Mid-Valley Behavioral Care Network

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PRACTICE GUIDELINES: CO-OCCURRING DISORDERS

Prepared by: MH/CD Integration Group and Quality Management Committee
Approved by: Regional Advisory Council, March 19, 2004

Vision[1]

MVBCN believes that every individual, regardless of the severity and disability associated with co-occurring mental health and substance abuse disorders, is entitled to experience the promise and hope of recovery and every individual should be considered to have the potential to achieve that recovery. It is the long-term intention of the MVBCN to develop a service delivery system that maximizes the opportunity and support for such recovery.

Values[1,2]

1. The service system shall ensure that an individual with a co-occurring disorder is welcomed for care and receives treatment, or referral for treatment, wherever he or she seeks help for a mental health problem, or a substance abuse problem.
2. Services shall be consumer-centered (designed from the consumer's needs), age-appropriate and culturally competent. Mental health and substance abuse consumers and their families shall be actively involved not only in treatment decisions, but also in program design, administration and evaluation.
3. When mental health and substance disorders coexist, each of these disorders should be considered primary and integrated dual primary diagnosis-specific treatment is indicated.
4. Both mental illness and chemical dependence can be treated within the philosophical framework of a "disease and recovery model" with parallel phases of recovery. For youth a family focus and developmental perspective are incorporated into these models.
5. Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship that provides integrated treatment and coordination of care through the course of multiple treatment episodes. Supportive care, empathic detachment and appropriate contingency management are clinically balanced at each point in time. Interventions are individualized.
6. The national consensus four-quadrant model (see following page) for categorizing co-occurring disorders is a guide for service planning on the agency and system levels.

Target Group[3]

Individuals for whom mental health and substance use concerns rise to the level that both must be addressed for successful treatment.

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[1] Excerpted from *THE PATH FROM VISION TO REALITY,* MVBCN, July 2003. Based on Ken Minkoff, M.D.
[2] In Oregon 2003 there is not enough public funding to treat all who seek care; these expectations are for care provided
[3] Definition approved by Integration Group to direct BCN COD data capture

Guidance for applying the definition:

1. The consumer, clinician, or primary care provider defines the problems;
2. It is not necessary that the client be motivated to address both issues;
3. In a CD setting, consider issues identified on ASAM Dimension 3; and
4. Substance use concern relates to drugs of abuse and excludes caffeine and tobacco unless must be addressed for treatment success.

Co-occurring Disorders Quadrants[1]

<table>
<tr>
<td><u>Quadrant III</u>:
Low MH, High CD
Serious chemical dependence with mild to moderate MH impairment due to mood, anxiety, trauma-based disorder or traits of personality disorder</td>
<td><u>Quadrant IV A:</u>
High MH, High CD
Serious MH impairment + chemical dependence

Include interventions to match stage of motivation and recovery; include intensive integrated case management

As they get better they begin to look like QII</td>
<td><u>Quadrant IV B:</u>
High MH, High CD
No serious MH impairment without substance use (i.e. substance induced psychosis)

Offer intensive integrated case management

As they get better they begin to look like QIII</td>
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<tr>
<td><u>Quadrant I:</u>
Low MH, Low CD
Mild to moderate MH impairment + substance abuse</td>
<td colspan="2"><u>Quadrant II:</u>
High MH, Low CD
Serious MH impairment + substance abuse

Include interventions to match stage of motivation and recovery</td>
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<u>Recommended Practice Guidelines</u>[4]

1. Welcoming expectation: Individuals with comorbidity are an expectation in every treatment setting, and should be engaged in an empathic, hopeful, welcoming manner in any treatment contact.

2. Access to assessment: Access to assessment or to any service should not require consumers to self-define as mental health OR substance disordered before arrival. Assessment should routinely expect that all consumers may have comorbid disorders, and that the assessment process may need to be ongoing in order to accurately determine what disorders are present, and what interventions are required. Arbitrary barriers to mental health assessment based on alcohol level or length of sobriety should be eliminated. Similarly, no one should be denied access to substance disorder assessment due to the presence of a comorbid psychiatric disorder and/or the presence of a regime of psychotropic medication.

[4] Excerpted from *Behavioral Health Recovery Management Service Planning Guidelines, Co-occurring Psychiatric and Substance Disorders, Kenneth Minkoff, M.D., 2001.*

3. Access to continuing relationships: For individuals with more severe comorbid conditions, empathic, hopeful, continuous treatment relationships must be initiated and maintained even when the individual does not follow treatment recommendations.

4. Balance case management and care with expectation, empowerment, and empathic confrontation: Within a continuing relationship or an episode of care, consumers are provided assistance with those things that they cannot do for themselves by virtue of acute impairment or persistent disability, while being empowered to take responsibility for decisions and choices they need to make for themselves, and allowed to be empathically confronted with the negative consequences of poor decisions.

5. Integrated dual primary treatment: Each disorder receives appropriate diagnosis-specific and stage-specific treatment, regardless of the status of the comorbid condition. Each disorder must not be undertreated because the other disorder is present; in fact, individuals often require enhanced treatment for either disorder because of the presence of comorbidity. For individuals with serious mental illness, for example, active substance use disorder may be an indication for using more effective psychotropic medication for the primary mental illness. Similarly, individuals with serious mental illness may require more addiction treatment than individuals with addiction only, in the sense that they need more practice, rehearsal, and repetition, in smaller increments, with more structure and support, to learn recovery skills.

6. Stage-wise treatment: Interventions - and expected outcomes - need to be matched to level of severity and to stage of change in relation to both disorders.
    a. Acute Stabilization: Detoxification or safe sobering up; initial stabilization of acute psychiatric symptoms.
    b. Motivational Enhancement: Individual motivational strategies and pre-motivational or persuasion groups. In the latter, group process facilitates discussion of substance use decisions for group members who are likely to be actively using and have made no commitment to change.
    c. Active Treatment: Individual and group treatment interventions for substance use disorders in individuals with psychiatric disorders and disabilities often require focus on specific substance reduction or elimination skills, including participation in self-help recovery programs (particularly for those with addiction), but with modification of skills training to accommodate disability-impaired learning capacities. These interventions may require smaller groups, with more specific role-playing and behavioral rehearsal of more basic skills.
    d. Relapse Prevention: May require specific skills training on participation in self-help recovery programs, as well as access to specialized self-help programs like Dual Recovery Anonymous and Double Trouble in Recovery.
    e. Rehabilitation and Recovery: Focus on developing new skills and capacities, based on strengths, and on developing improved self-esteem, pride, dignity, and sense of purpose in the context of the continued presence of both disorders.

7. Early access to rehabilitation: Disabled individuals who request assistance with housing, jobs, socialization, and meaningful activity are encouraged to access that assistance even if they are not initially adherent to mental health or substance disorder treatment recommendations.

7. Coordination and collaboration: Both ongoing and episodic interventions require consistent collaboration and coordination between all treaters, family caregivers, and external systems. Collaboration with families should be considered an expectation for all individuals at all stages of change, as families may provide significant assistance in developing strategies for motivational enhancement and contingent learning, in identifying specific skills or techniques required for modification of substance using behavior, and in actively supporting participation in recovery-based programming to promote relapse prevention. With regard to external systems, significant new research has identified valuable models for integrated treatment of individuals involved in the correctional system, the child protective service system, and the primary health care system.

Competency in the Treatment of Individuals with Co-Occurring Disorders

It is the expectation of the MVBCN that all behavioral health professionals are competent to provide care to consumers with co-occurring disorders (COD).

Behavioral health practitioners, regardless of setting, should routinely:

1) Demonstrate a welcoming, empathic, and hopeful philosophy of dual recovery.
2) Screen for possible co-occurring disorders, through interview, use of standardized screening instruments, and/or laboratory testing for drug and alcohol use. Understand that clients have a myriad of reasons for minimizing or denying use, and be aware of the potential for false negative responses to screening questions.
3) Use motivational approaches in responding to positive lab results.
4) Arrange for immediate intervention when either co-occurring disorder is identified as emergent.
5) Obtain a release to acquire existing assessment information and complete or arrange for an assessment for a co-occurring disorder.
6) Provide disorder specific, recovery-focused integrated treatment planning, including goal setting and problem solving with the consumer and their support system (within the competency/ scope of practice of the clinician/agency).
7) Refer when necessary to an appropriate treatment provider to address the co-occurring disorder. Collaborate with other providers to assure that treatment plans are coordinated, realistic and effective.
8) Be aware of client's diagnosed conditions, and support treatment recommendations for both substance use and mental health disorders.
9) Support adherence to prescribed medications for substance use and mental health treatment that enhance recovery.
10) Identify and document stage of change in both areas of dual recovery.
11) For clients who are not motivated to change, engage the client in individual, group and/ or system strategies (e.g. family, court) for motivational enhancement.

12) For clients who are motivated to change, review their recovery and relapse prevention activities and provide stage specific interventions to reduce harm and promote dual recovery.
13) Help clients identify disorder specific signs for relapse, and work to manage them while avoiding problem substances/behaviors.
14) Provide educational information and materials regarding the relationships between substance use, mental illness, and dual recovery.
15) Advocate for clients and educate medical and social services providers regarding managing mental illness in the context of substance use disorders.
16) Communicate and collaborate with other treatment providers, including PCP's, to provide a unified message regarding integrated treatment and dual recovery.
17) Promote access to dual recovery mutual self-help groups, peer supports, and other recovery-oriented support systems.
18) Become familiar with community supports such as NAMI and 12 Step-based groups, preferably through attendance. Educate clients regarding how to attend and participate in mental health group treatment and recovery meetings, while being aware that information/advice given to those with single disorders may be in conflict with recommendations for their own treatment of co-occurring disorders. Encourage clients to be assertive about their own unique needs and how they manage their recovery.
19) Know how to modify interventions so that neither mental illness nor substance use can interfere with acquisition of dual recovery and relapse prevention skills.
20) Recognize and manage (with supervisory support) the strengths and limitations of one's personal experiences and beliefs related to the treatment process.

Treatment of COD individuals with high severity of both mental health and chemical dependency conditions (Quadrant IV) requires specialized competency. The agency is responsible to match such clients with appropriately skilled practitioners, after assessing the clinician's individual education and training, experience, and availability of supervisory support.