BEHAVIORAL HEALTH RECOVERY MANAGEMENT

SERVICE PLANNING GUIDELINES

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

KENNETH MINKOFF, M.D.

These guidelines were developed for the Behavioral Health Recovery Management project by Kenneth Minkoff, M.D.

The Behavioral Health Recovery Management project is an initiative of Fayette Companies, Peoria, IL; Chestnut Health Systems, Bloomington, IL; and the University of Chicago Center for Psychiatric Rehabilitation

The project is funded by the Illinois Department of Human Services' Office of Alcoholism and Substance Abuse.

Dr. Minkoff is Medical Director of Choate Health Management in Woburn, MA, Assistant Clinical Professor of Psychiatry at Harvard Medical School, and a nationally known consultant and trainer on co-occurring disorders.

April, 2001

SERVICE PLANNING GUIDELINES
CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Introduction

During the past two decades, as awareness of individuals with co-occurring psychiatric and substance disorders has increased, there has been a steady accumulation of data to permit the development of both evidence- based and consensus-based best practice models for the treatment of these individuals. These 'best practices" need much more study, but they are sufficiently well developed at present that it is possible to use them to formulate coherent practice guidelines for assessment, treatment, and psychopharmacology of individuals with co-occurring disorders. These practice guidelines are outlined in this document. Before delineating the practice guidelines themselves, however, it is important to describe the data-based and consensus-based foundation in the literature that supports them. This evidence base incorporates the following principles: (Minkoff, 2000):

1. **Dual diagnosis is an expectation, not an exception.** Both the Epidemiologic Catchment Area survey (Regier et al, 1990) and the National Comorbidity Survey (Kessler et al, 1996) support the high prevalence of comorbidity in both mentally ill populations and substance disordered populations. 55% of individuals in treatment for schizophrenia report lifetime substance use disorder (Regier et al, 1990), and 59.9% of individuals with substance disorder have an identifiable psychiatric diagnosis (Kessler et al, 1996).
2. **The population of individuals with co-occurring disorders can be organized into four subgroups for service planning purposes, based on high and low severity of each type of disorder.** (NASMHPD/NASADAD, 1998; Ries & Miller, 1993). In 1998, the National Association of State Mental Health Program directors and the National Association of State Alcohol and Drug Abuse Directors arrived at an unprecedented consensus to use this "four quadrant" model for service planning purposes.
3. **Treatment success involves formation of empathic, hopeful, integrated treatment relationships.** (Drake et al, 1993, 2001 Minkoff, 1998) This principle derives from analysis of multiple program models. Integrated treatment does not imply a single type of intervention, so much as the capacity, in the primary treatment relationship, to integrate appropriate diagnosis-specific interventions for each disorder into a client-centered coherent whole, with the ability to modify interventions for each disorder to take into account the other.
4. **Treatment success is enhanced by maintaining integrated treatment relationships providing disease management interventions for both disorders <u>continuously</u> across multiple treatment episodes, balancing case management support with detachment and expectation at each point in time.** (Drake, et al 1993; 2001 Minkoff, 1998) Progress is usually incremental, and no data supports a single brief intervention as providing definitive treatment for persistent comorbid conditions. The extent of case management support and

structure required are proportional to the individual's level of disability and impairment in functioning.

5. **Integrated dual primary diagnosis-specific treatment interventions are recommended.** (Minkoff, 1998) The quality of any integrated intervention depends on the accuracy of diagnosis and quality of intervention for each disorder being treated. In this context, integrated treatment interventions should apply evidence-based best practices (for psychopharmacology as well as for other interventions) for each separate primary disorder being addressed. In addition, a growing data set supports the high prevalence of trauma histories and trauma-related disorders in these individuals, women (85%) (Alexander, 1996; Harris, 1998) more so than men (50%) (Pepper, 1999), and there is increasing evidence of the value of trauma-specific interventions being combined with interventions for other psychiatric disorders as well as for substance disorders. (Harris, 1998; Evans and Sullivan, 1995, Najavits et al, 1998)

6. **Interventions need to be matched not only to diagnosis, but also to phase of recovery, stage of treatment, and stage of change.** The value of stagewise (engagement, persuasion, active treatment, relapse prevention) treatment (Mueser et al, 1996;Drake et al, 1993, 2001) has been well-documented, as well as stage specific treatment within the context of the transtheoretical model of change (Prochaska & DiClemente, 1992). Minkoff (1989, 1998) has articulated parallel phases of recovery (acute stabilization, motivational enhancement, prolonged stabilization, rehabilitation and recovery) that have been incorporated into national consensus guidelines.

7. **Interventions need to be matched according to level of care and/or service intensity requirements, utilizing well-established level of care assessment methodologies.** Both ASAM PPC2 (ASAM, 1995) and LOCUS (AACP, 1998) have been demonstrated in preliminary studies to be valid tools for assessment of level of care requirements for individuals with addictive disorders and psychiatric disorders, respectively. Both instruments use a multidimensional assessment format to determine multiple dimensions of service intensity that comprise appropriate placement. ASAM PPC2R (2001) incorporates additional capacity for level of care assessment and placement for individuals with co-occurring disorders, though it has not yet been field tested.

8. **Based upon all of the above together, there is no single correct dual diagnosis intervention, nor single correct program. For each individual, at any point in time, the correct intervention must be <u>individualized,</u> according to subgroup, diagnosis, stage of treatment or stage of change, phase of recovery, need for continuity, extent of disability, availability of external contingencies (e.g., legal), and level of care assessment.** This paradigm for treatment matching forms the basis for the design of the practice guidelines.

9. **Outcomes of treatment interventions are similarly individualized, based upon the above variables and the nature and purpose of the intervention. Outcome variables include not only abstinence, but also amount and frequency of use, reduction in psychiatric symptoms, stage of change, level of functioning, utilization of acute care services, and reduction of harm.** (Drake et al, 2001; Minkoff, 1998)

I. **Target Group:** Any psychiatric disorder (including both Axis I and Axis II disorders, as well as substance-induced psychiatric disorders), combined with substance dependence and/or abuse.
N.B. For individuals with SMI associated with persistent disability, any persistent pattern of substance use may be defined as abuse.

II. **Recommended Practice Standards** (derived from the above principles.)

A. Practice Standards

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 or treatment due to the presence of a comorbid psychiatric disorder and/or the presence of a regime of non-addictive psychotropic medication.

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 stage of change.

   a. Acute stabilization: Detoxification or safe sobering up; initial stabilization of acute psychiatric symptoms.

   b. Motivational Enhancement: Individual motivational strategies (Miller & Rollnick, 1991; Carey, 1996; Ziedonis & Trudeau, 1997) and pre-motivational or persuasion groups (Sciacca 1991, Mueser & Noordsy, 1996). 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. (Mueser & Noordsy, 1996;, Bellack & DiClemente, 1999; Roberts et al, 1999.)

   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 (Hamilton & Samples,1995) and Double Trouble in Recovery (Vogel, 1999)

   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 provided access to that assistance even if they are not initially adherent to mental health or substance disorder treatment recommendations.

8. 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 (Peters & Hills, 1997; Godley et al, 2000), the child protective service system, and the primary health care system.

III. **Assessment, Differential Diagnoses, and Comorbid Conditions**

A. Principles of Diagnostic Assessment: Screening, Detection, and Diagnosis

1. Welcoming expectation: Because of the high prevalence of comorbidity, routine assessment in all settings should be based on the assumption that any client is likely to have a comorbid condition. Direct communication to the client that such a presentation is both welcome and expectable will facilitate honest disclosure.

2. Structured Assessment Process: Accurate diagnostic assessment for individuals with co-occurring disorders is complicated by the difficulty of distinguishing symptom patterns that result from primary psychiatric illness from symptom patterns that are caused or exacerbated by primary substance use disorders. In many individuals with co-morbidity, both psychiatric and substance disorders are simultaneously and interactively contributing to symptoms at the point of assessment, particularly if assessment occurs when the patient is acutely decompensated. Consequently, differential diagnostic assessment requires a careful, structured approach to assessment, often over a period of time, in order to best elucidate diagnosis accurately.

3. Accessibility and Flexibility: Assessment begins at the point of clinical contact, regardless of the client's clinical presentation. Initiation of assessment should not be made conditional on arbitrary criteria such as length of abstinence, non-intoxicated alcohol level, negative drug screen, absence of psychiatric medication, and so on. Although in some individuals with co-occurring disorder, establishing an accurate diagnosis of one disorder requires the other disorder to be at baseline, in most cases diagnosis can be reasonably established by history (see below). Moreover, treatment must usually be initiated when neither disorder is at baseline; consequently, initial diagnoses are often presumptive, and the initial goal of assessment is to engage the individual in an ongoing process of continual reassessment as treatment progresses, during which diagnoses may be continually revised as new data emerge.

4. Screening and Detection:

   a. Screening tools in the mental health setting for substance disorders may include the following: Checklists of substances, including amounts and patterns of use for each (include inquiry regarding over the counter preparations, caffeine, nicotine, and gambling); screening tools validated for use in people with mental illness (e.g., CAGE, MAST/DAST, MIDAS, DALI, RAFFT for adolescents – see Appendix A.); and selective use of urine screens, particularly for adolescents and for unreliable historians with puzzling presentations.

   b. For mental health screening in substance treatment settings, the use of symptom checklists (e.g., Brief Psychiatric Symptom Inventory, MINI, Project Return Mental Health Screening Form III, SCL-90 – See Appendix A.) can be helpful to facilitate referral for a more comprehensive mental health diagnostic evaluation.

5. Collateral Contact: screening AND assessment should routinely incorporate obtaining permission to contact – and contacting- all available collaterals, including family.

friends, case manager, probation officer, protective service worker, and other treaters, as well as obtaining records of previous treatment episodes.

6. Diagnostic Determination:

   a. Diagnosis of either mental illness or substance use disorder can rarely be established only by assessment of current substance use, mental health symptoms, or mental status exam. In most cases, diagnosis is more reliably established by obtaining a good history that is integrated, longitudinal, and strength-based.

   b. Diagnosis of substance use disorders involves review of past and current patterns of substance use, and observing whether those patterns meet criteria for substance dependence or substance abuse.

   c. Diagnosis of substance dependence is frequently based on evidence of lack of control of substance use in the face of clear harmful consequences, whether or not tolerance and withdrawal symptoms are present. Once substance dependence has been identified in the past, that diagnosis persists, even if the person currently exhibits reduced use or abstinence.

   d. Diagnosis of substance abuse requires exclusion of substance dependence, and identifying a pattern of harmful use in relation to the individual's own context. For a person with a mental illness, any controlled use of substances that interferes with treatment or outcome can be defined as abuse, and the extent of use that would be considered problematic is inversely related to the severity of the psychiatric disorder or disability. For individuals with severe mental illness who are disabled at baseline, any persistent use of substances is likely to be considered abuse, even though harmful effects may not be apparent on each occasion.

   e. Diagnosis of non- substance related psychiatric disorders similarly requires careful review of past and current patterns of mental health symptoms, in relation to presence or absence of appropriate medication and periods of substance abstinence or reduced use. Presence of symptoms meeting criteria for DSM IV psychiatric disorder during periods of abstinence or reduced use that exceed the resolution period for those symptoms based on the type and extent of substance use (see SUPS Table in Appendix B) meet presumptive criteria for mental illness.

   f. All diagnoses should be initially considered to be presumptive, and subject to continual reevaluation and revision during the course of continuing treatment.

   g. Whenever a psychiatric disorder and a substance disorder co-exist, even if the psychiatric disorder is substance-induced, both disorders should be considered primary, in the sense that each disorder requires appropriately intensive primary diagnosis-specific treatment simultaneously.

7. SMI Determination: SMI determination requires establishing (using the assessment methodology in the previous paragraph) a presumptive (NOT necessarily definitive) diagnosis of an SMI eligible psychiatric disorder, persistence of that disorder, and

functional incapacity in accordance with state guidelines for SMI determination. If necessary, the SUPS Table (Appendix B) may be utilized to assess the resolution period after which substance-related contribution to symptomatology and functional incapacity are likely to be significantly reduced or eliminated.

B. Differential Diagnoses

1. Substance Disorder: Distinguish substance use, substance abuse, and substance dependence. Distinguish types and categories of substances.

2. Psychiatric Disorder: Distinguish substance induced psychiatric disorder, non-SMI psychiatric disorder, SMI psychiatric disorder.

3. Co-occurring Disorder Subtype: SMI + substance dependence (high-high); SMI + substance abuse (high-low); non-SMI/ substance-induced disorder + substance dependence/severe abuse (low-high); non-SMI/psychiatric symptoms + substance abuse (low-low).

C. Assessment of Common Comorbid Conditions

1. Trauma related disorders: Individuals with co-occurring psychiatric disorders (SMI) and substance disorders have a high prevalence of trauma histories and trauma related symptoms, women (85%) more so than men (50%). **Use of a trauma screening tool for both men and women, and ensuring that the engagement and assessment procedures are trauma-informed and trauma-sensitive are highly recommended.**

2. Cognitive disorders: Individuals with co-occurring disorders have a high risk of comorbid cognitive impairment, with causes ranging from congenital conditions (ADD, learning disabilities) to sequela of substance use, medical conditions, and/or head injuries. **Assessment of cognitive impairment (e.g., with the Mini Mental Status Exam and with specific assessment of reading skills and auditory/ visual learning capacity) is important in modifying treatment in accordance with the individual's ability to learn most effectively.**

3. Personality traits and disorders: Individuals with co-occurring axis I disorders will frequently exhibit symptoms and behavior characteristic of axis II disorders. At times, these dysfunctional personality traits will resolve as recovery progresses; at times they represent enduring personality disorders. **Diagnosis of personality disorder is based on patterns of dysfunctional behavior that are present either prior to onset of substance disorder, or during periods of abstinence, and are not simply the result of the axis I mental illness or substance disorder.**

4. Medical conditions: Individuals with co-occurring disorders are a high risk population for multiple medical conditions, most notably sexually transmitted diseases. **Obtaining medical history and medical records is an important component of diagnostic assessment.**

D. Additional Assessment to Determine Treatment Needs

1. Phase of Recovery/Stage of Change/Stage of Treatment: The literature on co-occurring disorders has identified four **phases of recovery** (Minkoff, 1989): acute stabilization; motivational enhancement/engagement; prolonged stabilization (active treatment/relapse prevention); rehabilitation and recovery; five **stages of change** (Prochaska & DiClemente, 1992): pre-contemplation, contemplation, preparation, action, maintenance; four **stages of treatment** for seriously mentally ill individuals with substance disorders (Osher & Kofoed, 1989): engagement, persuasion, active treatment, and relapse prevention. Research of the latter two groups clearly states that effective interventions must be stage specific. Consequently, stage specific assessment is required. The Substance Abuse Treatment Scale (McHugo,et al, 1995) is validated for SMI populations; the URICA (DiClemente) and Readiness to Change Scale (Rollnick et al) with less seriously mentally ill populations. (Appendix A.)

2. Multidimensional Assessment: Significant research (McLellan et al) has identified the value of problem-service matching for individuals with substance disorders, including co-occurring psychiatric disorders. Use of multidimensional assessment tools like the Addiction Severity Index or the GAIN offer the opportunity to assess problems in multiple dimensions for the purpose of service matching. The ASI is not as well-validated in dual diagnosis populations, however, and does not permit integration of dimensions, or connection of dimensional problems to a particular disorder.

3. Continuous Integrated Treatment Relationship: One of the priorities of treatment is to establish a primary treatment relationship. Assessment for the presence and quality of such a relationship is a necessary prerequisite for treatment planning.

4. Family or Caregiver Support: Available supports supply both assistance and contingencies for mobilizing treatment progress.

5. Extent of Impairment: Assess strengths and disabilities to determine extent to which individuals require care and support unconditionally, and in what areas (housing, money management, ADLs). Also, assess capacity to learn recovery skills and to participate in substance disorder treatment, with regard to need for DDC or DDE addiction programming. (See below)

6. External Contingencies: Evaluate for presence of legal involvement, child protective service involvement, or other external contingency. Also evaluate for possible contingencies within existing mental health or substance program settings, including payeeships.(Ries & Comtois, 1997).

7. Level of Care: Assessment of level of care requires use of multidimensional assessment instruments, such as the ASAM PPC 2R (2001) for addiction related presentations, and LOCUS (2.001) for mental health related presentations. Both instruments have capacity to address comorbidity in level of care assessment.

IV. **Treatment Interventions**

There is no one single correct intervention for individuals with co-occurring disorders. Intervention strategies must be appropriately matched to individualized clinical assessment based on the parameters listed below. Diagnosis specific interventions for psychiatric and substance disorder are addressed in the practice guidelines for each separate disorder; this section will cover only those issues that relate to individuals with co-occurring disorders specifically. **One of the most important overarching principles is the value of continuous, integrated, unconditional treatment relationships that provide ongoing dual recovery management and support over time, regardless of treatment adherence or level of substance use. Within the context of these ongoing relationships, individuals can receive a variety of episodic clinical interventions matched to particular needs and stages of change.** The nature of these interventions is described below. See Appendix C for a template for matching interventions according to subtype of dual disorder and stage of change/phase of recovery.

A. Continuity of Dual Recovery Management and Care: Research-based principles (Drake et al, 1993, 2001; Minkoff et al, 1998) emphasize the importance of empathic, hopeful, continuing treatment relationships, provided by an individual clinician, team of clinicians (Continuous Treatment Team – CTT; Integrated ACT), or community of recovering peers and clinicians (Modified Therapeutic Community [Sacks et al, 1999]; Dual Recovery Clubhouse), in which integrated treatment and coordination of care take place across multiple treatment episodes. Integrated treatment implies that the primary treatment relationship integrates mental health and substance interventions at any point in time and over time into a person-centered whole. **For individuals with complex problems and/or severe impairment, establishment of a relationship to provide continuous integrated dual recovery management is the first priority of treatment planning.**

B. Episodic Interventions: Both psychiatric and substance disorders are chronic relapsing conditions, and individuals may be appropriately served by a variety of episodic interventions at different points in time. Within the context of a continuous dual recovery disease management approach, episodic interventions may occur in acute, subacute, or long-term settings, in either mental health or substance treatment settings. (See Programs in Section V (C).) Ideally, there is a continuous interaction between "continuity interventions", which are unconditional and flexible, with various treatment interventions which have time-limits and expectations which affect entry and discharge.

C. Subtype of Co-occurring Disorder: Subtype of co-occurring disorder affects locus of responsibility for client. Individuals who are seriously mentally ill (SMI) are commonly eligible for types of services provided in the mental health system (including continuing case management) that individuals with non-SMI symptoms or disorders may not be able to get. Non-SMI individuals require specific mechanisms for providing such continuity of care or case management through other means. Similarly, individuals with substance dependence are more likely to be appropriate for involvement in addiction episodes of care in the addiction system than are individuals with only substance abuse.

D. Diagnosis-Specific Treatment:

1. Integrated Dual Primary Treatment: When mental illness and substance disorder co-exist, both disorders are considered primary, and appropriately intensive simultaneous diagnosis- specific treatment for each disorder is required. Integrated dual primary treatment is NOT a new intervention. Rather, it involves a variety of methods by which diagnosis-specific, evidence-based strategies for each type of disorder are appropriately combined and coordinated in a single setting and in an integrated treatment relationship, and in which the interventions for each disorder are appropriately modified (if necessary) to address treatment impediments resulting from the other disorder.

2. Psychiatric Disorder: Treatment for known diagnosed mental illness must be initiated and maintained, including maintaining non-addictive medication, even for individuals who may be continuing to use substances. In addition, the best available psychiatric medication regime for each disorder may promote better outcomes for both disorders. Non-psychopharmacologic treatment regimes (e.g., dialectic behavioral therapy for borderline personality disorder) may be appropriately utilized to develop cognitive-behavioral skills to manage the mental illness, while applying similar skills to managing substance use, and integrating direct substance disorder treatment interventions as well. Diagnosis-specific integrated interventions have been developed and researched for trauma-related disorders (Najavits et al, 1998; Harris, 1998, Evans and Sullivan, 1995), and bipolar disorder (Weiss et al).

3. Substance Disorder:

   a. Substance abuse treatment: individual and group interventions to help individuals make, and implement, better choices regarding substance use in relation to their mental illnesses. Outcomes focus on limitation of use to achieve reduction in harmful outcome. For individuals with severe mental illness and baseline disability, abstinence outcomes are recommended, even though use can be controlled.

   b. Substance dependence treatment (addiction treatment) for individuals with co-occurring disorders is fundamentally similar to addiction treatment for anyone, with abstinence as a goal, and with the need to develop specific skills for attaining and maintaining abstinence, including use of generic recovery meetings (AA) and dual recovery programs (DRA, DTR). Individuals with serious psychiatric impairment often require more addiction treatment in smaller increments with more support over a longer period to attain recovery skills. Treatment interventions must be simpler, more concrete, with more role rehearsal, to meet the needs of seriously psychiatrically impaired individuals, and require maintaining continuing mental health supports and integrated treatment relationships while the learning process takes place.

E. Phase of Recovery/Stage of Change/Stage of Treatment: As noted above, interventions need to be phase or stage-specific. This implies that the strategy for individuals who are pre-contemplative is to apply motivational enhancement interventions (individual and/or

group) to help those individuals to be contemplators, and so on. Existing motivational enhancement strategies (cf. Miller and Rollnick, 1991; CSAT TIP #35, 1999) have been successfully adapted to individuals with serious mental illness (Carey, 1996; Ziedonis and Trudeau, 1997). Stage-specific group interventions have demonstrated effectiveness with dually diagnosed populations. (Mueser & Noordsy, 1996).

F. Extent of Impairment:

1. Case management support needs to be provided, usually unconditionally, to assist individuals in basic needs that they cannot provide for themselves.

2. At each point in time during the course of treatment, however, whether in the context of a continuing treatment relationship, or during an episode of care, case management and care must be balanced with empathic detachment, empowerment, expectation, and empathic confrontation for each individual, in order to promote learning and growth.

3. More seriously impaired individuals at baseline (e.g., individuals with serious mental illnesses) are likely to require more extensive case management, support, and structure (unconditionally) to accommodate their psychiatric disabilities.

4. Methods for providing contingent learning opportunities within such structure include tightly managed payeeships, residential and day programs with a variety of contingent learning opportunities, etc. Contingencies and expectations must be matched to the individual's stage of change and capacity for learning, and are ideally developed maximizing consumer choice and participation.

5. For individuals requiring episodes of addiction treatment, requirement for psychiatric enhancement or modification of addiction treatment settings is proportional to the extent of psychiatric symptomatology or disability. Thus, different categories of addiction program (Dual Diagnosis Enhanced – DDE; Dual Diagnosis Capable – DDC) are required for different populations. (See Section V(B) for more description of program categories.)

G. External Contingencies:

1. Involvement of the criminal justice system or the protective service system may create treatment leverage that enhances motivation and treatment participation. Such interventions often require close collaboration between primary mental health and addiction clinicians with protective service workers and probation officers.

2. External contingencies may also be present through the involvement of natural caregivers (e.g., families) to develop collaborative strategies of contingency management and intervention.

3. Contingencies may emerge through participation in programmatic interventions within the treatment system: payeeships, abstinence-expected housing, etc. Careful integration of contingency management strategies into ongoing treatment planning can substantially enhance outcome, provided the contingencies are tightly managed, non-

punitive, and organized to promote continuous learning rather than treatment discontinuation.

H. Level of Care: Diagnosis specific and stage specific interventions can often occur at almost any level of care, depending on formal service intensity assessment as described above. Specific program examples at various levels of care are described below.

V. **Program Types**

A. Program Categories (ASAM 2001; Minkoff, 2000): Within any system of care, available programmatic interventions can be categorized according to dual diagnosis capability. The expectation is that all programs in either system evolve to become at least dual diagnosis capable (DDC-CD; DDC-MH), and a subgroup of services is designed to be dual diagnosis enhanced (DDE-CD; DDE-MH).

1. DDC-CD: Welcomes individuals with co-occurring disorders whose conditions are sufficiently stable so that neither symptoms nor disability significantly interfere with standard treatment. Makes provision for comorbidity in program mission, screening, assessment, treatment planning, psychopharmacology policies, program content, discharge planning, and staff competency and training.

2. DDC-MH: Welcomes individuals with active substance use disorders for MH treatment. Makes provisions for comorbidity as above. Incorporates integrated continuity of case management and/or stage-specific programming, depending on type of program.

3. DDE-CD: DDC program enhanced to accommodate individuals with subacute symptomatology or moderate disability. Enhanced mental health staffing and programming, increased levels of staffing, staff competency, and supervision. Increased coordination with continuing mental health or integrated treatment settings.

4. DDE-MH: MH program with increased substance related staffing skill or programmatic design: e.g., dual diagnosis inpatient unit, providing addiction programming in a psychiatrically managed setting; intensive dual diagnosis case management teams (CTT), providing pre-motivational engagement and stage-specific treatment for the most impaired and disengaged individuals with active substance disorders; comprehensive housing or day programs, providing multiple types of stage-specific treatment interventions and substance-related expectations.

B. Program Models

1. Continuous Integrated Case Management: Range from high intensity to low intensity, and DDC or DDE. High intensity DDE programs include Continuous Treatment Teams (CTT) (Drake et al, 2001), or integrated ACT teams. Moderate intensity programs include DDC or DDE case management teams (ICM, SCM). Low intensity intervention may be provided by individual outpatient clinicians (plus psychopharmacologists) in outpatient clinic settings.

2. Continuous Recovery Support: Dual Recovery Clubhouse programs (DDE) or Clubhouse programs with dual recovery supports or tracks (DDC); Dual Recovery self-help programs.

3. Emergency Triage/ Crisis Intervention (DDC): Welcomes any type of mental health and/or substance presentation, provides initial triage, level of care assessment, and crisis intervention and/or referral

4. Crisis Stabilization Beds (DDC): Hospital diversion in staffed setting for individuals with psychiatric presentations who may be actively using substances, but do not require medically monitored detox.

5. Psychiatric Inpatient Unit or Partial Hospital (DDC or DDE): The former does routine assessment, engagement, motivational enhancement, and stage-specific groups; the latter provides more sophisticated assessment plus addiction treatment in a psychiatrically managed setting. DDE programs have also been designed and implemented in state hospitals for individuals in long-term care.

6. Detoxification programs (DDC or DDE). Specialized psychiatrically enhanced detox (Wilens) can provide supervised detoxification for individuals who may have psychiatric exacerbations during episodes of acute substance intoxication (e.g., suicidality, aggressive impulsivity, psychosis) but who can be safe in an unlocked staffed setting.

7. Psychiatric Day Treatment (DDC or DDE): Intermediate to long-term programs for psychiatric support that provide varying degrees of stage-specific programming and integrated case management. DDE programs have more sophisticated staff, more linkages with substance programming, and a full range of stage-specific groups.

8. Addiction IOP, Partial, Residential (DDC or DDE): Episodes of abstinence-oriented <u>active</u> addiction treatment in settings with varying degrees of psychiatric capability. Programs can be very long term (years), such as Modified Therapeutic Community, or short term (one to two weeks, up to 90 days)

9. Psychiatric Housing Programs: Provide housing supports for individuals with psychiatric disabilities. Programs need to be matched according to stage of change;

   a. Abstinence-expected ("dry") housing: This model is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than "one strike and you're out".

   b. Abstinence-encouraged ("damp") housing. This model is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively discouraged.

However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than substance use per se. Motivational enhancement interventions are usually built in to program design.

c. Consumer-choice ("wet") housing. This model has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (Tsemberis & Eisenberg, 2000: "Pathways to Housing Program"). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

VI. Psychopharmacology Practice Guidelines (Minkoff, 1998; Sowers & Golden, 1999)

The new Psychopharmacology Guidelines can be found at:

http://www.bhrm.org/guidelines/psychopharmacology.pdf

VII. **Outcome Measures**

A. Overview

Outcome for individuals with co-occurring disorders needs to be individualized, in accordance with a range of variables that specify treatment interventions and programs for particular subpopulations (see below). These variables include:

1. Subtype of co-occurring disorder

   a. Serious mental illness (SMI) + substance dependence

   b. SMI + substance abuse

   c. Substance dependence + non-SMI psychiatric disorder

   d. Substance abuse + non-SMI psychiatric symptoms

2. Seriousness of baseline psychiatric disability

3. Extent of substance use, and associated problems

4. Specific psychiatric and substance diagnoses

5. Behavioral or medical risk/ involvement in other systems

   a. Homelessness

   b. Criminal behavior/violence

   c. Medical involvement (e.g., STD)

   d. Familial disruption/ child neglect or abuse

6. Stage of treatment/stage of change

7. Intensity of service utilization
   Outcome must also be categorized as **long term**, defining the ultimate outcome of a continuing course of treatment with multiple interventions, versus **short term,** defining the expected outcome of a particular program or episode of care.

   Finally, there are multiple dimensions of outcome, and the selection of which dimensions to measure depends on the variables listed above. These dimensions are enumerated in the following sections.

B. Improved Outcome of Psychiatric Illness
   Improved psychiatric outcome is measured by reduction in symptomatology, increased functionality and stability, identification and attainment of recovery goals, reduction in high end service utilization, and improved quality of life.

   For individuals with co-occurring psychiatric and substance disorders (ICOPSD), psychiatric outcomes are defined by the desired outcomes specified in the service planning guidelines for each psychiatric diagnosis.

C. Improved Outcome of Substance Disorder

1. Long-term outcome:

   a. For individuals with substance dependence: sustained abstinence, increased functional capacity, and increased subjective experience of recovery and serenity. (N.B. For ICOPSD in methadone maintenance treatment, desired outcomes regarding substance use, and continuation of methadone, are the same as for MMT in general.)

b. For individuals with serious mental illness and substance abuse: sustained non-harmful use (abstinence or occasional (less often than weekly) use of mild substances not to intoxication) and elimination of substance-related psychiatric symptom exacerbations.

c. For individuals with substance abuse and non-serious psychiatric symptoms: sustained non-harmful use defined by elimination of substance-related psychiatric symptoms or symptom exacerbations.

2. Short-term outcomes: dependent on specific program and stage of treatment.

a. Acute stabilization: safe detoxification or sobering up, plus safe stabilization of substance-induced or substance-exacerbated psychiatric symptoms or disorders, plus referral to continuing interventions for motivational enhancement and/or prolonged stabilization of each disorder.

b. Motivational enhancement: treatment engagement and progress through stages of change.

c. Active treatment for substance abuse: incremental small step changes in substance use patterns in order to achieve reduction in harm with minimum change. The pattern of use that is non-harmful is defined by successive trials in relation to the severity of psychiatric disability and symptoms.

d. Active treatment for substance dependence: commitment to abstinence and acquisition of skills and supports to maintain abstinence at the next level of care.

e. Relapse prevention: maintenance of abstinence or non-harmful use patterns through appropriate use of recovery supports and specific relapse prevention skills.

f. Rehabilitation and recovery: development of new skills and functional abilities to manage feelings and situations, to improve self-concept, serenity, and self-esteem, as stability continues.

D. Stage of Change

1. For individuals who are engaged in treatment for psychiatric disorders, but are pre-motivational regarding substance use: initial treatment outcome is defined by progress through stages of change or stages of treatment, as measured by Stages of Treatment Scale (McHugo et al, 1995) for SMI, Readiness to Change Scale, etc. Expected outcomes for individuals with SMI who are pre-motivational (in the “engagement” phase), based on the work of Drake et al, are that approximately 80% will move through one stage of treatment in six months.

2. For individuals who are not engaged in treatment for psychiatric disorders, and have co-occurring substance disorder: outcome can be defined by progress through stages of change regarding psychiatric treatment.

E. Reduction in Service Utilization

Interventions targeted to high service utilizers (e.g. intensive case management), often in managed care systems, will have the expected short-term outcome of reducing more intensive service utilization (e.g., hospitalization, detoxification) and increasing ambulatory contact. Evidence-based best practices targeting very high utilizers have achieved dramatic reductions within one year.

F. Harm Reduction and/or Improved Functioning and Stability

1. In the context of motivational enhancement interventions: individualized harm reduction goals can be identified as short-term outcome targets.

2. In the context of general functioning and involvement in other systems, harm reduction outcomes can include increased housing stability and reduced homelessness; reduction in arrest, incarceration, and/or criminal activity; reduction in abuse, neglect, and family disruption; increased medical stability and treatment adherence (e.g. for HIV regime); reduction in sexual risk behaviors; increased job stability and/or financial stability (e.g., reduction in level of payeeship supervision); increased socialization with healthy peers; and increased mental health treatment adherence and reduction of prescription drug misuse.

3. Achievement of harm reduction outcomes may often occur long before abstinence (or even full non-harmful use) is achieved.

Treatment Matching Paradigm:
Subtype of Dual Disorder by Phase of Treatment

Quadrant I: Low Severity MI/ Low Severity SA

Examples

45-year-old married man presents with complaints of depression, anxiety, increased alcohol use, and insomnia, in association with marital stress, and increased job pressure.

23-year-old single female graduate student reports increasing anxiety and panic attacks. She is a regular marijuana user, and is also under considerable stress due to financial and academic pressures.

Continuity Interventions

1. Integrated longitudinal assessment, possibly extending over several sessions, to establish possible diagnosis and formulation.
2. Intervention in outpatient clinic setting, type of clinic depending on type of initial presentation (MH vs. SA).
3. Involvement of collaterals in assessment process.
4. Stage-specific interventions as indicated for each disorder, while ongoing assessment and reformulation continue.

Stage- and Phase-Specific Interventions

Acute Stabilization

1. Outpatient setting only.
2. Discontinuation of substance use via outpatient contract.
3. Initiation of medication as indicated for possible psychiatric disorders.
4. Counseling interventions for stress management and problem-solving.
5. Modification of interventions as indicated for individuals with personality disorders.

Motivational Enhancement

1. Application of motivational enhancement strategies in outpatient counseling, as part of assessment and intervention.
2. Involvement of collaterals in the motivational process.
3. Group interventions not usually used.

Active Treatment/Relapse Prevention

1. Identify cognitive and behavioral strategies required to address substance use difficulties.
2. Outpatient substance abuse group may be indicated.
3. If criteria met for MI independently of substance use, initiate or continue appropriate medication.
4. Individual, group, and/or family counseling to address problematic issues or stresses.

Quadrant II: SPMI + Substance Abuse

Examples

39-year-old man with schizophrenia, living in a community residential program, who drinks a six-pack of beer on the weekend, when he has access to it. He also uses marijuana and cocaine occasionally. When he uses substances, he sometimes becomes more aggressive and loud, but he reports he enjoys using and wishes he could do it more often.

25-year-old woman with bipolar disorder and PTSD, living with her mother, and her two children, attending a mental health day treatment program, and receiving case management services, who drinks alcohol excessively during periods of hypomania, but not at other times, feeling that she is entitled to "have a good time" when she feels a bit high, since most of the time she feels depressed.

Continuity Interventions

1. Continuing case management with an individual clinician, case management team, or ACT team, depending on intensity of need.
2. Ongoing responsibility of mental health agency/system.
3. Unconditional support, access to crisis intervention, social support, psychosocial rehabilitation/day treatment, and housing support commensurate with disability.
4. Continued medication, regardless of continuing substance use.
5. Development of ongoing treatment plan, balancing care and support with structured expectation and contingencies, while maintaining continuity.
6. Stage-specific interventions as indicated.

Stage- and Phase-Specific Interventions

Acute Stabilization

1. For severe MI decompensation, DDC inpatient unit.
2. For substance use stabilization, no detox needed.
3. For substance related symptomatic exacerbation of MI, without severe decompensation, DDC psychiatric crisis stabilization bed.

Motivational Enhancement

1. Individual motivational interviewing, assuming role of dual recovery companion.
2. Encourage participation in pre-motivational and persuasion groups.
3. Involve families and other collaterals to support the motivational process and to promote interventions.
4. Promote harm reduction interventions during the motivational process.
5. Develop contracts and behavioral plans to promote contingency based learning, using payeeships and other available contingencies.
6. Utilize negative consequences and adverse outcomes in a supportive context to promote learning and encourage change.
7. Use best psychotropic medication available, including clozapine. Certain medication changes can be contingent upon reduced substance use.
8. Wet housing and damp housing supports
9. Individualized placement and support for vocational rehabilitation.

Active Treatment

1. Continuing medication for mental illness, along with appropriate treatment supports: individual therapy, group therapy, day treatment/psychosocial rehabilitation, housing support, case management, etc.
2. Emphasize building strengths and skills (including substance reduction skills) to promote recovery from mental illness.
3. Cognitive-behavioral skills training (appropriate for level of psychiatric disability) to promote substance reduction and elimination, in individual and group settings integrated into mental health treatment.
4. Skills training may be integrated into day treatment or psychosocial rehabilitation program.
5. Abstinence is recommended goal, but appropriate outcome can be non-harmful use (e.g., alcohol less than weekly, not to intoxication; no use of hallucinogens or amphetamines)
6. May benefit from dry or sober housing, or damp housing with active treatment focus.
7. AA/NA/DRA/DTR optional; addiction treatment referrals NOT appropriate.

Recovery/Rehabilitation/Relapse Prevention

1. Continued recovery and rehabilitation programming re: psychiatric disability.
2. Ongoing relapse prevention groups, peer supports, and other sobriety supports integrated into mental health settings.
3. AA/NA/DRA/DTR optional, according to consumer preference.

Quadrant III: Low Severity Psychiatric Disorder, High Severity Substance Disorder (Addiction)

Examples

32-year-old woman with severe crack cocaine dependence, working as prostitute, children under custody of protective services, with lifelong and ongoing trauma, HIV positive, suffering symptoms of post-traumatic stress disorder and dysthymia, particularly when not using crack. She is currently on probation, and has been referred for mandatory addiction treatment.

48-year-old man with alcohol dependence and opiate dependence who has been experiencing progressive anxiety and panic attacks over the past three years. He reports these are relieved when he drinks, yet keep getting worse.

Continuity Interventions

1. Outpatient counseling, in addiction treatment or mental health treatment setting, depending on level of dual diagnosis capability and consumer preference. Primary counselor coordinates and integrates interventions for each problem.
2. Intervention can be integrated with systems in which external contingencies are present, such as corrections, protective services.
3. If patient has established psychiatric disorder requiring medication, continuing psychopharmacology integrated as well.

Stage- and Phase-Specific Interventions

Acute Stabilization

1. For substance exacerbations, may need DDC detox.
2. For substance exacerbations accompanied by significant psychiatric impairment (suicidal impulses, overwhelming panic), may need DDE detox or DDC psychiatric crisis bed, depending on need for medical treatment for withdrawal, DDC/DDE inpatient psych if the appropriate lesser level of care is not available.

Motivational Enhancement

1. Individual or group motivational enhancement interventions, to promote either recognition of addiction or more consistent adherence with treatment recommendations.
2. Involvement of families, collaterals (e.g., probation officer), etc. in development of contingency strategies to promote motivation (e.g., drug court).
3. Harm reduction strategies can focus on improvement of medical outcomes, avoidance of jail, etc.
4. Initial medication evaluation may be made contingent upon brief initiation of abstinence (one week); If medication is already in use, medication reassessment can be made contingent.

Active Treatment

1. Addiction treatment in DDC setting (occasionally symptomatic acuity will require DDE setting), with level of care determined by ASAM PPC 2R.
2. Specific mental health counseling to address psychiatric issues and disorders.
3. Maintain non-addictive psychotropic medication as indicated.

4. Modify addiction treatment interventions to accommodate mental health issues (e.g., trauma issues, learning impairments).
5. Integrate attention to other primary problems: medical care, vocational rehab, parenting skills, and coordinate with other treaters (e.g., PCP) if present.

Relapse Prevention/Recovery

1. Continued addiction recovery program, utilizing any available addiction treatment tools, including AA/NA, and, if available, DTR/DRA.
2. Continued integrated outpatient counseling addressing both disorders.
3. DDC sober living setting if indicated.
4. Continued psychopharmacology, with regular review to determine if medication needs change, and/or any symptoms improve or worsen as sobriety proceeds.
5. Ongoing attention to medical care, vocational rehab, parenting skills, etc.

Quadrant 4A: High Severity Psych (SPMI) + High Severity Substance (Addiction)

Examples

27-year-old woman with paranoid schizophrenia and crack cocaine dependence, homeless, living on the streets, prostituting and panhandling to support herself.

35-year-old man with schizoaffective disorder and alcohol dependence, living in a group home, attending day treatment, with frequent episodes of intoxication and symptom exacerbation, which are not dangerous, but are disruptive to the group home. He has had multiple detoxes and alcohol treatment episodes, but has maintained sobriety only for brief periods.

Continuity Interventions

1. Continuing case management with an individual clinician, case management team, or ACT/CTT team, depending on the intensity of need. DDE level of competency may be indicated.
2. Ongoing, responsibility of mental health agency/system
3. Unconditional support, access to crisis intervention, social support, psychosocial rehabilitation/day treatment, and housing support commensurate with disability.
4. Continued non-addictive medication, regardless of continuing substance use.
5. Development of ongoing treatment plan, balancing care and support with structured expectation and contingencies, while maintaining continuity.
6. Stage-specific interventions for addiction, as indicated.
7. Continued encouragement of participation in abstinence oriented addiction recovery program, but not mandating abstinence as a condition of treatment until client is in appropriate stage of change.

Stage- and Phase-Specific Interventions

Acute Stabilization

1. For severe MI decompensation, DDC or DDE inpatient unit, depending on willingness to address addiction
2. For substance stabilization only, while MI at baseline, DDC or DDE detox depending on level of MI disability at baseline. In some systems, DDE psych inpatient will be the only level of care that can provide this service for SPMI.
3. For substance related symptomatic exacerbation of MI, without severe decompensation or need for medical detox (e.g., binge drinking), DDC or DDE psychiatric crisis bed.

Motivational Enhancement

1. Individual motivational interviewing, assuming role of dual recovery companion.
2. Encourage participation in pre-motivational and persuasion groups.
3. Involve families and other collaterals to support the motivational process and to promote interventions.
4. Promote harm reduction interventions during the motivational process.
5. Develop contracts and behavioral plans to promote contingency based learning, using payeeships and other available contingencies, positive and negative.

6. Utilize negative consequences and adverse outcomes in a supportive context to promote learning and change.
7. Use best psychotropic medication available, including clozapine. Certain medication changes can be contingent on reduced substance use.
8. Wet housing and damp housing supports
9. Individualized placement and support for vocational rehabilitation.
10. Unsuccessful efforts to engage in active treatment for substance abuse may be part of the motivational process.
11. Utilize indications of lack of control of substance use to demonstrate presence of addiction (vs. abuse) and encourage recognition of need for abstinence rather than controlled use.

Active Treatment

1. Continuing medication for mental illness, along with appropriate treatment supports: individual therapy, group therapy, day treatment/psychosocial rehabilitation, housing support, case management, etc.
2. Emphasize building strengths and skills (including relapse prevention and abstinence maintenance skills) to promote recovery from mental illness and addiction.
3. Skills training appropriate for level of psychiatric disability integrated into day treatment, psychosocial rehabilitation, and/or residential programming.
4. Continued contingent reinforcement strategies to promote treatment adherence and abstinence.
5. Referral to DDE addiction treatment, at intensive outpatient or residential level of care, may be appropriate, with continuing integrated mental health case management maintained.
6. Addiction treatment interventions in all settings focus on specific skills training for developing recovery support, including attendance at 12 Step Meetings, as well as cognitive-behavioral relapse prevention skills.
7. Abstinence is consistently recommended goal, but slips are not regarded as failures, so much as learning opportunities. Positive outcome can also be measured as days sober, reduction in total use, etc.
8. Medication for treatment of addiction, including methadone maintenance, may be appropriate as indicated.
9. May benefit from dry or sober housing, either group home or supported housing model.
10. AA /NA/DRA/DTR strongly recommended on a daily basis.
11. Integrated attention to other primary problems (e.g., medical care, vocational rehabilitation.)

Recovery/Rehabilitation/Relapse Prevention

1. Continued dual recovery and rehabilitation programming
2. Ongoing relapse prevention groups, peer supports, and other sobriety supports integrated into mental health settings.
3. Continued involvement in addiction recovery programming, at consumer's level of capacity, including AA, NA, DRA, DTR.
4. Utilization of recovery concepts from each disorder to promote recovery and growth from the other disorder (e.g. "One day at a time.")

Quadrant IVB: High Severity Psychiatric Disturbance (non-SPMI) and High Severity Substance Disorder (Addiction)

Examples

43-year-old woman with severe alcohol dependence, borderline personality disorder, and post traumatic stress disorder, with a history of multiple detox admissions for alcohol, as well as multiple psychiatric hospitalizations and emergency room visits for suicidal behavior.

29-year-old man with polysubstance dependence, attention deficit disorder, atypical mood disorder, explosive disorder, personality disorder, who is on probation for recurrent violent behavior and criminal assault, and who has a history of psychiatric admissions for explosive behavior, homicidal impulses, and paranoid thinking, particularly when intoxicated. He lives with his girl friend, and works intermittently as a painter.

Continuity Interventions

1. Continuing case management with an individual clinician, case management team, or ACT team (or equivalent), depending on intensity of need.
2. Ongoing responsibility may be assigned to mental health agency, substance agency, or specialized program related to specific issues like court involvement, parenting issues, HIV status, etc.
3. May not be appropriate for programs designed for individuals with psychotic disorders.
4. Unconditional support, access to crisis intervention, social support, rehabilitative interventions, and housing support commensurate with disability.
5. Continued non-addictive medication for any known mental illness, regardless of continuing substance use.
6. Development of ongoing treatment plan, balancing care and support with structured expectation and contingencies, while maintaining continuity.
7. Stage-specific interventions as indicated, integrating contingencies from other systems (e.g., legal, protective services) where appropriate.

Stage- and Phase-Specific Interventions

Acute Stabilization

1. For severe decompensation of SA with active MI symptoms, DDE inpatient psych unit or DDE detox, depending on severity of mental health symptoms.
2. For less severe exacerbations of substance use and psychiatric symptoms, DDC/DDE crisis stabilization bed.

Motivational Enhancement

1. Individual or group motivational enhancement interventions, to promote recognition of addiction and psychiatric disturbance, and more consistent adherence with treatment recommendations for either disorder.
2. Involvement of families, collaterals (probation officer), etc. in development of contingency strategies to promote motivation.
3. Harm reduction strategies to focus on improvement of mental health outcomes, medical status, avoidance of jail, etc.

4. Provision of mental health intervention in the context of empathic, hopeful, integrated relationships can promote willingness to address substance related issues.
5. Medication reassessment may be made contingent upon initiation of abstinence oriented treatment efforts.

Active Treatment

1. Maintain integrated unconditional case management
2. to coordinate care.
3. Addiction treatment in a DDE setting, with level of care determined by ASAM PPC 2R. For individuals with very severe behavioral disturbances at baseline, treatment may occur in DDE mental health settings (day treatment/psychosocial rehabilitation).
4. Integrated primary treatment relationship to apply simultaneous interventions to both disorders, in the context of addiction recovery efforts.
5. Mental health counseling, medication, and cognitive-behavioral skills training to address issues like trauma, self-harm, and anger.
6. Modified addiction treatment interventions to teach specific recovery skills within the context of limitations imposed by mental health issues (trauma history, impulsivity, learning disability).
7. Continued contingency reinforcement strategies to promote treatment adherence and abstinence, as indicated.
8. Medication for treatment of addiction, including methadone maintenance, may be indicated.
9. DDE residential treatment, halfway house, or sober housing may be indicated.
10. Integrate attention to other primary problems: medical care, vocational rehab, parenting skills, legal issues, and coordinate care with other primary treaters if present.

Relapse Prevention/Rehabilitation/Recovery

1. Continued involvement in dual recovery and rehabilitative programming.
2. Addiction recovery supports utilizing all available tools, including medication, sober housing, and DRA/DTR.
3. Continued mental health support and rehabilitation, including individual, group, and family counseling, as well as medication.
4. Continued integrated outpatient counseling and case management regarding both disorders.
5. Regular psychopharmacologic review to determine if medication needs change, and/or any symptoms improve or worsen as sobriety proceeds.
6. Ongoing attention to medical care, vocational rehab, parenting skills, housing needs, etc.

Kenneth Minkoff, MD

RESOURCE BIBLIOGRAPHY

American Association of Community Psychiatrists, Level of Care Utilization System (LOCUS 2.001), Dallas, AACP 2000.

American Association of Community Psychiatrists, Principles for the care and treatment of individuals with co-occurring psychiatric and substance disorders. Dallas, AACP 2000. (AACP web site: www.comm.psych.pitt.edu)

American Society of Addiction Medicine. Patient Placement Criteria 2R. Washington, DC, ASAM. 2001.

Adelman S, Fletcher K, & Bahnassi A. Pharmacotherapeutic management strategies for mentally ill substance abusers. J. Subst. Abuse. Treatment. (1993) 10: 353-8.

Albanese M, Khantzian E, et al. Decreased substance use in chronically psychotic patients treated with clozapine. Am. J. Psych. (1994) 151:780-1.

Alexander MJ. Women with co-occurring disorders: an emerging profile of vulnerability. Am. J. Orthopsychiatry. (1996) 66:61-70.

Alexander MJ & Haugland G. Integrating services for co-occurring disorders: final report for NY State Conference of Local Mental Hygiene Directors. Nathan Kline Institute, Orangeburg, NY. March, 2000. See Appendix A: Assessment Tools.

Arbour Health System. Required basic competencies in addiction/dual diagnosis for adult/child clinicians, and self-learning workbook and examination. Arbour Health System. Jamaica Plain, MA 2000

Barreira, P, Espey, E, et al. Linking substance abuse and serious mental illness service delivery systems: initiating a statewide collaborative. Journal of Beh Health Serv Res, 2000. 27: 107-13.

Bastiaens, L, Francis G, & Lewis, K. The RAFFT as a screening tool for adolescent substance use disorders. Am. J. Addictions. (2000) 9:10-16.

Baker, J & Rohacek, J. Integrated Dual Recovery Program. McPike Addiction Treatment Center & Mohawk Valley Psychiatric Center. Utica, NY 2000.

Bellack AS, et al. Behavioral treatment for substance abuse in schizophrenia (BTSAS). Abellack@umaryland.edu.

Bellack AS & DiClemente CC. Treating substance abuse among patients with schizophrenia. Psych Services (1999) 50:75-80.

Biederman, J, Wilens, T, et al. Pharmacotherapy of ADHD reduces risk for substance use disorder. Pediatrics (1999).104(2).

Brady, KT. Co-morbidity of substance use and axis I psychiatric disorders. Medscape Mental Health 3(4) 1998. www.medscape.com.

Brady KT & Roberts J. The pharmacotherapy of dual diagnosis. Psych Annals (1995) 25:344-52.

Bricker, M. STEMSS. Milwaukee, 1988.

Brunette, M, & Drake, RE. Gender differences in homeless persons with schizophrenia and substance abuse. Comm MH Journal (1998).34:627-33.

Carey KB. Substance use reduction in the context of outpatient psychiatric treatment: a collaborative, motivational, harm reduction approach. Comm MHJ (1996) 32:291-306.

Carey KB, Bradizza CM, et al. The case for enhanced addictions training in graduate programs. Behavior Therapist (1999) 22:27-31.

Center For Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol #35. CSAT, Washington, 1999.

Center for Substance Abuse Treatment. Treatment of Persons with co-occurring disorders: program examples. SSDP V Co-occurring Institute. Orlando, 2000. (Contact Carol Coley: ccoley@samhsa.org)

Ciraulo, DA & Nace, EP. Benzodiazepine treatment of anxiety or insomnia in substance abuse patients. Am. J. Addictions (2000) 9:276-84.

Cline, C. Enhancing care for individuals with co-occurring psychiatric and substance use disorders. New Mexico DOH/BHSD. Santa Fe, 2001.

Comtois KA, Ries R, & Armstrong HE. Case manager ratings of the clinical status of dually diagnosed outpatients. Hospital and Comm. Psych. (1994) 45:568-73.

Drake, RE, Bartels, SJ, et al. Treatment of substance abuse in severely mentally ill patients. J. Nervous Mental Disease (1993) 181:606-11.

Drake, RE, Essock, SM, et al. Implementing Dual Diagnosis services for clients with severe mental illness. Psych Services (2001) 52(4).

Drake, RE, Mercer-McFAdden, C, et al (eds.) Readings in Dual Diagnosis. International Association of Psychosocial Rehabilitation Services. Columbia, MD. 1998.

Ekleberry, SC. Personality Disorders and Addiction. sekleberry@hotmail.com. Materials available on Dual Diagnosis Website: www.toad.net/~arcturus/dd/ddhome.htm.

Evans K & Sullivan JM. Treating Addicted Survivors of Trauma. Guilford, New York. 1995.

Evans K & Sullivan JM. Dual diagnosis: Counseling the Mentally Ill Substance Abuser. 2nd Edition. Guilford, New York. 2001.

Federation of Families for Children's Mental Health. Blamed and ashamed: the treatment experiences of youth with co-occurring disorders and their families. October, 2000.

Godley SH, Finch M, et al. Case management for dually diagnosed individuals involved in the criminal justice system. J. Sub Ab. Treatment.(2000) 18:137-48.

Goldfinger, SM, Shute, RK, et al. Housing placement and subsequent days homeless among formerly homeless adults with mental illness. Psych Services (1999) 50:674-9.

Hamilton, T. & Samples, P. The 12 Steps and Dual Disorders. Hazelden, Center City, MN. 1995.

Harris M. Trauma Recovery and Empowerment Manual. Free Press. New York. 1998.

Illinois Alcohol and Other Drug Abuse Professional Certification Association. The Illinois standard for board registered MI/SA I/II. IAODAPCA, Springfield, IL. 1998.

Illinois MISA Institute. Program Development and Cross Training for Dual Disorders. The Illinois MISA Newsletter 2(2): 1-4. 2000.

Kessler RC, Nelson CB et al. The epidemiology of co-occurring addictive and mental disorders. Am. J. Orthopsychiatry. (1996) 66:17-31.

Kosten, TR. Management of anxiety in substance abusers. American Academy of Addiction Psychiatry Newsletter. Spring, 2000. AAAP, Prairie Village, KS.

Leshner AI. Addiction is a brain disease, and it matters. Science (1997) 278:45-7

Lucksted, A, Dixon, L, & Sembly, JB. A focus group pilot study of tobacco smoking among psychosocial rehabilitation patients. Psych Services(2000). 51:1544-8.

Massaro, J. Substance Abuse and Mental/Emotional Disorders: Counselor Training Manual. The Information Exchange, New City, NY. 1995.

McKillip, R. The Basics: a curriculum for co-occurring mental health and substance use disorders. In press. Available from author: 509-258-7314.

Mehr, J. State of Illinois Second Task Force Report on MI/SA Dual Disorders. Illinois Offices of Mental Health and Alcoholism and Substance Abuse, Springfield, IL. May, 1998.

Mercer-McFadden C, Drake RE, et al. Substance Abuse Treatment for People with Severe Mental Disorders: a program manager's guide. NH-Dartmouth Psychiatric Research Center, Concord, NH. 1998.

Mid-America Addiction Technology Transfer Center. A Collaborative Response: Addressing the needs of consumers with co-occurring substance use and mental health disorders. (including: Psychotherapeutic Medications 2000: what every counselor should know). Kansas City, Missouri, 2000. Web site: www.mattc.org.

Miller, WR & Rollnick S. Motivational Interviewing. Guilford Press, New York. 1991.

Minkoff, K. CHOICE-Dual. Choate Outline for Intensity of Care Evaluations for Dual Diagnosis Services. 1997. Unpublished.

Minkoff, K. MIDAS: Mental illness drug and alcohol screening tool. 2001. Unpublished.

Minkoff, K, Chair. CMHS Managed Care Initiative Panel on Co-occurring Disorders. Co-occurring psychiatric and substance disorders in managed care systems: annotated bibliography. Center for Mental Health Policy and Services Research, Philadelphia, 1997. Web site: www.med.upenn.edu/cmhpsr

Minkoff, K. Chair. CMHS Managed Care Initiative Panel on Co-occurring Disorders Co-occurring psychiatric and substance disorders in managed care systems: standards of care, practice guidelines, workforce competencies, and training curricula. Center for Mental Health Policy and Services Research. Philadelphia, 1998. Web site: www.med.upenn.edu/cmhpsr

Minkoff, K. Model for the desired array of services and clinical competencies for a comprehensive, continuous, integrated system of care. Center for Mental Health Services Research, University of Mass. Dept. of Psychiatry. Worcester, MA. 1998.

Minkoff, K. An integrated model for the management of co-occurring psychiatric and substance disorders in managed care systems. Dis. Mgt & Health Outcomes (2000).8(5):251-7.

Minkoff, K. State of Arizona Service Planning Guidelines: Co-occurring Psychiatric and Substance Disorders. 2000. (Draft).

Minkoff, K & Cline, C. New Mexico Co-occurring Disorders Program Competency Assessment Tool. Santa Fe. 2001..

Minkoff, K & Drake, RE. Homelessness and dual diagnosis. In Lamb, HR (ed). Treating the Homeless Mentally Ill. Washington, DC, APPI. 1994. 221-35.

Minkoff, K & Regner, J. Innovations in integrated dual diagnosis treatment in public managed care: the Choate dual diagnosis case rate program. J.Psychoactive Drugs. (1999). 31(1): 3-11.

Mueser, KT, Bennett, M, & Kushner, MG. Epidemiology of substance use disorders among persons with chronic mental illnesses. In. Lehman, A & Dixon, LJ. Double Jeopardy. Chronic Mental Illness and Substance Use Disorders. Harwood Academic Publishers, Chur, Switzerland.. 1995.

Mueser, KT, Drake, RE, & Wallach, MA. Dual diagnosis: a review of etiological theories. Addictive Behaviors (1998) 23:717-34.

Mueser KT & Fox L. Stagewise Family Treatment for Dual Disorders: Treatment Manual. NH Dartmouth Psychiatric Research Center, Concord, NH. 1998.

Mueser, KT & Noordsy, DL. Group treatment for dually diagnosed clients. In Drake, RE & Mueser, KT. Dual diagnosis of major mental illness and substance disorder. Part 2. Jossey-Bass, San Francisco. 1996.

Mueser, KT, Noordsy, DL, Drake, RE, Fox, L. Integrated Treatment for Dual Disorders: Effective Intervention for Severe Mental Illness and Substance Abuse. New Hampshire Dartmouth Psychiatric Research Center. In press.

Mueser KT, Noordsy DL, & Essock S. Use of disulfiram in the treatment of patients with dual diagnosis. Am. J. Addictions (2001) In press.

NAMI. Position Statement: Integrated treatment and blended funding for co-occurring disorders. NAMI, Arlington, VA.

NASMHPD/NASADAD. The new conceptual framework for co-occurring mental health and substance use disorders. Washington, DC. NASMHPD 1998.

NASMHPD/NASADAD. Financing and marketing the new conceptual framework. Washington, NASMHPD. 2000.

National GAINS Center. The Courage to Change: Communities to create integrated services for people with co-occurring disorders in the justice system. GAINS Center, Delmar, NY. 1999.

Oregon DHS Statewide Task Force on Dual Diagnosis. Final Report and Recommendations. Oregon DHS DMH, Salem, OR. May, 2000.

Pennsylvania MISA Consortium. Report and Recommendations. OMHSAS, Harrisburg. August, 1999.

Peters RH & Bartoi, MG. Screening and Assessment of Co-occurring Disorders in the Justice System. National GAINS Center, Delmar, NY. 1997.

Peters RH & Hills HA. Intervention strategies for offenders with co-occurring disorders. What works?. National GAINS Center, Delmar, NY. 1997.

Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. Am. Psychol. (1992) 47:1102-14.

Project Return. Mental Health Screening Form III. Project Return, New York. 2000.

Quinlivan R & McWhirter DP. Designing a comprehensive care program for high cost clients in a managed care environment. Psych Services (1996) 47:813-5.

RachBeisel, J, Scott, J. & Dixon, L. Co-occurring severe mental illness and substance use disorders: a review of recent research. Psych Services (1999). 50:1427-34.

Regier, DA, Farmer ME, et al. Comorbidity of mental disorders with alcohol and other drug abuse. JAMA (1990) 264:2511-18.

Ridgely, MS, Lambert, D, et al. Interagency collaboration in services for people with co-occurring mental illness and substance use disorder. Psych Services (1999) 49:236-8.

Ries, RK & Comtois KA. Illness severity and treatment services for dually diagnosed severely mentally ill outpatients. Schiz. Bull. (1997a) 23:239-46.

Ries, RK & Comtois KA. Managing disability benefits as part of treatment for persons with severe mental illness and comorbid substance disorder. Am. J. Addictions (1997b) 6(4):330-8.

Ries, RK, Russo, J, et al. Shorter hospital stays and more rapid improvement among patients with schizophrenia and substance disorders. Psych Services. 2001. 52(2):210-4.

Roberts LJ, Shaner A, & Eckman TA. Overcoming addictions: skills training for people with schizophrenia. W.W. Norton, New York. 1999. (BHRM staff note: This manual and the accompanying tapes can be ordered from the UCLA Dissemination Coordinator, Tricia Doles, (805) 484-5663.)

Sacks, S. Co-occurring disorders: promising approaches and research issues. J. Substance Use & Misuse (2001), in press.

Sacks, S, Sacks, JY, & DeLeon G. Treatment for MICAs: design and implementation of the modified TC. J. Psychoactive Drugs. (1999) 31:19-30.

SAMHSA. Position statement on use of block grant funds to treat people with co-occurring disorders. 2000.

Sciacca, K. Sciacca Comprehensive Service Development and Curriculum for MIDAA. Materials available on dual diagnosis website: http://pobox.com/~dualdiagnosis. E-mail. Ksciacca@pobox.com.

Shaner A, Roberts LJ, et al. Monetary reinforcement of abstinence from cocaine among mentally ill persons with cocaine dependence. Psych Services (1997) 48:807-10.

Sowers, W & Golden, S. Psychotropic medication management in persons with co-occurring psychiatric and substance use disorders. J. Psychoactive Drugs. (1999) 31:59-67.

Texas Department of MH/MR. Co-occurring psychiatric and substance disorders: principles for programming and treatment in state mental health facilities. TDMHMR, Austin. 2000.

Tollefson GD, Montague-Clouse J, & Tollefson SL. Treatment of comorbid generalized anxiety in a recently detoxified alcoholic population with a selective serotonergic drug (buspirone). J. Clin. Psychopharm. (1992) 12:19-26.

Tsemberis, S & Eisenberg, RF. Pathways to Housing: Supported housing for street dwelling homeless individuals with psychiatric disabilities. Psychiatric Services (2000). 51(4):487-95.

Vogel, H. Double Trouble in Recovery (DTR): How to start and run a DTR group. NY Office of Mental Hygiene, Mental Health Empowerment Project, Albany 1999.

WELL Project. Principles for the trauma informed treatment of women with co-occurring mental health and substance abuse disorders. WELL Project, Cambridge, MA 1999.

Wilens, TE, Spencer, TJ, et al. A controlled clinical trial of bupropion for adult ADHD. Am J. Psych (2001) 158:282-88.

Ziedonis D & Trudeau K. Motivation to quit using substances among individuals with schizophrenia: implications for a motivation-based treatment model. Schiz. Bull. (1997) 23:229-38.

Zimmet SV, Strous RD, et al. Effects of clozapine on substance use in patients with schizophrenia and schizoaffective disorders. J. Clin. Psychopharm (2000) 20:94-8.

DUAL DIAGNOSIS VIDEO MATERIALS

Promise of Recovery. Gerald T. Rogers Productions. 800-227-9100.

Double Trouble. Gerald T. Rogers Productions.

Out of the Tunnel; Into the Light. Hazelden. 800-328-9000.

12 Steps & Dual Disorders. Hazelden.

Dual Diagnosis.(1994) NIDA, Rockville, MD.

Understanding Bipolar Disorder and Addiction (Dual Diagnosis Series), Hazelden

Understanding Depression and Addiction

Understanding Major Anxiety Disorders and Addiction

Understanding Personality Problems and Addiction

Understanding Posttraumatic Stress Disorder and Addiction.

Dual Diagnosis: An Integrated Model for Treatment. Kenneth Minkoff, MD. Mental Illness Education Project. 800-343-5540

Substance Use/Psychiatric Symptomatology Table

The psychiatric symptomology table is a guideline only and is not to be used as a substitute for professional clinical judgment.

Category of Substance	**Type of symptoms seen with use pattern**			**Resolution Period** *Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis.*
	Mild Use *Uses no more than 1-2 times/wk; does not use to severe intoxication; no observable impairment.*	**Moderate Use** *Uses regularly, but not usually to severe intoxication; and/or episodes of severe intoxication occur, but once/wk or less; and/or presence of negative out-comes (hangover, money loss), but not severe.*	**Heavy Use** *Uses regularly (more than 2x/wk) to point of severe intoxication; significant impairment, negative outcomes noted, such as ER visits, fights, can't pay rent, medical complications of substance dependence (liver disease, hemorrhage, etc.)*	
Alcohol Benzodiazepines Sedatives	None	Anxiety, depression, not dysfunctional	Hallucinosis, not psychosis *Patient usually reports hearing "voices", content non-bizarre, good reality testing, no thought disorder or bizarre behavior.*	30 days
			Anxiety Mood instability *Patients occasionally can develop a first true manic episode during withdrawal* Personality disorder	30-90 days *Most severe symptoms will resolve (if they do) within 30 days - disability/fragility may persist longer.*
Stimulants (cocaine, methamphetamine)	Mild anxiety, depression	Anxiety/panic, depression, mood instability	More severe anxiety & depression Personality disorder symptoms	30 days (mild/moderate) 30-90 days (heavy)
			Paranoid psychosis	30 days
Hallucinogens (Mescaline, LSD, peyote)	Anxiety & depression	Anxiety & depression	Psychosis	Usually 30 days *For heavy marijuana users, persistent anxiety, panic attacks, and mood/thought alteration may last up to 90 days.*
	Occasional psychosis or severe panic *A single episode of hallucinogen use can occasionally precipitate psychosis or severe panic. This may also happen with methamphetamine.*	Flashbacks/ hallucinotic experiences Sometimes, psychosis, panic, mood instability	Severe panic, mood instability	Up to 90 days

Substance Use/Psychiatric Symptomatology Table (continued)

The psychiatric symptomology table is a guideline only and is not to be used as a substitute for professional clinical judgment.

Category of Substance	**Type of symptoms seen with use pattern**			**Resolution Period** *Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis.*
	Mild Use *Uses no more than 1-2 times/wk; does not use to severe intoxication; no observable impairment.*	**Moderate Use** *Uses regularly, but not usually to severe intoxication; and/or episodes of severe intoxication occur, but once/wk or less; and/or presence of negative out-comes (hangover, money loss), but not severe.*	**Heavy Use** *Uses regularly (more than 2x/wk) to point of severe intoxication; significant impairment, negative outcomes noted, such as ER visits, fights, can't pay rent, medical complications of substance dependence (liver disease, hemorrhage, etc.)*	
Opiates	None	Mild-moderate anxiety & depression	More severe anxiety & depression, personality disorder symptoms	60-90 days
			Occasional psychotic symptoms, during withdrawal only	7-10 days

Category of Substance	**Type of symptoms seen with use pattern**			**Resolution Period** *Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis.*
	Mild Use *Smoking a single marijuana cigarette 1 - 2 times/wk*	**Moderate Use** *One or two marijuana cigarettes 3 -5 times/wk*	**Heavy Use** *Two or more marijuana cigarettes daily*	
Marijuana (cannabis sativa)	None	Mental confusion, agitation, feelings of panic	Acute toxic psychosis, paranoia, disorientation, severe agitation, depersonalization	Moderate - 24 - 72 hours Heavy - 30 to 60 days

EXHIBIT Q - SUBSTANCE ABUSE
Document consists of 36 pages.
Entire exhibit provided.
Meeting Date: 02-02-06