Public Policy Statement on Co-occurring Addictive and Psychiatric Disorders

Background:

The co-occurrence of addictive disorders with other psychiatric disorders is a common occurrence, both in the general population and in clinical populations of adult, adolescent and elderly patients. According to the Surgeon General (Mental Health: A Report of the Surgeon General, 1999) about 21% of adults in the United States population meet diagnostic criteria for a psychiatric disorder in any 12-month period. Of these, about 15% also meet criteria for a substance use disorder. Of the 9% of American adults who meet diagnostic criteria for a substance use disorder, about 1/3 also meet criteria for one or more psychiatric disorders. Thus approximately 3% of the adult population suffer from a combination of addictive and psychiatric disorders in any given year.

Because of the additional symptoms and greater severity of dysfunction in persons with so-called "dual diagnosis" (combinations of addictive and psychiatric disorders are often referred to as dual diagnosis, even when there are more than two diagnosable disorders), rates of co-occurrence of these disorders are much higher in populations of patients in treatment, whether they receive treatment in an identified mental health or addiction treatment setting. Among co-occurring psychiatric disorders commonly seen in addiction treatment patients are anxiety and mood disorders, post traumatic stress disorder, pathological gambling, sexual and eating disorders in adults and adolescents, and conduct disorders and attention deficit disorder in the latter. Co-occurring addictive disorders commonly seen in psychiatric patients include alcohol, nicotine, opiate, sedative, stimulant, marijuana and hallucinogen abuse and dependence, including dependence on prescription drugs.

In the past, dual diagnosis patients often received different treatment, depending on the setting in which they received services. Either the psychiatric or the addictive disorder was assumed to be "primary" or "underlying", and the co-occurring disorder was expected to disappear when the "primary" disorder was successfully treated. Unfortunately, when two independent disorders were present (rather than, for example, depression or anxiety symptoms related to alcohol or other drug withdrawal), this often failed to happen. If the patient became abstinent in addiction treatment without treatment of the patient's psychiatric disorder, relapse of the psychiatric disorder often resulted in relapse of the substance dependence. If the psychiatric disorder was treated without attention to the substance use disorder, the patient often failed to respond to psychiatric treatment.

These experiences led to an understanding of the need for careful evaluation of all patients entering treatment for both psychiatric and substance use disorders, with the goal of identifying independent co-occurring disorders. Accurate diagnosis then allows the development of an
appropriate treatment plan, taking into account the nature and acuity of each of the patient's disorders and the complex interaction between them. In doing such evaluations, it is important to distinguish symptoms of independent disorders from symptoms of substance intoxication or withdrawal, which sometimes mimic those of other psychiatric syndromes. Appropriate levels of care can be determined with the use of the ASAM Patient Placement Criteria for the Treatment of Substance Use Disorders. The use of medications in treating the psychiatric disorders of dual diagnosis patients requires consideration of the addictive potential of some prescription drugs. Counseling methods used to confront denial in some addicted patients may need to be modified in certain dual diagnosis cases. Appropriate training in these and other considerations is necessary for all health professionals evaluating and treating dual diagnosis patients.

Therefore, the American Society of Addiction Medicine recommends the following:

1. Clinicians working in all medical care settings, including primary care, specialty care for psychiatric or addictive disorders, other medical specialties and public health settings, should be educated about the prevalence and importance of co-occurring psychiatric and addictive disorders.

2. Clinicians referring patients to either mental health or addiction treatment should consider the possibility that co-occurring disorders are present in these patients.

3. Physicians and other health professionals treating patients for psychiatric or addictive disorders should carefully evaluate such patients for co-occurring disorders and incorporate attention to all of these disorders in the formulation of a treatment plan.

4. Treatment settings in which dual diagnosis patients receive care should assure that the training and competence of their staff members is sufficient to deal effectively with these patients. Where staff expertise is not adequate, dual diagnosis patients should be referred to appropriate services, or the treatment setting should develop cooperative treatment arrangements with other treatment facilities. Where such arrangements are made, frequent communication and close cooperation between the two treatment services and among all clinicians treating the patient are important.

5. Because families of persons with co-occurring disorders are often faced with special problems, family members should be included in the treatment plan and receive adequate and appropriate services.


7. Health insurance carriers should be aware of the special treatment needs of dual diagnosis patients and provide adequate coverage for their care.

8. Publicly funded addiction and mental health treatment at all levels of government (federal, state and local) should recognize the special needs of dual diagnosis patients in their program planning and budgeting.
9. Training in the recognition and treatment of patients with co-occurring disorders should be part of the curriculum in mental health and addiction education at all levels and for all professionals.

10. Research into the epidemiology, neurobiology, phenomenology, clinical course and treatment of these disorders should be a high priority for governments, universities and other research institutions.

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