Co-occurring Mental Health and Substance Use Disorders

Adopting A Systems Change Mode

Individuals with co-occurring mental health and substance use were recognized as a population with unacceptable outcomes and higher costs in multiple clinical domains. They are often poorly served in both mental health and substance abuse settings, with resulting over-utilization of resources in criminal justice, primary health care, child protection, and women's and homeless shelter systems. In addition to having unacceptable outcomes and high costs, individuals with co-occurring disorders are sufficiently prevalent in all mental health and addiction service settings that they can be considered an expectation, rather than an exception.

In order to provide more welcoming, accessible, integrated services to these individuals, the Co-occurring Mental Health and Substance Use Disorders Initiative (CODI) adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model developed by Dr. Minkoff. This model is based on a set of clinical consensus best practice principles. The following CCISC principles were adopted by Winnipeg CODI and whenever possible will be reflected in AFM's courses.

1. **Co-occurring disorders as an expectation, not an exception.**
   This expectation must be a consideration in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.

2. **Empathic, hopeful clinical relationships**
   The core of success in any setting is the availability of empathic, hopeful clinical relationships that provide integrated and coordinated service during each episode of care, and across multiple episodes.

3. **Four population sub-groups**
   The population of individuals with co-occurring disorders can be organized into four subgroups for service planning purposes, based on high and low severity of each type of disorder.

4. **Balancing support with empathic detachment**
   Within the context of any clinical or helping relationship, supportive case management needs to be balanced with empathic detachment at each point in time, based on each individual's specific needs, goals and strengths.

5. **Addressing both conditions as primary disorders**

When mental health and substance use disorders co-exist, a comprehensive, continuous, integrated approach, which supports the provision of concurrent responses to both as primary disorders, is recommended.

6. **Parallel phases of recovery**
   Mental health and substance use disorders both tend to be persistent, biopsychosocial problems that can be addressed using a CCISC model. Each disorder has parallel phases of recovery and stages of change. Helping services for individuals with co-occurring disorders need to be matched across all levels of care.

7. **Individualization of interventions**
   There is no one correct program or intervention. Service responses or interventions must be individualized for clients/patients according to: assessment/diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care requirements. Programs must also be sensitive to age, culture and gender specific needs of its clients/patients.

   In a CCISC environment, all programs are co-occurring disorder programs that meet at least minimum criteria of "dual diagnosis capability"[1], but each program has a different "job," that is matched to a specific cohort of patients/clients.

8. **Individualization of outcomes**
   Similarly, outcomes for patients/clients need to be individualized. Outcome variables need to include not only abstinence, but also reduction in harm, movement through stages of change, changes in type, frequency, and magnitude of substance use or psychiatric symptoms, and improvements in specific problem management skills and program adherence.