HEALTHWEST

Practice Guideline

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Subject: Prescribing for Individuals with Co-Occurring Disorders

I. PURPOSE

To provide safe, effective, and optimum guidelines for individuals receiving services from the Agency who are also either presently active or have a history of substance use.

II. APPLICATION

HealthWest Prescribers (Physicians, Physician's Assistants, and Nurse Practitioners).

III. DEFINITIONS

Abstinent: Not currently using non-prescribed pharmacologic, dietary, or otherwise ingestible agents having a potential for habituation or abuse.

Non-Habituating Psychotropic Medications: All psychotropic medications which are not listed as controlled substances by the Drug Enforcement Administration (DEA).

Substance Use Disorders: Disorders included in the DSM-IV-TR under the heading of "Substance-Related Disorders".

Sobriety: The state of abstinence. (See "Abstinent" definition above.)

IV. PROTOCOL

A. Screening and Assessment

1. Individuals presenting for service will be screened for both mental health and substance use disorders, as well as physical conditions that may present as behavioral health conditions.

2. There are no requirements related to blood alcohol levels, length of abstinence from psychoactive substances or length of medication adherence as a precondition for access to evaluations and appropriate care. Initial psychopharmacological treatment does not require individuals receiving services to be abstinent.

Positive screenings should lead to further integrated assessment and treatment planning. Laboratory studies, drug screening, electrocardiography (EKG) and imaging studies should all be considered as part of the assessment.

3. Assessment of individuals with co-occurring disorder (COD) should occur over time and include:

   a. A review of chronologic history, including time frames for onset and continuation of both mental and substance use disorders;

   b. Differentiate between substance induced disorders that resolve when substance use stops and independent co-occurring mental disorders that require ongoing intervention;

   c. A review of current and previous pharmacotherapy for behavioral disorders and effectiveness;

   d. A review of family history of both mental and substance use disorders.

4. When both a mental and substance use disorder is present, both disorders should be considered 'primary'.

B. Integrated Treatment Planning

1. Individualized treatment planning that includes pharmacologic strategies should be developed through a person-centered planning process and integrate interventions identified in the assessment including immediate risk and safety, recovery goals, cognitive functioning, social and physical functioning, other medical conditions, strengths, skills and periods of success, history of treatment response, motivation and stage of change, stage of treatment, culture and background.

2. Successful pharmacologic interventions are most likely to occur in the context of a relationship with the individual in which the prescriber positions himself/herself as a collaborator in the recovery process with a focus on a relationship that is empathetic, hopeful and strength-based.

3. Treatment should integrate best practice interventions, including both psychosocial and pharmacotherapy, to address each of the COD's. Individuals receiving services will be encouraged to participate in services and supports that will lead to recovery.

C. Pharmacologic Strategies

1. Medications that are used for symptom management and stabilization of known mental disorders or medical conditions should generally be maintained even when the individual continues to use substances. Individuals should be closely monitored and discontinuation of treatment should only occur when the risk of prescribing outweighs the benefits of continued therapy.

2. For individuals with COD, additional consideration should be given to the potential abuse of prescribed medication.

3. Side effects should be monitored carefully and differentiated from the effect of ongoing alcohol and/or drug use.

4. Potential toxicities and drug interactions that may occur between medications prescribed, medications being considered and tobacco, alcohol and/or drug use to treat individuals with COD should be considered (e.g., the combination of opiates and benzodiazepines carries a particularly high risk and tobacco can lower antipsychotics blood levels).

5. In general, the most appropriate medication for addressing an individual's mental disorder is likely to be the same medication for addressing these symptoms when the individual is diagnosed with a co-occurring substance use disorder. Likewise, the most appropriate medication for addressing an individual's substance use disorder is likely to be the same one when they are diagnosed with a co-occurring mental disorder.

6. Pharmacologic interventions should move from low risk to higher risk strategies, dependent on clinical response. The use of medications with the potential for abuse is risky in individuals with COD and requires careful risk/benefit assessment prior to initiation. However, these categories of medication should not be arbitrarily denied to individuals with COD.

7. Coordinated treatment of COD and concurrent medical conditions benefits overall recovery as these individuals are at high risk for concurrent medical problems due to substance toxicities, lifestyle factors e.g., injection drug use and homelessness) lack of regular medical attention and medication side effects.

V. REFERENCES

SAMHSA General Principles for the Use of Pharmacological Agents to Trust Individuals with Co-occurring Mental and Substance Use Disorders, 2012
Minkoff, 1998
Sowers & Golden, 1999
The Carlat Report Psychiatry, Volume 9, Number 7 and 8, July/August, 2011

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