American Academy of Addiction Psychiatry

Translating Science. Transforming Lives.

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE USE DISORDER TREATMENT POLICY

Introduction

Individuals with co-occurring psychiatric and substance-related disorders experience persistent and recurrent difficulties, which can interfere with every aspect of their lives. These individuals also have a high incidence of medical comorbidity and their clinical course is associated with higher costs and poorer outcomes. In almost all psychiatric and addiction settings, people with co-occurring disorders appear with sufficient frequency that their presence must be anticipated at every level of care. Settings that serve people with severe mental illness are likely to have a majority of the people seeking care with co-occurring disorders. These individuals are poorly served by systems where treatment for co-occurring disorders is provided in separate settings, with a lack of integration and continuity, and insufficient availability of appropriate programs.

Policy Statement

AAAP recommends that in every system of care the following core principles form the basis of a comprehensive, continuous, integrated system for individuals with co-occurring psychiatric and substance-related disorders:

Welcoming: The goal is to insure that each contact is welcoming, empathic, hopeful, culturally sensitive and makes an effort to engage individuals who are unwilling to accept or participate in recommended services, or who do not fit into available program model by providing motivational counseling.

Accessibility: Twenty-four hour crisis intervention services should be available to provide assessment and intervention for both psychiatric and substance-use disorders. Barriers to immediate evaluation that are based upon drug or alcohol levels rather than clinical presentation should be eliminated. At each level of care (acute, outpatient, residential, or inpatient) there should be programs available to accept patients without barriers or waiting lists. Patients should not be required to self-define as "psychiatric", "substance abuse" or "dual diagnosis" in order to be accepted
for evaluation and treatment.

Integration: Psychiatric disorders and substance-related disorders are both examples of primary mental illnesses and the recommended treatment approach is *integrated dual primary treatment* that utilizes a disease and recovery model in a single setting or service system. Individuals should have a primary treatment relationship that coordinates ongoing treatment interventions for all disorders. Each disorder should receive specific and individualized treatment, which takes into account complications resulting from co-occurring disorders, clinical variables such as the phase of recovery, the extent of disability, and the presence of external supports (e.g. supportive family) or stressors (e.g. no family, criminal justice involvement).

Continuity: Since integrated treatment is significantly associated with better outcome and reduction of more expensive service utilization, a comprehensive service system must develop mechanisms for identifying patients with

co-occurring disorders and establish a collaborative system of care management. The service system must be *proactive* to ensure continuity and prevent patients from "falling through the cracks". It should also seek out patients who are most disengaged and hardest to serve (e.g. individuals who are homeless). Services should be available regardless of initial motivation or adherence, and should include outreach and engagement. The system must be responsive to the needs of the patient, instead of patients needing to meet the specifications of the program or system.

Comprehensiveness: Due to the high cost and poor outcomes with this population, AAAP recommends that all programs provide dual diagnosis expertise. All programs should meet the standard of "Dual diagnosis capability "(ASAM PPC 2R). Program should incorporate safety screening with available interventions as this is a high risk population. Programs should provide availability of an Addiction Psychiatrist who is credentialed and knowledgeable with diagnosis, disability, phase of recovery, stage of change and level of care as well as psychopharmacological interventions. The program should offer range of psychopharmacological interventions including buprenorphine , naltrexone as well as medications to treat alcohol use disorder (naltrexone , Acamprosate , Antabuse and Naltrexone injection) and opiate safety kit.

Background

AAAP members are primary providers of treatment for individuals with co-occurring disorders and were participants in a 1998 SAMHSA funded a national consensus panel project on co-occurring disorders. Recommendations of that panel were utilized in the development of this AAAP policy on the treatment of individuals with co-occurring psychiatric and substance use disorders.

Approved by AAAP Board of Directors: December 2002
Revised: May 2015
Reviewed: July 2018