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Substance Use Best Practice Tool Guide

CO-OCCURRING DISORDERS

Division of Clinical Leadership in Collaboration with the
Division of Substance Abuse Services

Co-Occurring Disorders (CODs)

Co-Occurring Disorders Defined

People with co-occurring disorders (CODs) have at least one diagnosable mental illness along with one or more substance use disorders (SAMHSA/CSAT, 2013; TNCODC, 2013). The American Society of Addiction Medicine (ASAM) expands the definition to cover co-occurring conditions (COCs). Individuals are said to have COCs if they have any combination of any substance use or addictive behavior or any mental health condition, whether or not the condition is associated with a formal diagnosis. This definition allows for the targeting of at-risk populations for prevention and early intervention services. Nevertheless, individuals with CODs were at one time bounced from

agency to agency with limited results, costing a good deal of time and money. Each disorder was treated separately. Today, individuals with symptoms of addiction or mental health can be screened for COD through any door. Persons with COD typically have more episodes of

There are no specific combinations of mental disorders and substance use disorders that are uniquely defined as co-occurring disorders (SAMHSA, 2014b).

relapse, more inpatient hospital visits, more emergency room visits, and higher rates of chronic diseases, such as high blood pressure, diabetes, hepatitis, and HIV/AIDS. COD is found among adolescents as well as adults (TNCODC, 2013).

There are no specific combinations of mental disorders and substance use disorders (SUDs) that are uniquely defined as co-occurring disorders (CODs). They may include any combination of at least two mental disorders and substance use disorders identified in the DSM-5. Sometimes co-occurring disorders are referenced as “dual disorders” or as “having a dual diagnosis” (SAMHSA, 2014b). The focus on CODs is largely based on the “No Wrong Door” principle promulgated in the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Substance Abuse Treatment (2000) report entitled *Changing the Conversation*. It is this principle that has not only guided policy but decision making about treatment for CODs. The principle takes into account that most persons with substance use issues do not have a single-targeted problem and that rehabilitation and treatment programs must adapt to meet the specific needs of each individual.

Roughly 50 percent of the people seeking substance use treatment will also have another significant mental disorder (Miller, Forchimes, & Zweben, 2011).

People with a mental health issue are more likely to experience substance use disorder (SUD) than those without a mental illness. In fact, Miller, Forchimes, & Zweben (2011) contend that roughly 50 percent of the people seeking substance use treatment will also have another significant mental disorder. CODs can be difficult to diagnose due to the complexity of the symptoms. In some cases, both disorders are severe; in some cases, both are mild; and in some cases, one disorder is more severe than the other. Integrated treatment is highly recommended for persons with CODs. Untreated, undertreated, and/or undiagnosed CODs tend to result in negative outcomes such as a greater likelihood of experiencing

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homelessness, incarceration, suicide, medical illnesses, and early death (SAMHSA, 2014b). The most common cause of psychiatric relapse today in persons with COD is the use of substances. Similarly, the most common cause of relapse in substance use is untreated psychiatric disorder (Mental Health America. 2012). It is estimated that about two thirds of the 10 percent that account for most of the

health care costs
have a COD
diagnosis
(TNCOD, 2013).

Two thirds of the 10 percent that account for most of the health care costs have a co-occurring disorder diagnosis (TNCOD, 2013).

Data from the
2013 National
Survey on Drug

Use and Health (NSDUH) indicated that 3.2 percent of adults (ages 18 and older) in the United States had co-occurring “any mental illness” and substance use disorder (SUD). For adolescents, 1.4 percent had co-occurring major depressive episode and SUD (SAMHSA/CBHSQ, 2014). Statistics at Dual Diagnosis.org (n.d.) indicate that 51 percent of individuals with a mental disorder have at least one SUD and up to 66 percent of persons with an SUD have at least one mental disorder.

Essential Programming Components

This section describes the essential programming components that should be developed by substance use treatment providers seeking to deliver integrated substance use and mental health services to individuals with co-occurring disorders (CODs). The elements constitute the best practices presently available for designing COD programs in substance use treatment agencies (SAMHSA/CSAT, 2013b).

Screening, Assessment, and Referral.

The first step in being able to treat mental health disorders among people with substance use problems starts with recognition (Health Canada, 2007). Screening will help determine the likelihood that an individual has co-occurring substance use and mental disorders or that his or her presenting symptoms, signs, or behaviors may be influenced by co-occurring issues. Screening should be brief and occur soon after the person presents for services (SAMHSA/CSAT, 2006). Proper screening must occur, which involves, at the very least, asking the appropriate questions (Health Canada, 2007).

Clients with COD are best served when screening, assessment, and treatment planning are integrated, i.e., both substance use and mental health disorders, each in the context of the other, are addressed. The screening process should be comprehensive and include exploration of a variety of related service needs such as medical, victimization, trauma, housing, and so forth. In short, screening should expedite entry into appropriate services. Screening tools can be used because they offer efficiency and objectivity in gathering information. However, the screening process needs to be flexible enough to balance the need for consistency with the need to respond to important differences among individuals (SAMHSA/CSAT, 2006).

Integrated assessment should be used if screening points to the need for an in-depth assessment. Conducting an integrated assessment will assist in 1) making a formal diagnosis; 2) evaluating the

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level of functioning; 3) determining the individual's readiness for change; and 4) making initial decisions about appropriate level of care. Moreover, the assessment process should be client-centered, i.e., ensure that the person's perceptions of his or her issues and goals he or she wishes to accomplish are central to the assessment as well as to the recommendations that derive from it (SAMHSA/CSAT, 2006).

Also part of integrated assessment is the identification of the interactions among the symptoms of mental disorders and substance use, as well as the interactions of the symptoms of substance use disorders and mental health symptoms. Integrated assessment further considers how all the interactions connect to treatment experiences, especially stages of change, periods of stability, and periods of crisis. Diagnosis is a critical part of the assessment process (SAMHSA/CSAT, 2013b).

In the event the screening/assessment process identifies a substance use or mental disorder that is beyond the resources and capacity of the provider agency, a referral should be made to an appropriate provider. There should further be mechanisms in place to ensure ongoing collaboration and consultation so the referral is appropriate to the treatment needs of the individuals with CODs (SAMHSA/CSAT, 2013b).

Physical and Mental Health Consultation.

Standard staffing should be expanded to include mental health specialists and to add consultation to the treatment services. Master's level clinical staff with strong diagnostic skills and expertise in working with persons having COD are recommended as such staff would strengthen the agency's ability to deliver appropriate COD services. Additionally, these staff could function as consultants to the rest of the team on mental health disorders. If the agency is unable to hire a psychiatrist on a consultative basis, a collaborative relationship with a mental health agency should be established to provide those services (SAMHSA/CSAT, 2013b).

Prescribing Onsite Psychiatrist.

Psychiatrists are critical to stable functioning and sustaining recovery for individuals with COD. Thus, every reasonable effort should be made to add an onsite psychiatrist to the staff of the substance use treatment agency. Having the onsite psychiatrist will help the agency overcome barriers observed in offsite referral such as travel and distance limitations, the separation of clinical services, fears of being stigmatized as "mentally ill", the inconvenience associated with the individual's enrollment in another agency, cost, and the challenges linked to comfort level with different staff (SAMHSA/CSAT, 2013b).

To help reduce costs for this component, the agency might consider hiring the psychiatrist on a part-time basis (i.e., between four to sixteen hours per week). However, some agencies may be able to hire a full-time psychiatrist or have him or her share full-time status with a nurse practitioner (SAMHSA/CSAT, 2013b). In Tennessee, we use nurse practitioners and physician assistants.

The benefits of an onsite psychiatrist are numerous. He or she can foster development of the substance use treatment staff, enhancing their skill and comfort in working with individuals that have COD. The psychiatrist might also upgrade the skills of licensed staff through seminars on medication management and other pertinent topics. Having an onsite psychiatrist adds an extremely

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skilled professional to the treatment team, which should enhance the development of effective treatment plans for active cases involving persons with COD (SAMHSA/CSAT, 2013b).

Whenever possible, the substance use agency should hire a psychiatrist with expertise in COD, substance use treatment. Psychiatrists are typically certified by the American Academy of Addiction Psychiatry, the American Society of Addiction Medicine (ASAM), or the American Osteopathic Association (SAMHSA/CSAT, 2013b).

Finding a psychiatrist, even part-time, is difficult in our state. Ninety of the 95 counties (95%) have shortage area designations based on the limited number/lack of psychiatrists. Hence, treatment facilities may offer telebehavioral health services. Best practices in such services are available from the American Telemedicine Association (ATA). Clinical, technical, and administrative guidelines are provided.

Clinical

1. Professional/Patient Identify/Location
 - ✓ Verify the patient's full name, using typical documents such as a government-issued ID.
 - ✓ Confirm and document where the patient/client will be receiving services. (Licensure is generally tied to the location where the patient/client is at the time of service. Mandated reporting issues are also tied to the patient/client's location at the time of service.).
 - ✓ Verify and exchange contact information.
 - ✓ Clarify expectations regarding contact (ATA, 2013).
2. Patient Appropriateness for Telehealth Services
 - ✓ The literature has not shown harm or negative benefits for telehealth services. Nevertheless, the patient/client's expectations and comfort level with telehealth services should be taken into account (ATA, 2013).
3. Informed Consent
 - ✓ Such should be conducted with the patient/client in real time. The document/discussion should contain the same components as for in-person care, including structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality and any limits, etc. (ATA, 2013).
4. Physical Environment
 - ✓ Physical space of the professional and patient/client's room should aim to provide comparable, professional specifications as found in a standard services room. Also, any persons other than the professional or patient/client should be identified. Every reasonable effort should be undertaken to ensure a professional environment for services. Equipment quality should be good, at minimum (ATA, 2013).
5. Communication/Collaboration with Patient/Client's Treatment Team
 - ✓ Discuss coordination of care with a multidisciplinary team. As necessary, collaborative relationships should be developed with other telehealth professionals and/or community-based staff (ATA, 2013).
6. Emergency Management

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- ✓ Plan for patient/client's safety under various conditions of telehealth service delivery. This means that professionals should
 - a. Review the definition of "competence" for their particular profession in advance of providing telehealth services. Further professionals should have taken basic education and training in suicide prevention prior to telehealth service delivery.
 - b. Know the duty-to-notify laws as well as when involuntary hospitalization should be recommended.
 - c. Be familiar with the emergency procedures of the agency for which they are examining the patient/client.
 - d. Be familiar with emergency procedures in cases where other professional staff may not be immediately available.
 - e. Know how to respond when the patient/client is uncooperative during an emergency situation.
 - f. Have information about securing transportation for patients/clients under a variety of conditions.
 - g. Be familiar with how to contact local emergency personnel in the area where the patient/client is located (ATA, 2013).

7. Medical Issues

- ✓ Professionals should be familiar with the patient/client's prescription and medication dispensation options. Also, professionals should become familiar with the entity from which the patient/client is receiving medical services (ATA, 2013).

8. Referral Resources

- ✓ The professional delivering telehealth should familiarize himself/herself with local in-person resources in the event a referral may need to be made (ATA, 2013).

9. Community/Cultural Competency

- ✓ Professionals should deliver culturally competent services to the populations that they serve. Investigate recent significant events and cultural mores of the community in which the patient/client resides (ATA, 2013).

Technical

1. Videoconferencing Applications

- ✓ Such applications should have been vetted and have appropriate verification, confidentiality, and security parameters necessary to be used for telehealth services. Also, do not allow social media functions or video chat room functions on software that will be used for these services (ATA, 2013).

2. Device Characteristics

- ✓ Professional grade or high quality cameras and audio equipment should be used for telehealth services whenever possible. The device should further have up-to-date antivirus software, personal firewall, and the latest security patches and updates. Professionals should have a back-up plan in place in the event of a technology breakdown that results in a disruption of the session. For example, the professional may call the patient/client on the telephone so they can attempt to continue to work through issues together (ATA, 2013).

3. Connectivity

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- ✓ The minimum recommended bandwidth for telehealth services is 384 Kbps, with higher bandwidths preferred. Resolutions should minimally be 640 x 360 at 30 frames per second (ATA, 2013).
- 4. Privacy
- ✓ Plans to make recordings during service delivery should be discussed in advance, including how the information will be stored. Data sharing should also be addressed and clarified (ATA, 2013).

Administrative

1. Qualifications/Training of Professionals
- ✓ Staff should be appropriately credentialed to provide services. Check with the professional organization, licensure board, and/or other legal entities to verify the appropriateness of telehealth services for the patient/client (ATA, 2013).
2. Documentation/Record Keeping
- ✓ Maintain an electronic record for each patient/client for whom services are provided. The record should include assessment, patient/client identification information, contact information, history, treatment plan, informed consent, and information about fees/billing. Documentation and access requirements shall comply with applicable Federal and jurisdictional laws (ATA, 2013).
3. Payment/Billing
- ✓ Inform patient/client of any and all financial charges that may result from the services to be provided. Complete payment arrangement before services begin (ATA, 2013).

Medication and Medication Monitoring.

Medication is necessary for many persons with COD to control their psychiatric symptoms and stabilize their psychiatric status. Having an onsite psychiatrist will facilitate meeting the medication needs of individuals with COD for whom such is appropriate. The psychiatrist will further be able to provide appropriate medication monitoring and review medication adherence. Often combined psychopharmacological interventions in which the client receives medication to reduce cravings for substances as well as medication for a mental disorder are employed (SAMHSA/CSAT, 2013b).

Psychoeducational Classes.

These classes generally focus on signs and symptoms of mental disorders, effects of mental disorders on substance use problems, and medication. They help to raise awareness about the individual's COD and provide a positive and safe context in which to handle the information. A wide array of information in the form of pamphlets from government agencies and/or advocacy groups is also available to explain CODs in language that is very comfortable for the individual (SAMHSA/CSAT, 2013b).

Onsite Double Trouble Groups.

These groups provide a forum for discussion of the interrelated problems of mental health disorders and substance use, helping individuals identify their triggers for relapse. In these forums, individuals describe their psychiatric symptoms and their urges to use substances. Individuals are encouraged to use discussion to deal with these urges rather than to act on their impulses. Sometimes these groups focus on helping individuals monitor the extent to which they adhere to taking their medication appropriately, psychiatric symptoms, substance use, and their adherence to attending/participating in scheduled meetings (SAMHSA/CSAT, 2013b). Double Trouble in Recovery (DTR) is a 12-step, peer support group that addresses both substance use and mental health.

Offsite Dual Recovery Self-Help Groups.

There are typically a variety of dual recovery mutual self-help groups in the communities in which individuals with COD reside. Hence, substance use agencies likely make referrals to these groups. Similar to psychoeducational classes, these groups also provide safe forums for discussing mental health issues, substance use issues, and medication. These groups offer an understanding, supportive environment where coping skills can be shared (SAMHSA/CSAT, 2013b).

Treatment

Understanding that substance use and mental health issues interact with each other is important as a co-occurring disorder (COD) can complicate recovery if it is not adequately addressed at the same time (CMCS, 2014). In working successfully with individuals that present with CODs, it is initially important to establish a successful therapeutic relationship. Research wholeheartedly supports the fact that clients, specifically those with COD, are much more responsive when the therapist acts consistently in a nonjudgmental and nurturing way. Of course, the comfort level of the clinician can impact his/her ability to build an appropriate therapeutic alliance with the client. Therefore, it is imperative that he or she recognize certain patterns that might invite unsettling feelings regarding the client and not let those feelings interfere with appropriate treatment. Clients presenting with COD frequently experience despair and demoralization because of the complexity of having more than one problem and difficulty achieving treatment success. Encouraging hope helps to give clients with COD at least short-term relief in exchange for long-term work, despite some uncertainty regarding benefit and time frame (SAMHSA/CSAT, 2013b).

Working with clients that have COD can be challenging. Many individuals that use substances may additionally present with some antisocial-type traits. Thus they are less amenable to treatment, pharmacological or psychosocial, and may work to avoid contact with treatment staff (SAMHSA/CSAT, 2013b). The problem becomes extremely difficult if the client with COD has both a substance use disorder and a diagnosis of schizophrenia. The literature emphasizes that substance use is one of the most common comorbid conditions for clients with this particular mental disorder (Schwartz, Hilscher, & Hayhow, 2007). A consensus panel recommends the following strategies in forming a therapeutic alliance with clients that have problems with COD:

- Show acceptance and understanding of the client.
- Assist the client in clarifying the nature of his/her problem.

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- Indicate to the client that he or she and you, the clinician, will be working collaboratively.
- Communicate to the client that, as the clinician, your role will be helping him/her to help himself/herself.
- Demonstrate empathy and a willingness to really listen to the way the client defines his/her problem.
- When necessary, help the client to solve some external problems immediately and directly.
- Genuinely foster hope for positive change (SAMHSA/CSAT, 2013b).

It will be important for clinicians to promote a recovery perspective. Treatment plans should be developed in such a way as to provide for continuity of care over time. This means that the treatment plan, like the assessment process, should also be client centered. Components of a client-centered treatment plan are shown in Table 1 below.

Table 1. Components of a Client-Centered Treatment Plan

Acute Safety Needs	Determines need for immediate acute stabilization to establish safety prior to routine assessment
Severity of Mental and Substance Use Disorders	Guides choice of most appropriate setting for treatment
Appropriate Care Setting	Determines client's program assignment
Diagnosis	Determines recommended treatment intervention
Disability	Determines case management needs as well as whether enhanced level of intervention is required
Strengths and Skills	Determines areas of prior success around which to organize future treatment interventions along with determining areas of skill-building needed for management of either disorder
Availability and Continuity of Recovery Support	Determines whether continuing relationships need to be established as well as availability of existing relationships to provide contingencies to promote learning
Cultural Context	Determines most culturally appropriate treatment interventions/settings
Problem Priorities	Determines problems to be solved specifically, along with opportunities for contingencies to promote treatment participation
State of Recovery/Client's Readiness to Change	Determines appropriate treatment interventions and outcomes for client at given stage of recovery or readiness for change

Source: SAMHSA/CSAT, 2006.

Maintaining a recovery perspective also means devising treatment interventions that are specific to the challenges and tasks that may be encountered at each stage of the COD recovery process. Make every effort to gain a thorough understanding of the interrelationship between stages of change and stages of treatment. The expectation for the client's progress through treatment stages must be consistent with his/her stage of change (SAMHSA/CSAT, 2013a; SAMHSA/CSAT, 2013b). Stages of changes are delineated in the table below.

Table 2: Stages of Change

<u>Stage</u>	<u>Characteristics</u>
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<i>Precontemplation</i>	Change is not a possible goal in the foreseeable future; may be under aware or unaware of problems.
<i>Contemplation</i>	Awareness that a problem exists and thinking seriously about overcoming it, but no commitment to take action yet made; weighing pros and cons of the problem and its solution.
<i>Preparation</i>	Combines intention and behavior—action is planned within the next month, and action has been taken, though unsuccessfully in the past year; some reductions have been made in problem behaviors, but criterion for effective action has not been determined.
<i>Action</i>	Behavior, environment, or experiences are modified to rise above the problem; successful change of addictive behavior for anywhere between a single day to six months (<i>Note:</i> Action does not equal Change; only total abstinence counts.)
<i>Maintenance</i>	Working to prevent relapse and consolidate gains attained during the Action stage; remaining free from addictive behavior and engaging consistently in new incompatible behavior(s) for longer than six months.

Source: SAMHSA/CSAT, 2013a; SAMHSA/CSAT, 2013b.

Integrated Treatment.

The preferred treatment for people with COD is integrated. Integrated treatment encompasses any mechanism by which treatment interventions for COD are combined within the context of a primary treatment relationship or service setting. It is effective in treating both disorders, related problems, and the whole person (SAMHSA/CSAT, 2013b). SAMHSA recommends and supports the use of integrated treatment for persons with CODs. Dealing with mental health and substance use issues simultaneously lowers cost while creating better treatment outcomes (SAMHSA, 2014a). Combining strategies from addiction treatment and psychiatry can lower the relapse rate among rehab graduates, foster long-term abstinence, and reduce the number of suicide attempts (DualDiagnosis.org, n.d.). Furthermore, the treatment should be culturally competent, provided in the context of the client's language, culture, socioeconomic status, gender, age, ethnicity, geographic area, sexual orientation, religion, spirituality, and any cognitive or physical disabilities. Integrated treatment utilizes integrated interventions as well. Among the techniques that might be used are:

- Combined pharmacological interventions in which individuals receive medication to reduce cravings for substances as well as medication for a mental disorder.
- Dual recovery groups where recovery skills for both disorders are discussed).
- Dual recovery mutual self-help meetings.

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- Group interventions for persons with the triple diagnosis of substance use disorder, mental disorder, and trauma, or which are designed to meet the needs of persons with COD and another shared problem such as homelessness or criminality.
- Integrated screening and assessment processes.
- Motivational enhancement interventions (group or individual) that address issues related to both substance use and mental health problems (SAMHSA/CSAT, 2013b).

These interventions can be part of a single program or employed in multiple program settings (SAMHSA/CSAT, 2013b). The interactive nature of the disorders requires that each be continually assessed and treatment plans adjusted accordingly. It is an utter disservice to individuals with COD to emphasize attention to one disorder at the expense of the other. The relationship between the disorders is always there and must therefore routinely be evaluated and managed. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for the provision of integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients. (SAMHSA/CSAT, 2007).

Hazelden-Betty Ford has a Co-Occurring Disorders Program that offers an integrated treatment approach for persons with non-severe psychiatric disorders that co-occur with substance use disorders. Consistent with the vision of integrated services, the program is designed to help people recover by offering both substance use and mental health services at the same time and in a single setting. They use the treatment modalities of cognitive-behavioral therapy, motivational enhancement therapy, 12-step facilitation therapy (Hazelden Publishing, n.d.a). Dartmouth Psychiatric Rehabilitation Center and Hazelden-Betty Ford also have a program for CODs with an elevated mental health acuity (IDDT)—Integrated Dual Disorders Treatment for the severely mentally ill.

In January 2010, SAMHSA released an Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit. The kit can be ordered and/or downloaded at no charge from the SAMHSA Web site at <http://store.samhsa.gov/product/SMA08-4367>. Key elements in the kit are:

- Cognitive-behavioral approach.
- Cross-trained practitioners.
- Integrated medication services.
- Integrated services.
- Motivational interventions.
- Multiple formats.
- Stage-wise treatment (SAMHSA, 2014a).

Systems integration
supports the provision

The overall vision of an integrated system is to effectively serve individuals with CODs no matter where they enter the system (SAMHSA, 2014a).

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of integrated services and may include any or all of the following: integrated system planning/implementation; continuous quality improvement; and mechanisms for addressing regulations and policies, program design and certification, financing, inter-program collaboration and consultation, clinical ‘best practice’ development, clinician licensure, competency and training, information systems, data collection, and outcome evaluation (SAMHSA/CSAT, 2007). The overall vision of an integrated system is to effectively serve individuals with CODs no matter where they enter the system (SAMHSA, 2014a).

Dr. Larke Nahme Huang, Director, Office of Behavioral Health Equity at SAMHSA is concerned that many care providers on both sides, mental health and substance use, do not possess the training necessary to treat COD in an integrated way. She expresses that whoever is doing the treatment--whether it is a psychiatrist, psychologist, counselor, or social worker--must have the expertise to treat the COD. In addition, clinicians must have training to simultaneously screen for the substance use and mental health conditions (Knopf, 2015).

Suicidality.

Suicidality, which ranges from ideation (i.e., thoughts of suicide and making suicide plans) to suicide attempts to completed suicide, is a major public health problem (SAMHSA/CSAT, 2013b). The act of suicide is particularly traumatic, especially for family and friends. In addition to experiencing the five stages of grief and loss, survivors of suicide are left with more questions than answers.

Current data show higher suicidal behaviors among persons with a substance use disorder and

Clients with COD, in particular those with substance use and affective disorder, have two of the highest risk factors for suicide (SAMHSA/CSAT, 2013b).

every major mental disorder (SAMHSA/CSAT, 2013b). Ninety percent of adults that commit suicide have a mental disorder (Centre for Suicide Prevention, 2014). Most often the disorder is PTSD or a major affective illness. Clients with COD, in particular those with substance use and affective disorder, have two of the highest risk factors for suicide (SAMHSA/CSAT, 2013b). Nevertheless, persons with substance use disorders (SUDs) alone are six times more likely to commit suicide than the general population (Ross, 2014).

Alcohol has been implicated as a primary culprit in suicidal behaviors. Using meta-analysis, a group of researchers addressed the association between alcohol use disorder (AUD) and suicide. They observed a significant association between AUD and suicidal ideation, suicide attempt, and completed suicide. They concluded that AUD could be considered an important predictor of suicide and a great source of premature death (Darvishi, Farhadi, Haghtalab, & Poorolajal, 2015).

Approximately 70 percent of individuals who commit suicide by intentional overdose use only a single substance to achieve their goal, and for 80 percent of those suicides, the drug of choice is a prescription medication. Persons who commit suicide with two or more substances most often combine alcohol with a prescription drug. Compared to men, women are four times more likely to intentionally kill themselves with alcohol and/or drugs. White men intentionally kill themselves with

particularly troublesome statistics for many clients with COD. People that have mental disorders are at 10 times greater risk for suicide than the general population. Furthermore, the risk of suicidal behavior and suicide increases with nearly

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alcohol and/or drugs about twice as often as Black men. Nearly 20 percent of people between the ages of 40 and 64 who commit suicide do so with alcohol or drugs (Elements Behavioral Health, 2013).

Substance use has been identified as the top risk factor for suicide in youth by both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. Findings from a study examining 2001 to 2009 Youth Risk Behavior Survey (YRBS) data indicated that:

- A history of substance use was an independent, strong risk factor for adolescent suicide ideation, plans, and attempts.
- Illegal substances (e.g., methamphetamine, steroids, heroin) had a higher association with suicidal thoughts and behaviors than legalized substances, though any substance was associated with increased risk of suicide attempts.
- The strongest association with suicidal ideation, planning, attempts, and attempts requiring medical attention was found for heroin, followed by methamphetamines.
- Adolescents reporting an increased number of substances used in their lifetime reflected increased risk of suicidal ideation, planning, attempts, and attempts that required medical attention (Wong, Wong, Goebert, & Hishinuma, 2013).

Studies have shown that the most promising way to prevent suicide and suicidal behavior in persons with COD is through early recognition and treatment of substance use and mental illnesses. If clients mention sadness or depression or appear to be experiencing those emotions, it is essential that the extent to which suicidal thinking is present be explored. Similarly, clinicians should clarify and monitor clients that report thinking of doing harm to someone else. In short, clinicians should ask explicitly about suicide or the intention to do harm to another person when screening and/or assessment indicates that either of those possibilities is an issue (SAMHSA/CSAT, 2013b). Let the patient/client know that he/she is not alone, that someone cares, and that there is hope (Ross, 2014). In addition, clinicians should routinely follow up on appointments missed by clients that have presented with sadness and/or depression (SAMHSA/CSAT, 2013b). Try collaborating with the individual and his or her family/significant others to create a recovery plan that first ensures safety and also addresses the underlying issues (Ross, 2014). A substance use professional may need to secure the services of an appropriate mental health professional for the client and have the client closely monitored by that professional. Twenty-four hour coverage should be made available, such as hotlines for the client to call for help during non-business hours. (SAMHSA/CSAT, 2013b). The following treatment regimen incorporating cognitive therapy has been recommended for suicidal patients/clients with SUDs:

Early Phase

The clinician will:

- ✓ Conduct an assessment of the presenting problem (SAMHSA/CSAT, 2015). For adolescents in particular, gathering information about the lifetime number and types of substances used will be extremely helpful in informing suicide risk (Wong et al., 2013).
- ✓ Develop a safety plan with the patient/client.

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- ✓ Develop a cognitive case conceptualization involving identification and characterization of the patient/client's dispositional vulnerability factors, key automatic thoughts, beliefs (core, anticipatory, relief-oriented, and permissive), early experiences, and suicide-relevant cognitive processes.
- ✓ Establish treatment goals with the patient/client.

Intermediate Phase

The clinician will help the patient/client:

- ✓ Add to the number of reasons for living.
- ✓ Develop coping strategies.
- ✓ Increase compliance with other services.
- ✓ Enhance social resources.

Late Phase

Together the clinician and patient/client will:

- ✓ Work to consolidate the skills learned in treatment.
- ✓ Work on relapse prevention.
- ✓ Review progress toward treatment goals.
- ✓ Prepare for termination of the acute phase of treatment (SAMHSA/CSAT, 2015).

Research has suggested that substance use prevention is the best strategy for suicide prevention. In fact, the connection between suicide prevention and the prevention/treatment of substance use is either explicitly or implicitly addressed in each of the 13 goals of the recently revised National Strategy for Suicide Prevention (NSSP). Among the actions that should be taken are:

- ✓ Train staff in substance use treatment settings to ask their patients/clients directly and nonjudgmentally whether they are having thoughts of suicide or think things would be better if they were dead. These questions should be part of intake and repeated periodically throughout the course of treatment. All questions should be posed in a way that opens the door for a truthful response.
- ✓ Work with patients/clients, families and/or other social groups, and communities to reduce access to drugs, especially access to lethal amounts of drugs among persons at increased risk for suicide. Such efforts might include reducing inventory of locking up commonly abused medications; and encouraging proper disposal of unneeded and/or unused prescription drugs medications kept in the home (Litts & Carr, 2013).

Every reasonable effort should be undertaken to strengthen the collaboration between substance use, mental health, and suicide prevention actions at all levels—community, state, and nation.

TDMHSAS has a statewide crisis number: **855-CRISIS-1(855-274-7471)**. Help is available 24 hours a day, 7 days a week. Suicide screening tools are located in the *Screening Tools*

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module of this document. An extensive discussion of this topic can be found in Chapter 8 under “Cross-Cutting Issues” of TIP 42 (i.e., Treatment Improvement Protocol: Substance Abuse Treatment for Persons with Co-Occurring Disorders), as well as in Appendix D of TIP 42. Chapter 4 in TIP 42 provides detailed information on screening for suicide risk. TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, is another excellent resource.

In addition, TDMHSAS has been awarded two five-year grants to reduce suicidal ideation, suicide attempts, and deaths resulting from suicide by developing and implementing cross-system suicide prevention strategies. Strategies will include rapid and enhanced follow-up as well as prevention training for providers and stakeholders statewide. The **Tennessee TARGET Zero Suicide** project is designed for working-age adults 25-64 years and **Tennessee Lives Count-Connect (CONNECT)** is aimed at youth and young adults ages 10-24 years. Partnerships will be developed with gatekeepers (schools, law enforcement, foster care, etc.), emergency departments, and inpatient psychiatric units to ensure success of the projects (M. Murphy, July 1, 2016, personal communication).

Trauma Informed Care.

Persons with COD have likely experienced a great deal of trauma in their lives. In the United States, 51 percent of women and 61 percent of men have reported exposure to at least one lifetime traumatic event (Recoverymonth.gov, 2016). Thus, clinicians should consider the possibility of a trauma history even before any screening/assessment begins. Trauma may encompass experiences of rape or interpersonal violence as an adult; early childhood sexual, physical, or emotional abuse; and/or traumatic experiences associated with political oppression, as could be the case with refugees or other immigrant populations. The client should be approached with sensitivity, in consideration of the possibility that he or she has indeed suffered previous traumatic experiences that could interfere with his/her ability to be trusting in a therapeutic relationship. Any guardedness on the part of the client may indicate the possibility of trauma, so make every effort to promote safety in your interactions with him or her. Provide support and gentleness rather than trying to “break through” evasiveness that may erroneously be perceived initially as resistance or denial. Any questioning of the client should avoid “re-traumatizing” the client. SAMHSA/CSAT has released a TIP (TIP 57) that addresses the issue of trauma. (See SAMHSA, 2014d). Clinicians are asked to engage patients/clients with appropriate sensitivity (SAMHSA/CSAT, 2013b).

Behavioral health treatment providers are becoming increasingly aware that they are encountering a very large number of men and women who are survivors of traumas, including childhood physical and sexual abuse. Many clinicians have moved to the approach called **Trauma-Informed Care** (TIC) to help make treatment more appropriate and effective. TIC emphasizes how services must take into account an understanding of trauma, and place priority on the **safety, choice and control** of trauma survivors. Clients may choose to seek out specific trauma treatments to work through and minimize the consequences of a traumatic event in some cases. These specific treatments employ different ways to work with clients so they are able to understand, manage, and transform the aftereffects of trauma (California Department of Health Care Services, n.d.).

Select trauma screening tools are included in the *Screening Tools* module of this document.

Treating Adolescents with Co-Occurring Disorders.

It has become the rule rather than the exception to recognize comorbidity among adolescents with substance use disorders. Evidence for integrated or co-occurring treatment for young people is growing. For example, evidence continues to mount that identifying and treating depression in young people that are substance involved improves substance use outcomes. The literature indicates that the converse is also true (ASAM, 2013). Among those youth entering substance use treatment, 83 percent of females and 62 percent of males also have an emotional disorder (Hazelden, n.d.b). David Rotenberg of Caron Treatment Centers, e.g., says that any credible provider of behavioral health services will do an integrated treatment of both the substance use and mental health issue concurrently (Knopf, 2015).

As with adults, it is often impossible to say with confidence which problem came first. In one case, an individual develops anxiety based on a childhood trauma and turns to drugs to cope, developing an addiction. In another case, the individual has negative experiences from his or her heroin use, which then leads to post-traumatic stress disorder (PTSD). In most cases, however, the scenarios are rarely clear cut. Nonetheless, the important thing is the need to provide treatment for both problems. Sometimes the fact that the different specialists cannot or do not coordinate treatment for the various problems presents a real challenge in the treatment of CODs, for adults and young people alike. Similar to treatment for adults, treatment must focus on the whole person (Bellum, 2012).

There are a number of interventions that work for young people with co-occurring disorders. Support groups are an important component. The youth support each other as they learn about the negative role that drugs and alcohol have had on their lives. They also learn social skills, as well as how to replace substance use with new behaviors and thoughts. The youth get help with concrete situations that arise because of their mental illness. Programs that have support groups for family members and friends help to enhance outcomes (NAMI Minnesota, n.d.).

Here are tips for parents/caregivers of young people with co-occurring disorders, of which one is a substance use issue:

1. **Don't** regard the substance issue as a family disgrace. Focus on the realization that recovery is possible just as it is with other illnesses.
2. **Do** encourage and facilitate participation in support groups during and after treatment.
3. **Don't** preach, lecture, or nag.
4. **Don't** lay on guilt by using the "if you loved me" approach. It is like saying, "If you loved me, you would not have tuberculosis."
5. **Do** establish consequences for behaviors. Don't be afraid to involve law enforcement if your teen engages in and/or promotes underage drinking on your premises. You can be held legally responsible for endangering minors if you do not take timely action.

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6. **Do** avoid making threats unless you think them through carefully and definitely intend to carry them out. Idle threats only make the person with an SUD feel you don't mean what you say.
7. **Do** encourage your teen to engage in after-school activities, such as sports or debate team, with adult supervision during recovery. Part-time employment or volunteer work can build also self-esteem.
8. **Don't** expect an immediate, 100-percent recovery. Like any illness, there is a period of convalescence. There may be relapses and times of tension and resentment among family members.
9. **Do** offer love, understanding, and support during the recovery (NAMI Minnesota, n.d.).

Experts contend that tackling behavioral problems early can change the trajectory of co-occurring disorders in adolescence. Children with behavioral problems in their elementary school years have high risk for developing SUDs. Good parenting and early intervention have been recommended to ameliorate at least some of the risk (Knopf, 2015).

What Research Says about Provider Assessment Practices for Adolescents with Co-Occurring Disorders (CODs).

A study by Lichtenstein, Spirito, & Zimmermann (2010) assessed the typical practice of providers in employing assessments with adolescents with co-occurring depression and substance use. Structured interviews were conducted with 30 providers that were on staff at either primarily substance use agencies or primarily mental health agencies. Interview findings follow:

- One hundred percent of mental health providers reported treating adolescents with co-occurring disorders.
- Eighty-two percent of substance use providers reported treating adolescents with co-occurring disorders.
- Slightly more than 40 percent of mental health providers conducted formal assessments for depression.
- Nine percent of substance use providers conducted formal assessments for depression.
- Only five percent of mental health providers conducted formal assessments for substance use.
- More than half of the substance use providers conducted formal assessments for substance use.

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- Sixteen percent of mental health providers reported using a specific treatment protocol for co-occurring diagnoses.
- None of the substance use providers reported using a specific treatment protocol for co-occurring diagnoses (Lichenstein et al., 2010).

The Lichenstein et al. (2010) study involved only 30 providers from a single city in one geographical region of the country. However, it provided useful information about assessment and treatment of adolescents with co-occurring disorders by community mental health and substance use treatment providers. First and foremost, the study indicated that providers were failing to adequately assess for co-occurring mental health and substance use disorders among adolescents. This finding was particularly concerning because leaving a disorder untreated or undiagnosed can only serve to exacerbate the youth's problem. Then there is the issue of providers rarely using treatment protocols that address the multiple problems of adolescents with COD, a function of the failure to conduct assessments. Hence, providers may be missing the mark on treatment interventions, evidence based or otherwise.

Co-Occurring Disorder Program Types in Tennessee

Dual Diagnosis Capability Measures.

Dual diagnosis capability measures have been developed to assess co-occurring capacity at the treatment-provider-organization level and quality improvement activities for the organizations (ASAM, 2013). SAMHSA has promoted two practical measures of program-level capacity to address co-occurring disorders: Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDCMHT). The measures supply standardized, objective, comparable benchmarks for co-occurring services in substance use only and mental health only programs. Both measures examine seven areas (SAMHSA, 2014a):

- Program structure.
- Program milieu.
- Assessment.
- Treatment
- Continuity of care.
- Staffing.
- Training. (SAMHSA, 2014a).

Treatment programs are ranked along a continuum from Addiction or Mental Health-Only Services, Dual Diagnosis Capable, and Dual Diagnosis Enhanced (SAMHSA, 2014a).

Tennessee COD Programs.

Co-occurring capable addiction treatment programs (i.e., dual diagnosis capable programs) tend to serve a diverse population. If some of the persons in such a program have no mental health condition or trauma history, they will only receive addiction-focused treatment. Most persons in co-occurring capable addiction treatment programs will have a range of mental health conditions, trauma issues, and/or cognitive/learning issues. A typical program will be able to manage a small percentage of persons who have more serious psychiatric conditions as well as persons who may intermittently have flare-ups of acute symptoms but do not need acute mental health treatment. These types of clients will still be interested in receiving addiction treatment and, with support, be capable of succeeding in the addiction program. Enhanced programs (i.e., dual diagnosis enhanced programs) are designed to routinely deal with clients who have mental health or cognitive conditions that are more acute or associated with more serious issues. These programs will have higher levels of staffing, smaller patient (client)-to-staff ratios, and typically a high mix of mental health specialty staff than the “capable” programs (ASAM, 2013).

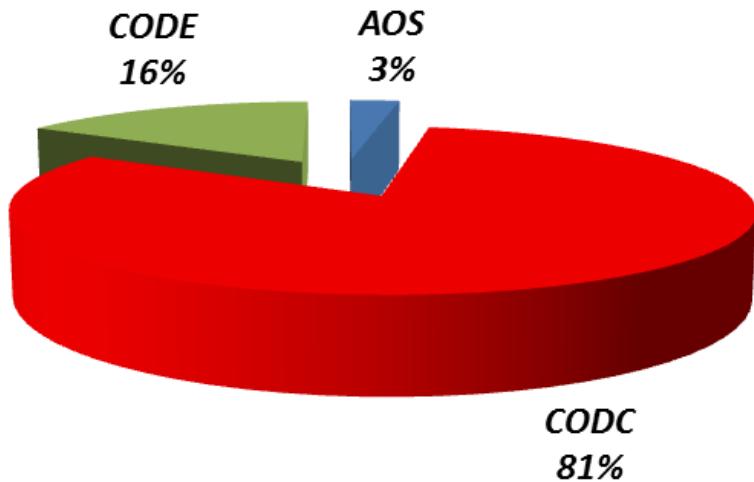
The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) contracts with numerous treatment providers that are recognized as Co-Occurring Disorder (COD) providers. For the most part, these providers operate either Co-Occurring Disorders Capable (CODC) programs or Co-Occurring Disorders Enhanced (CODE) programs (TDMHSAS/DSAS, 2014).

CODC programs address co-occurring mental and substance –related disorders in their policies and procedures, assessment, program content, treatment planning, and discharge planning. Even when the programs are geared primarily toward treating mental health or substance use disorders, program staff address the interaction between mental and substance use disorders, along with their effect on the individual’s readiness to change through individual and group program content. Relapse and recovery environment issues are also addressed (TDMHSAS/DSAS, 2014).

CODE programs provide a higher level of integration of mental health and substance use treatment and recovery services. They provide unified and integrated substance use and mental health treatment and recovery to persons who have disabling or unstable co-occurring disorders. The programs typically are indistinguishable as either a mental health or addiction treatment and recovery program (TDMHSAS/DSAS, 2014).

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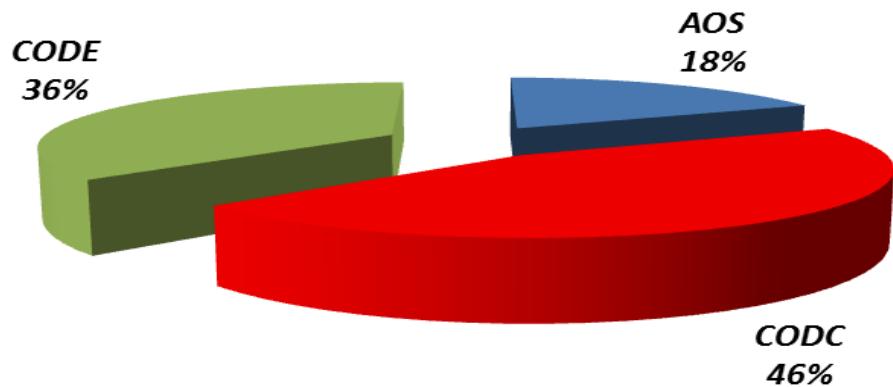
Figure 1. Co-Occurring Disorders Treatment Providers for Adults as of July 1, 2015



Source: K. Horvath, June 25, 2015, personal communication

As of July 1, 2015, there were 37 COD treatment providers for adults funded through the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. Approximately 81 percent of the providers will have co-occurring capable (CODC) programs. Less than three percent will offer addiction only services (AOS) (K. Horvath, June 25, 2015, personal communication).

Figure 2. Co-Occurring Disorders Treatment Providers for Adolescents as of July 1, 2015



Source: K. Horvath, June 25, 2015, personal communication

For COD treatment providers serving adolescents and funded through the SAPT Block Grant, almost half have co-occurring capable (CODC) programs as of July 1, 2015. However, close to 20 percent were providing addiction only services (AOS). All total, there were 11 COD treatment providers as of July 1, 2015 (K. Horvath, June 25, 2015, personal communication).

Co-Occurring Addiction and Psychiatric Disorders

Some of the most common psychiatric disorders seen in patients with co-occurring addiction issues include (SAMHSA/DPT, n.d.).

- Anxiety and mood disorders, including major depression (SAMHSA/DPT, n.d.).

Nearly 20 percent of Americans with an SUD also have an anxiety or mood disorder and almost 20 percent of persons with an anxiety or mood disorder such as depression have an SUD (ADAA, n.d.).

- Attention deficit disorder (SAMHSA/DPT, n.d.).

Among adults being treated for SUD, the rate of attention deficit disorder is about 25 percent. The attention disorder is five to 10 times more common among adults who are alcoholics than in adults without the condition. Moreover, it is more common for youth with attention disorders to begin using alcohol in their teenage years, with studies hovering around a mean starting age of 15 years (Goldberg, 2014)

- Bipolar disorder (SAMHSA/DPT, n.d.).

A national study revealed approximately 56 percent of people with bipolar had experienced SUD during their lifetime (DualDiagnosis.org, n.d.).

- Borderline personality disorder (BPD) (SAMHSA/DPT, n.d.).

A large survey found that almost 51 percent of people with a lifetime diagnosis of BPD also had an SUD over the previous 12 months. The same survey also found that, for individuals with a lifetime diagnosis of an SUD, about 10 percent also had a lifetime diagnosis of BPD, an incidence of BPD significantly higher than in the general public (SAMHSA, 2014c).

- Conduct disorders (SAMHSA/DPT, n.d.).

Early substance use is typically a symptom of conduct disorder (CMHF, 2003). Recent statistics show these disorders as the number one co-occurring condition with SUDs (Knopf, 2015).

- Pathological gambling (PG) (SAMHSA/DPT, n.d.).

A nationally representative study found that overlapping criteria of PG with those for SUD were frequently acknowledged by persons meeting the PG diagnoses (Wareham & Potenza, 2010).

- Post-traumatic stress disorder (PTSD) (SAMHSA/DPT, n.d.).

One national epidemiologic study has shown that 46 percent of people with lifetime PTSD also met criteria for SUD. Another national epidemiologic study showed the breakdown by gender, with nearly 28 percent of women and 52 percent of men with lifetime PTSD also having SUD (Hamblen & Kivlahan, 2014).

- Schizophrenia (SAMHSA/DPT, n.d.).

About half of persons with schizophrenia also present with a lifetime history of SUD, a rate that is much higher than seen in the general U.S. population (Volkow, 2009).

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- Eating disorders (SAMHSA/DPT, n.d.).

Research shows that as many as 35 percent of individuals with SUD also have an eating disorder. Additionally, up to 50 percent of those with eating disorders have a concurrent SUD (Addiction.com, 2010).

More Co-Occurring Disorders Facts



Nearly half of people with severe mental illness are affected by substance use.



37% of persons that abuse alcohol and 53% of persons that abuse drugs also have at least one serious mental illness.



An estimated 50% of homeless adults with serious mental illnesses have a co-occurring SUD.



16% of jail and prison inmates are estimated to have severe substance use and mental disorders.



72% of detainees with mental disorders also have a co-occurring SUD.

Source: HealthyPlace.com, 2014.

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