does not refer to seeking new people for enrollment. This refers to engaging with individuals who would clearly benefit from services, but individual or systemic barriers are in their way.

Recommendation: Reduce organizational red tape and create pre-treatment programming, perhaps with peer specialists, that can engage individuals while they wait for initial appointments and reduce wait times as much as possible.

Conduct intake/assessment

1. Empathy

2. Person-centered

3. Trauma-informed

4. Culturally sensitive

    a. The underrepresentation of people of color, ethnic minorities, and LGBTQ in mental health and SUD treatment may be due to the lack of culturally sensitive services or culturally relevant staff.

    b. Many treatment agencies do not provide on-site childcare, which makes it challenging for single mothers to access care.

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[1] https://store.samhsa.gov/shin/content/PHD1130/PHD1130.pdf, page 5

[2] For further suggestions about care delivery (e.g., potential targets for outreach, multidisciplinary teams, etc.), please see the fidelity scale from the integrated treatment for COD EBP (https://store.samhsa.gov/shin/content//SMA08-4367/EvaluatingYourProgram-ITC.pdf, pp. 27-34)

c. Some individuals often have prefer gender-specific treatment (e.g., women-only groups).

Recommendation: Use one single assessment that addresses both substance use and mental health disorders. Create specialized programs that consider various individual characteristics for mental health conditions, SUDs, or both.

Obtain collateral information

Universal screening across service settings for both mental health and SUDs.

1. This includes:

    a. Screening for alcohol misuse by all adults, including pregnant women.

    b. Screening for COD at initial presentation.

    c. Screening of youth entering child welfare and juvenile justice systems.

2. Screening should occur on-site.

Determine severity of symptoms

Determine appropriate level of care (CALOCUS/LOCUS/ASAM)

Recommendation: Use one single tool that addresses both substance use and mental health disorders, if regulations allow, to determine the levels of care for individuals.

Formulate diagnosis

1. All types of disorders are considered "primary". While an assessment, such as SAMHSA's four quadrant model, may suggest that one condition is more severe than another, the treatment focus should reflect individual choice. As such, no program, type of disorder, or approach to treatment is considered more important than others.

2. Diagnoses in COD are often unclear for a period of time, but this should not interfere with ongoing engagement and interventions.

Determine disability and functional impairment

1. Identify strengths and supports

2. Identify cultural and linguistic needs and supports

3. Identify problem domains

4. Determine stage of change (use of motivational interviewing)

5. Plan treatment / Continuity of care / Discharge planning

Interventions

There should be comprehensive services across programs and across disorders. Furthermore, staff should receive ongoing supervision and support in their use of evidence-based practices (EBPs). At minimum:

1. EBPs for:

    a. Individuals with co-occurring disorders:

        - Motivational interviewing (MI)
        - Cognitive behavioral therapy (CBT)
        - Skill-building
        - Medication assisted treatment (MAT)

        Recommendation: COD services should include an on-site psychiatrist or ARNP.

    b. Group interventions

        - Psychoeducation (e.g., Seeking Safety, Seven Challenges)
        - Dialectical behavioral therapy (DBT) skills groups
        - Wellness groups

        Recommendation: Staff should receive training and supervision on how to facilitate groups.

    c. Recovery communities (family, friends, other supports)

        - "Family" collaboration
        - "Family" education
        - Multiple family group
        - Peer support services

2. Other treatment approaches may have value if they help reach the individual's desired outcomes and improves their health.

References

SAMHSA TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders

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Sterling S, Chi F, Hinman A. Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions. Alcohol Res Health. 2011;33(4):338-49.

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Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT