

## **TDMHSAS BEST PRACTICE GUIDELINES**

### ***Co-occurring Disorders: An Integrated Approach***

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#### **Introduction and Definitions**

Co-occurring disorders (CODs) present significant concerns among adolescents and their families. Increasing attention has been paid to the prevalence and impact of co-occurring mental illness and addiction. In general, co-occurring disorders are associated with poorer treatment outcomes, increased utilization of emergency room services, repeat admissions to inpatient psychiatric hospitals, and higher rates of relapse and medical problems (Sterling et. al., 2011)

SAMHSA's 2002 report to Congress defines co-occurring disorders as:

*“Individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other”* (p. 3).

For adolescents, it is noted that mental health conditions typically manifest prior to substance use disorders. While establishing a history and prior onset can serve to clarify the nature of a mental health disorder, it is less important to determine what came first than to address both conditions, simultaneously, and in an integrated manner. CODs often present as distinctive third disorders that are more than the “*sum*” of the individual disorders, and each of the disorders influences the other. This interaction ultimately affects the course of treatment and intervention, as well as the potential for relapse.

While it is important to address disorders in a co-occurring fashion, it is important to consider that early interventions with children and youth who have an identified mental disorder could prevent or change the course and development of a substance use disorder: Therefore prevention of substance use might be considered an important secondary outcome of interventions for early-onset mental disorders. (Glantz et al., 2008)

Alumbaugh (2008) states: “Different philosophies in mental health and substance abuse treatment have resulted in the development of parallel but not intersecting treatment systems with different funding streams, mandates and treatments.” Co-occurring disorders are at the nexus of this culture clash.”

The “*no wrong door approach*” is vital to treatment of co-occurring disorders, in which programs address both mental health and substance use, and an important way in which to overcome this “culture clash.” Integrating care further transcends the problems inherent in a fragmented treatment system. While this is sometimes approached through linkages to agencies and coordinated care, the ideal treatment system is one that integrates services.

As defined by SAMHSA’s Co-Occurring Center of Excellence brief, *Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders*, (SAMSHA, 2011) “*no wrong door*” denotes a system of care that is accessible from multiple entry points, integrates and addresses treatment for both mental illness and addiction, and collaborates with all entities involved with the adolescent and family.

“Research results suggest that sequential treatment (treating one disorder first, then the other) and purely parallel treatment (treatment for both disorders provided by separate clinicians or teams who do not coordinate services) are not as effective as integrated treatment (Drake, O’Neal, & Wallach, 2008)”. Treatment approaches that treat a singular disorder without consideration of the impact of a co-occurring disorder(s) are less suited to the special needs of individuals with CODs .” (Rosenthal and Westreich, 1999; Sterling et. al., 2011).

“It is estimated that only two percent of the 5.6 million adults in the United States who are living with co-occurring substance use and mental health disorders actually receive evidence-based integrated care, due in large part to the lack of professional training on this approach. “ (van Hoof-Haines, 2012).” It is doubtful that the rate for children or youth is any higher. However, adolescents with co-occurring mental health and substance use issues who received psychiatric services are more likely to remain abstinent (especially if services were provided in co-located settings [mental health and substance abuse]) (Sterling and Weisner, 2005).

Adolescents with co-occurring disorders have greater rates of family, school, legal and social problems (Grella, et al, 2010; Rowe et al, 2004; & Libby et al, 2005). Therefore, approaches to prevention, screening and assessment, treatment and recovery will involve collaboration, including collaboration among the juvenile justice system, education, primary health care and human services. Services should also be family-centered and driven.

A standard array of treatment services should be available to address the appropriate level of care needed and include screening for COD, psychiatric evaluation, outpatient therapy and psychiatric evaluation, intensive outpatient programs and short-term residential treatment. Recovery services may include self-help groups, family education and support and other peer-led opportunities for adolescents to access social and emotional support.

### **Prevalence Rates**

For a majority of adolescents referred to treatment for substance use disorders, a co-occurring mental illness also exists. Co-occurring disorders are an “*expectation and not an exception.*” (Minkoff and Ajilore, 1998).

- Twenty-one percent of US children ages 9 to 17 have a diagnosable mental disorder or addictive disorder with impairment (Kessler et al., 2005).
- Adolescents with SED (serious emotional disturbance) are five times more likely to have an alcohol dependence problem than those without SED (SAMSHA, 2000) .
- Forty-three percent of youth receiving mental health (MH) treatment services (CMHS, 2001) have a co-occurring disorder. Fifty percent of all lifetime cases of mental disorders are manifest by age 14; 90 percent with co-occurring disorders had one mental disorder prior to the onset of an SUD (Kessler et al., 2005).
- Individuals with a mental health disorder are at **greater risk** for a substance use /chemical dependency disorder, and individuals with a substance use problem are at **greater risk** for a mental health disorder. Van Hoof –Haines (2012) notes: that “the lifetime prevalence of individuals [all ages] with substance abuse or dependence in the general population is 16.7 percent; however, the prevalence is significantly higher among people who suffer from schizophrenia (47 percent), any mood disorder and obsessive/compulsive disorder (both 32 percent) and any anxiety disorder (23 percent).”
- In samples from SAMSHA treatment studies (CSAT 1997-2002), 62 percent of the male and 83 percent of female adolescents who received substance use treatment also had an emotional or behavioral disorder (SAMSHA, 2002). The co-occurring mental disorders most commonly noted were Conduct Disorder, Attention Deficit and Hyperactivity Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, and Post Traumatic Stress Disorder (SAMSHA, 2002).
- With early onset, there is greater risk for lifetime alcohol abuse or dependence (Dewitt, Adlaf, Offord & Ogborne, 2000). Also, individuals with co-occurring disorders use substances over longer periods. *Archives of General Psychiatry*. 2005 Jun; 62(6): 593-602. Kessler RC, Berglund PA, Demler O, Jin R, Walters, EE. Furthermore, individuals with co-occurring mental health and substance use disorders have poorer outcomes, including higher rates of relapse, suicide, homelessness, incarceration, hospitalization, and lower quality of life (Compton et al., 2003; Wright, Gournay, Glorney, & Thornicroft, 2000; Xie, McHugo, Helmstetter, & Drake, 2005; SAMSHA, 2011) and at least 50 percent of individuals who are homeless have co-occurring disorders (SAMHSA, 2011). This again highlights the importance of early intervention in changing the life-time course for individuals with co-occurring disorders.
- Individuals with co-occurring disorders have greater rates of family, school, legal social problems (Grella, et al., 2010; Rowe et al., 2004; & Libby et al., 2005).
- Youth involved in the juvenile justice system experience higher rates of mental illness and substance use disorders than the general population. Findings from the Northwest Juvenile Project noted that nearly two-thirds of males and three-fourths of females met the diagnostic criteria for one or more mental disorder. Youth diagnosed with a major mental illness had significantly greater chances of also having substance use disorders. The Office of Juvenile Justice and Delinquency Prevention publication, *Psychiatric Disorders of Youth in Detention* (April, 2006) noted that among adolescents with mental health conditions, substance use

disorders and attention deficit disorder or disruptive behavior disorders were most common (OJJDP, April, 2006).

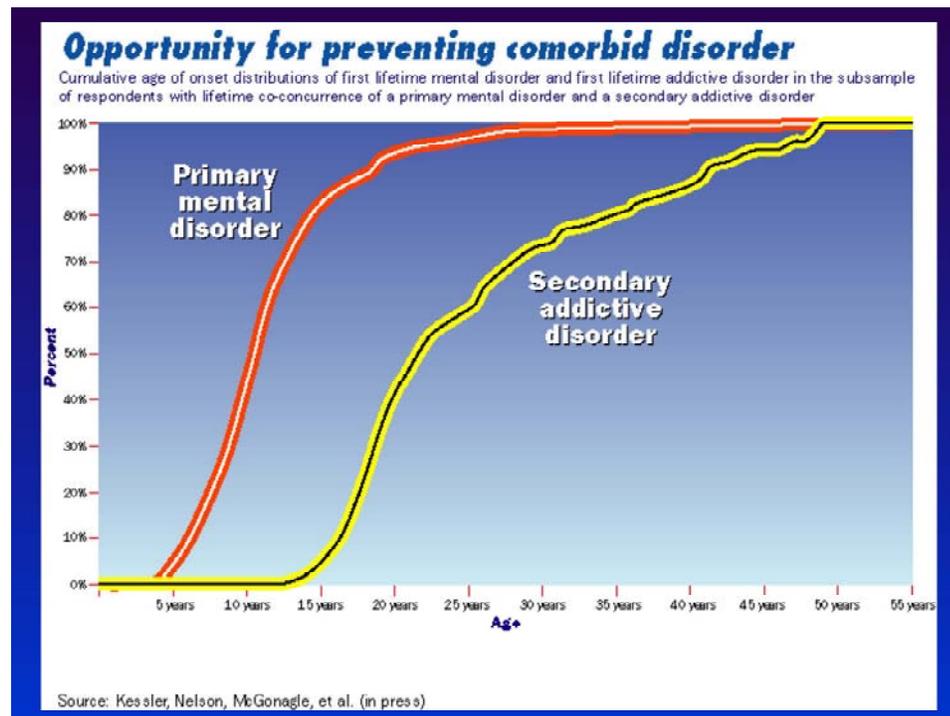
- Funk et al. (2003) report that 71 percent of adolescents in substance use treatment also have a history of trauma.
- Deykin & Buka (1997) report in a study of chemically dependent adolescents in treatment a lifetime prevalence rate for Post-Traumatic Stress Disorder (PTSD) of 29.6 percent.
- In an epidemiological study, researchers found a moderate overall co-occurrence of PTSD and substance abuse, with rates ranging from 13.5 percent to 29.7 percent (Kilpatrick, Ruggiero, Acierno, Saunders, Resnick, & Best, 2003). In this sample: — 29.7 percent of males and 24.4 percent of females who met diagnostic criteria for PTSD also met diagnostic criteria for either substance use or dependence disorders — 13.5 percent of males and 24.8 percent of females who met criteria for a substance use disorder also met diagnostic criteria for PTSD.
- Thirteen and a half percent of males and 24.8 percent of females who met criteria for SUD, also met PTSD criteria (Kilpatrick et al, 2003).

### Guiding Principles

Based on prevalence rates, clinical practice guidelines for COD need to take into consideration the following guiding principles:

- COD is an *expectation* rather than an exception.
- Providers of Mental Health COD services need to take a “no wrong door approach.” Assessment and treatment services need to be:
  - Integrated (SAMSHA, 2011a; 2011b).
  - Offer a full continuum of services from prevention, screening, through treatment and recovery.
  - Be family focused.
- Staff needs to be cross trained on assessment and treatment of COD. It is important that both addiction and mental health counselors are proficient in the screening, assessment and treatment of co-occurring disorders, including the unique presentation of CODs, as CODs really constitute a third disorder (van Hoof-Haines, 2012).
- Focus on multi-systemic and culturally-competent approaches that involve all environments and systems that impact a child/ adolescent including educational, family , medical (especially primary pediatric/adolescent care), and the justice system.
- The process for assessment and diagnosis will be evolving and needs to be ongoing.

- Trauma always needs to be a consideration due to high prevalence rate among COD populations; and therefore needs to be screened and addressed clinically.
- For the purposes of these guidelines, the focus will be on family based services.
- A developmental/prevention perspective: High prevalence rates emphasize the high rates of co-occurring disorders in a younger population, and the importance of prevention and early intervention in changing the life-time course for individuals with co-occurring disorders. COD affects the psychosocial and physical development of youth as drug abuse changes the brain chemistry of developing brains. (Degenhardt & Hall, 2006; 2006; Smit and P. Cuijpers,2004). Early interventions (and screenings) with children and youth who have an identified mental disorder may change or prevent the course and development of a substance abuse disorder. Ninety-percent with co-occurring disorders had one mental disorder prior to onset of SUD (Kessler et al 2005). The following graph cited in Alumbaugh (2008) clearly indicates a typical onset of a mental disorder prior to an SUD:



**\*Note:** Permission to use the above slide was obtained from Ronald Kessler, MD, first author.

- Coordination of care is important, as is assisting adolescents in negotiating the transition to the adult service system of care.
- Best practices in the area of co-occurring services indicate a need for integrated approaches to treatment, including an integrated care of plan (SAMSHA, 2011a & 2011b) that addresses and incorporates all of the bio-psychosocial needs of the individual and family.

- Psychosocial factors may influence treatment such as socioeconomic issues that present barriers to accessing care.

## **Screening**

The identification and use of appropriate screening and assessment tools for the co-occurring diagnoses is helpful in determining plans of care for co-occurring disorders.

According to Dr. Mary Jane Alumbaugh, PhD in her presentation on “Co-Occurring Disorders Best Practices and Adolescents, “ Double Trouble- Early” (June 26, 2008, CiMH), “the process of screening, assessment, and treatment planning should be an integrated approach that addresses both substance abuse and mental health disorders, each in the context of the other and neither should be considered primary.” (Myers, Brown, & Ott, 1995) She recommends that assessments for co-occurring disorders include:

- A comprehensive bio-psychosocial assessment
- An assessment for substance use disorder using a brief screening tool in ALL adolescents entering a behavioral health or healthcare system
- A follow-up with a comprehensive substance use disorder assessment for adolescents who present with a co-morbid substance abuse disorder
- An assessment for trauma/victimization

### **Screening Instruments:**

The following screening protocols are recommended by Alumbaugh (2008) and others:

- Adolescent Alcohol Involvement Scale
- Adolescent Drug Involvement Scale(ADIS)
- Problem Oriented Screening Instrument for Teenagers (POSIT)
- Global Appraisal of Individual Needs Short Version—(GSS)
- CAGE-AID
- Modified Mini-Screen (MMS)

### **General Checklists:**

- Achenbach YSR
- Revised Behavior Problem Checklist
- Youth Outcome Questionnaire YOQ
- Youth Outcome Questionnaire Self Report YOQ- SR

### **Substance Use Disorder Interviews:**

- Adolescent Diagnostic Interview (ADI)

- Diagnostic Interview for Children and Adolescents (DICA)

### **Comprehensive Assessment Instruments:**

- Comprehensive Adolescent Severity Inventory (CASI)
- The American Drug and Alcohol Survey (ADAS classroom use)
- Personal Experience Inventory (PEI)
- Substance Abuse Subtle Screening Inventory—SASSI

### **Trauma:**

In addition, Coreena Hendrickson, (LCSW), Director, Substance Abuse Prevention and Treatment Services, Division of Adolescent Medicine, Children’s Hospital, Los Angeles, CA, in her article, “Trauma and Co-Occurring Disorders among Youth,” (2009, June) encourages the screening and assessment of trauma along with the screening of youth with co-occurring disorders due to the close association between the two. She says of diagnostic considerations that,

“Ideally, careful assessment of traumatic stress and co-occurring disorders would be an integral part of the services provided by all agencies working with adolescents. In reality, although much progress has been made in the treatment of both substance abuse and traumatic stress, these fields remain primarily independent of each other and few service providers are skilled in assessing the multiple needs of youth with trauma and co-occurring disorders. Screening and assessment instruments for identifying trauma, mental health, and substance related problems of adolescents differ considerably in the kinds of psychological and behavioral characteristics that they evaluate. Most instruments focus on deficits and impairment, looking at symptoms and behavioral problems. An essential part of a complete assessment includes attention to the strengths of youths and the family or systems from which they have been referred” (p. 36).

CSAT (2000) recommends that “Questions about trauma be brief and general, without evoking details that might precipitate stress.” Hendrickson (2009) recommends the following validated instruments for Traumatic Stress and Substance Abuse\*:

**Global Appraisal of Individual Need (GAIN)** is a series of clinician administered bio-psychosocial assessments designed to provide information useful for screenings, diagnosis, treatment, planning, and monitoring progress. Domains measured on the GAIN-Initial (GAIN-I) include substance use, physical health, risk behaviors, mental health, environment, legal and vocational. Several scales are derived from the GAIN-I, including substance problem, traumatic stress, and victimization indices. Dennis, M., White, M., Titus, J., and Unsicker, J. (2006) *Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures (Version 5.4.0)* Bloomington, IL: Chestnut Health Systems <http://www.chestnut.org/LI/gain>

- **Trauma Symptom Checklist for Children (TSCC)** is a self-rating measure used to evaluate both acute and chronic post-traumatic stress symptoms. John Briere, Ph.D. Psychological Assessment Services, <http://www3.parinc.com/products/product>.

- **University of California Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA PTSD RI for DSM - IV)** is used to screen for exposure to traumatic events and DSM-IV PTSD symptoms. Three versions exist: a self report for school-age children, a self report for adolescents, and a parent report. An abbreviated version of the UCLA PTSD RI is also available. This nine-item scale provides a quick screen for PTSD symptoms. UCLA Trauma Psychiatry Service, 300 UCLA Medical Plaza, Ste. 2232, Los Angeles, CA 90095-6968, [rpynoos@mednet.ucla.edu](mailto:rpynoos@mednet.ucla.edu).
- In addition to the above screening instruments for trauma, a number of agencies in Tennessee, including the Tennessee Department of Children Services, include an adjustment to trauma module on the Child Assessment of Needs and Strengths (CANS) (PRAED, 2012), which is used extensively for developing plans for youth in state custody.
- **CRAFFT** is a six-item measurement tool that assesses adolescent substance use. The CRAFFT questions were developed by The Center for Adolescent Substance Use Research (CeASAR). The measure assesses reasons for drinking or other substance use, risky behavior associated with substance use, peer and family behavior surrounding substance use, as well as whether the adolescent has ever been in trouble as a result of his or her substance use. To obtain permission to make copies of the CRAFFT test, email [info@CRAFFT.org](mailto:info@CRAFFT.org). (2008) [\*Listed in NTCSN's *Understanding the Links Between Adolescent Trauma and Substance Abuse*, 2008.]

Well researched instruments for screening substance abuse and co-occurring disorders include:

- **Teen Addiction and Severity Index (T-ASI)** is a semi-structured interview that was developed to fill the need for a reliable, valid and standardized instrument for a periodic evaluation of adolescent substance abuse. The T-ASI uses a multidimensional approach of assessment as an age-appropriate modification of the Addiction Severity Index. It yields 70 ratings in seven domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. Information about the T-ASI can be obtained from [http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/70\\_T-ASI.pdf](http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/70_T-ASI.pdf).

**(Note:** The T-SAI is utilized by providers of Tennessee Department of Mental Health and Substance Abuse Services providers.)

- Another instrument cited in several articles was the “*Michigan Assessment Screening Test for Alcohol and Drugs*” (MAST/AD). - Westermeyer, Joseph; Yargie, Ilhan; Thoras, Paul.

***Screening in Primary/Pediatric Care Settings:*** Providers in all settings including primary care, mental health and substance abuse should consider co-occurring illness to be an expectation rather than an exception. Screenings for substance use and mental disorders may also be performed by PCPs as part of EPSDT and other wellness visits. A typical screening instrument is the CRAFFT ([info@CRAFFT.org](mailto:info@CRAFFT.org), 2008) PCPs may be able to include medical findings such as laboratory findings. Screenings as a component of a primary care visit can also indentify substance use problems that may be emerging and sub-threshold in terms of not meeting full diagnostic criteria; this is important since early intervention

*and prevention may change the course and development of SUDs. It is also important for behavioral health providers to develop relationships with PCPs for referrals.*

## **Diagnosis/Medication**

The importance of assessment for possible behavioral disorders and/or substance abuse is crucial. While co-occurrence is expected, individuals with a behavioral condition or substance abuse are at greater risk for co-occurring conditions.

- Due to the higher risk of a co-occurring disorder when a substance use (SU) or mental health (MH) disorder already exists, it is important that behavioral health (BH) specialists be cross-trained in the assessment of substance abuse and mental disorders, as well as integrated approaches to treatment and recovery.
- Behavioral health professionals need to take a watchful approach in assessment regarding diagnosis, as a co-occurring condition can emerge or abate over time. Substances can have the effect of interacting with, masking, exacerbating, mimicking, synergizing, or moderating a mental disorder. A period of recovery and/or abstinence can change the presentation; thus assessment and diagnostic considerations need to be ongoing as the presentation of symptoms can evolve over time.
- A careful history, if possible, should be collected to further determine if one problem (i.e. adjustment problems) may have preceded the other. This may help to clarify and define the type of mental disorder, but even if this is established, the focus still needs to be upon dual or “co”-recovery (from both mental illness and SUD), including promotion of abstinence.
- There may be competing attitudes regarding the use of medication. Some traditionally oriented substance abuse programs for instance may frown on the use of medication and are slow to adopt psychopharmacological interventions for individuals with COD (Sterling et al, 2011) However, an integrated approach involves a multi-modal one that incorporates both therapy and , medication management, where indicated “The use of medication for either type of disorder does not imply that it is no longer necessary for the patient to focus on the importance of his/her own work in recovery from addiction. Consequently, utilizing medication to help treat addiction should always be considered as an ancillary tool to a full addiction recovery program.” (Minkoff, 2005).

## **Psychopharmacological Treatment Strategies**

**A. General principles:** In patients with psychotic presentations, with or without active substance dependence, initiation of treatment for psychosis is generally urgent. In patients with known active substance dependence and non-psychotic presentations, it is recommended to utilize the integrated longitudinal assessment process to determine the probability of a treatable mental health diagnosis before medication is initiated. It can be very difficult to make an accurate diagnosis and effectively monitor treatment without this first step. It is understood that all diagnoses are “presumptive” and subject to change as new information becomes available. If there is uncertainty about diagnosis after reasonable history taking, evidence for initial efforts to discontinue substance use may need to occur prior to initiation of psychopharmacology, in order to establish a framework for further diagnostic evaluation. However, for high risk patients, with or without psychosis, developing a treatment

relationship is a priority, and there should not be an arbitrary length of time required before treatment initiation takes place, nor should absolute diagnostic certainty be required. Individuals with reasonable probability of a treatable disorder can be treated

Psychotropic medications, particularly for anxiety and mood disorders, should be clearly directed to the treatment of known or probable psychiatric disorders, not to medicate feelings. It is important to communicate to patients with addiction that successful treatment of a comorbid anxiety or mood disorder with medication is not intended to remove normal painful feelings (such as normal anxiety or depressed feelings). The medication is meant to help the patient feel his or her painful feelings accurately, and to facilitate the process of developing healthy capacities to cope with those feelings without using substances. If psychotropic medications are used for mental illness in individuals with addiction, or if medication is used in the treatment of the addiction itself, the following precepts may be helpful to communicate to the patient:

Addicts in early recovery have great difficulty regulating medication; fixed dose regimes, not PRN's, are recommended in the treatment of mood and anxiety disorders.

Just as in individuals with single disorders, and perhaps more so, it is important to engage patients with co-occurring disorders as much as possible in understanding the nature of the illness or illnesses for which they are being treated, and to participating in partnership with prescribers in determining the best course of treatment. For this reason, most established medication algorithms (e.g. TMAP) and practice guidelines recommend that medication education and peer support regarding understanding the risks and benefits of medication use are incorporated into standard treatment practice. This is certainly true for individuals with co-occurring disorders, for whom information provided by peers may be particularly helpful in making good choices and decisions regarding both taking medication and reduction or elimination of substance use.

## **B. Diagnosis specific psychopharmacological treatment for mental illness**

1. **Psychotic Disorders:** Use the best psychotropic agent available for the condition. Improving psychotic or negative symptoms may promote substance recovery. This includes treatment of substance-induced psychoses, as well as psychosis associated with conventional psychiatric disorders.
  - a. **Atypical neuroleptics:** Consider olanzapine, risperidone, quetiapine, aripiprazole, ziprasidone or clozapine. In addition, it is well documented that clozapine has a direct effect on reducing substance use in this population, beyond any improvement in psychotic symptoms, and therefore may be specifically indicated for selected patients.
  - b. **Typical neuroleptics:** Consider use in adjunct to the atypicals, especially in situations of acute agitation, unresolved psychosis, and acute decompensation
  - c. Many individuals with cod will benefit from depot antipsychotic medications. Both typical and atypical neuroleptics (e.g., risperidone) are available in depot form. There have not been specific studies about the utilization of depot risperidone in individuals with co-occurring substance use disorder, but there is no apparent contraindication to its use.
2. **Major Depression:** The relative safety profile of SSRI's (and to a somewhat lesser extend SNRI's such as venlafaxine), other newer generation antidepressants and possibly bupropion (though higher seizure risk must be considered) make their use reasonable (risk-benefit assessment) in the treatment

of individuals with CODs. SSRI's have been demonstrated to be associated with lower alcohol use in a subset of alcohol dependent patients, with or without depression. The use of tricyclic antidepressants (TCAs) and MAO inhibitors (MAOIs) can be more difficult and possibly more dangerous in the COD population if there is a risk of active substance use.

3. **Bipolar Disorder:** Use the best mood stabilizer or combination of mood stabilizers that match the needs of the patient. Be aware that rapid cycling and mixed states may be more common, hence consider valproate, oxycarbamazepine, carbamazepine or olanzapine (and other atypicals), in patients who may have these variants.
4. **ADHD:** Initial treatment recommendations, in early sobriety, have included bupropion. Recently, atomoxetine has been available, and may be a reasonable first choice, though there have not been specific studies in co-occurring populations. In both adolescents and adults, there is clear evidence that if stimulant medications are necessary to stabilize ADHD, then these medications can be used safely, once addiction is adequately stabilized and/or the patient is properly monitored, and will be associated with better outcomes for both ADHD and substance use disorder.
5. **Anxiety disorders:** Consider SSRIs, venlafaxine, buspirone, clonidine and possibly mood stabilizers such as valproate, carbamazepine, oxycarbamazepine, gabapentin, and topiramate, as well as atypical neuroleptics. There is evidence of effectiveness of topiramate for nightmares and flashbacks associated with PTSD.

For patients with known substance dependence (active or remitted), the continuation of prescriptions for benzodiazepines, addictive pain medications, or non-specific sedative/hypnotics is not recommended, with or without comorbid psychiatric disorder. On the other hand, medications with addiction potential should not be withheld for carefully selected patients with well-established abstinence who demonstrate specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for individuals with diagnosed substance dependence, is an indication for both (a) careful discussion of risks and benefits with the patient (and, where indicated, the family) and (b) documentation of expert consultation or peer review.

Sleep disturbances are common in mental illness as well as substance use disorders in early recovery. Use of non-addictive sedating medications (e.g., trazodone) may be used with a careful risk benefit assessment.

### **References:**

Minkoff, K. (2005). Comprehensive continuous integrated system of care (CCISC): Psychopharmacology practice guidelines for individuals with co-occurring psychiatric and substance use disorders (COD). Boston: Harvard Medical School.

### **Treatment/Interventions**

Identification of possible best practices while not meeting evidenced based practices (SAMSHA criteria) is promising. Treatment approaches include *Double Trouble and Recovery*, (peer support) and programs

from Hazelden, an intensive outpatient program. Also included are evidence based components such as cognitive behavioral therapy (CBT) and contingency management that are incorporated into treatment programs.

In a 2005 report produced by the University of Kansas, School of Social Welfare entitled, *Best Practices in Children's Mental Health*, recommendations for substance use and co-occurring treatment were cited. Those recommendations, based upon literature reviews of empirical studies, publications related to clinical experiences and SAMSHA's Report to Congress, included the following:

- Co-occurring disorders in children and adolescents vary in severity, and require *ongoing assessments*, including random urine tests throughout treatment and careful psychopharmacological treatments to decrease abuse of substance for self-medication, as well as *adjustments of treatment along a continuum of care*.
- Treatment must be *developmentally appropriate*, which includes the recognition that *confrontation may not be an appropriate method* for adolescent populations or for populations that may be more psychologically vulnerable and less likely to handle the stress of more traditional approaches to treatment. For instance the concept of "*powerlessness*" may be difficult for an individual dealing with trauma or living with schizophrenia. Because 12-Step AA/NA models were not designed for adolescents and do not appear as effective with this population, some authors recommend use of such groups only when the model and group appear to be a good match for the young client, or the model has been adapted for a particular population
- *Comprehensive approaches best integrate domains* such as health, educational, legal, and recreational services using a *variety of approaches* including group, family and individual treatment modalities.
- *Cognitive treatment* such as identifying negative self-talk and distorted thoughts as well as *behavioral techniques* such as gradual exposure/desensitization to traumatic memories are recommended for youth with substance abuse and PTSD. *Skill training*, such as stress management/relaxation, problem-solving, drug refusal, safety, social, and *psycho-education* should be included as well.
- Interventions may need to be timed and sequenced; e.g. an individual may need to establish a period of recovery and stability before addressing issues such as trauma. Trauma presents a unique challenge: adolescents may be denied entry into programs that can address their substance abuse issues until their emotional distress is addressed, or into mental health programs until they have gained abstinence. The more appropriate course is to gauge the youth's readiness to address clinical issues, including factors such as the relative threat to safety, health and immediate well being (NCTSN, 2008)
- Since a good *therapeutic alliance* is considered a crucial element, the *active involvement of youth and family in the design of their program* and recovery is recommended, along with clear structure and flexibility to individualize treatment methods and goals.
- Treatment needs to include relapse prevention strategies.

- A “no wrong door” perspective allows any door to be the right door to receive treatment for co-occurring disorders, while understanding both disorders as “primary”. Agencies vary in their capacities: do they offer a full continuum of care, emphasize recovery, integrated treatment plans? Do they have providers who are cross-trained and who offer integrated approaches? Integration of services is a key to successful outcomes. More programs are emerging that serve individuals with co-occurring disorders. To enable this process there are now assessment tools available to assess the degree of integration of mental health and substance abuse services. SAMSHA offers the following toolkits: ***Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Toolkit Version 4.0 (SAMSHA 2011a) and Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit.*** TDMHSAS is recommending program evaluations using the toolkit as a means to assess an agency’s program COD capabilities.
- Treatment plans should be *client-centered, individualized* and include family involvement in treatment. There is *no single correct intervention*. Strengths of the individual and family also need to be identified, including personal goals and life plans for recovery. Best practices in the area of co-occurring services indicate a need for integrated approaches to treatment, including an integrated care of plan that addresses and incorporates all of the bio-psychosocial needs of the individual and family (SAMSHA, 2011a & 2011b).
- Prevention and treatment services must be *culturally competent*, and appropriate for the diversity of age, sexual orientation and gender.
- PCP screening may identify patterns of abuse in early stages that do not rise above the threshold diagnostic criteria for specific disorders ( Sterling et al, 2011). However individuals with less severity level of severity may benefit from brief interventions that may prevent more severe problems ( Sterling et al, 2011), such as Screening, Brief Intervention, and Referral to Treatment [SBIRT] (SAMSHA, 2012) that can be delivered in primary care settings.
- Community-based case management may assist adolescents with CODs in making the transition to the adult care system.

**Family Systems Approaches:** Family therapy is strongly recommended in combination with any individual or group treatment and seems to have the highest proficiency for success. The recommended guiding principles of treatment, according to Holly (2007) are:

- Building a strong relationship and motivating clients to attend treatment;
- Creating a treatment plan that centers on client-generated goals;
- Applying empirically supported treatments, focused on interventions specific to the client’s diagnostic presentation;
- Using culturally and developmentally sensitive content;
- Focusing on client strengths, with an emphasis on impulse control, communication, problem solving, and regulation of affect;

- Designing goals and objectives focus on change that is sustainable over the long term;
- Monitoring motivation, substance use and medication compliance, if utilized;
- Increasing intensity if the intended response is not achieved;
- Using relapse prevention strategies;
- Fostering peer group influences; and
- Conducting psychoeducation for parents. (Holly, H. 2007)

According to Mueser, Torrey, Lynde, Singer, and Drake (2003), family engagement in treating COD's is beneficial in that they offer the possibility of increasing the person's self-efficacy, can encourage treatment compliance, and help facilitate needed support systems. Fals-Stewart and O'Farrell (2003) suggest that family involvement can improve over all coping skills for clients, and with family psycho-educational efforts, reduce unintentional enabling. Engaging the family as part of any treatment model according to Fals-Stewart and O'Farrell can have a positive influence on relapse prevention and adherence to treatment goals.

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**Evidenced-based practices:** The following treatment models have been approved as evidence-based programs for treatment of substance use disorder in the adolescent population by the Substance Abuse and Mental Health Services Administration (SAMHSA) as cited on the National Registry of Evidence-Based Programs and Practices website (SAMHSA, 2010):

- **Adolescent Community Reinforcement Approach (A-CRA)** - The Adolescent Community Reinforcement Approach (A-CRA) to alcohol and substance use treatment is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery.
- **Brief Strategic Family Therapy (BSFT)** is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve pro-social behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school.
- **The Chestnut Health Systems-Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model** is designed for youth between the ages of 12 and 18 who meet the American Society of Addiction Medicine's criteria for Level I or Level II treatment placement.
- **Family Behavior Therapy (FBT)** is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth, as well as common co-occurring problem behaviors, such as depression, family discord, school or work attendance, and conduct problems in youth.

- **Family Support Network (FSN)** is an outpatient substance abuse treatment program targeting youth ages 10-18 years. FSN includes a family component along with a 12-session, adolescent-focused cognitive behavioral therapy--called **Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT12)** and case management.
- **Moral Reconnection Therapy (MRT)** is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.
- **Multidimensional Family Therapy (MDFT)** is a comprehensive and multi-systemic family -based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency.
- **Multisystemic Therapy (MST) for Juvenile Offenders** addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior.
- **Not On Tobacco (N-O-T)** is a school-based smoking cessation program designed for youth ages 14 to 19 who are daily smokers. N-O-T is based on social cognitive theory and incorporates training in self-management and stimulus control; social skills and social influence; stress management; relapse prevention; and techniques to manage nicotine withdrawal, weight, family and peer pressure.
- **Parenting with Love and Limits (PLL)** combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation.
- **Phoenix House Academy** (formerly known as Phoenix Academy) is a therapeutic community (TC) model enhanced to meet the developmental needs of adolescents ages 13-17 with substance abuse and other co-occurring mental health and behavioral disorders.
- **Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment)** is a **screening, brief intervention, and referral to treatment (SBIRT)** model designed for use in health clinics or emergency departments (EDs).
- **Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students)** is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.

- **Project Towards No Tobacco Use (Project TNT)** is a classroom-based curriculum that aims to prevent and reduce tobacco use, primarily among 6<sup>th</sup> to 8<sup>th</sup> grade students. The intervention was developed for a universal audience and has served students with a wide variety of risk factors.
- The **Residential Student Assistance Program (RSAP)** is designed to prevent and reduce alcohol and other drug (AOD) use among high risk multi-problem youth ages 12 to 18 years who have been placed voluntarily or involuntarily in a residential child care facility (e.g., foster care facility, treatment center for adolescents with mental health problems, juvenile correctional facility).
- **Seeking Safety** is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: in group or individual formats, male or female clients, and a variety of settings (e.g., outpatient, inpatient, residential).
- **The Seven Challenges** is designed to treat adolescents with drug and other behavioral problems. Rather than using pre-structured sessions, counselors and clients identify the most important issues at the moment and discuss these issues while the counselor seamlessly integrates a set of concepts called the seven challenges into the conversation.
- **Teen Intervene** is an early intervention program targeting 12 to 19 year olds who display the early stages of alcohol or drug use problems (e.g., using or possessing drugs during school) but do not use these substances daily or demonstrate substance dependence.

*The following items are NOT on the Evidence Based Registry for adolescents, but either widely endorsed by professionals or the State of Tennessee Department of Mental Health and Substance Abuse Services:*

- **Dialectical Behavior Therapy (DBT)** is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes.
- **Double Trouble in Recovery (DTR)** is a mutual aid, self-help program for adults aged 18 to 55 who have been dually diagnosed with mental illness and a substance use disorder. In a mutual aid program, people help each other address a common problem, usually in a group led by peer facilitators rather than by professional treatment or service providers.
- **Motivational Enhancement Therapy (MET)** is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner.
- **Motivational Interviewing (MI)** is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal.

- **Hazelden Adolescent Co-Occurring Series** utilizes an integrated therapies approach in conjunction with a family program and medication management. The therapy approach includes Motivational Enhancement Therapy, Cognitive-Behavioral Therapy and Twelve Step Facilitation.

**Other Interventions:** A systems approach may focus on working with a family unit or providing services in the natural environments of child/adolescents. Examples of promising and innovative approaches include:

- **Case management services:** Family-focused case management services have proven effective with adults with co-occurring disorders and their children. **“Parent participants experienced reduced mental health–related stigma and stress, improved parenting skills and social support networks, and had relatively few psychiatric hospitalizations. Families were supported by providing children enhanced access to services for cognitive and/or developmental delays and through the facilitation of many lasting reunifications”** (Finnel & Vogel, 2012).
- **School and community-based programs:** Recent findings suggested that medications for SED could yield favorable treatment results for youth receiving alcohol treatment in school settings, community-based intervention programs, clinic treatment, partial day treatment, day treatment, and short-term inpatient treatment (SAMSHA, 2000).

The examples of innovative treatment programs for adolescents with substance use problems include recovery programs that occur in an individual’s natural environment such as school-based student assistance programs (True North, 2012).

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