

Prevalence of Adults with Co-Occurring Mental Health and Substance Use Disorders and Treatment Issues

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***May 14, 2009
Southeastern Regional Action Council (SERAC)
Uncasville, CT***

Why Focus on Co-Occurring Disorders?

- Co-Occurring disorders are common.
- Typically poor treatment outcomes for people with co-occurring disorders **in the absence of integrated care.**

If both conditions are not recognized and treated, recovery can be jeopardized.

National Initiatives

- Significant attention to Co-Occurring Disorders
 - 1999: Surgeon General's Report on Mental Health
 - 2002: Report to Congress
 - 2003: President's New Freedom Commission Report
 - 2003: Substance Abuse and Mental Health Services Administration (SAMHSA) begins Co-Occurring State Incentive Grant (COSIG) awards (currently 19 states) and national Co-Occurring Center for Excellence (COCE)
 - 2005: SAMHSA's Treatment Improvement Protocol (TIP) #42 – Substance Abuse Treatment For Persons With Co-Occurring Disorders
 - 2009: New COCE?

Department of Mental Health and Addiction Services (DMHAS)



**Single State Authority that has responsibility for
both mental health and addiction services for adults.**

Subgroups of the Population with Co-Occurring Disorders (COD)

<p>Quadrant III</p> <p><i>High Severity Substance Use Disorders</i></p> <p>Low Severity Mental Illness</p>	<p>Quadrant IV</p> <p>High Severity Mental Illness</p> <p><i>High Severity Substance Use Disorder</i></p>
<p>Quadrant I</p> <p>Low Severity Mental Illness</p> <p><i>Low Severity Substance Use Disorder</i></p>	<p>Quadrant II</p> <p>High Severity Mental Illness</p> <p><i>Low Severity Substance Use Disorder</i></p>

National Prevalence Estimates

- 5 million US adults have a serious mental illness and a co-occurring substance use disorder.
- MH treatment settings: 20-50% have a lifetime co-occurring substance use disorder
- SA treatment settings: 50-75% have a lifetime co-occurring mental health disorder

(COCE, 2007)

CT Prevalence Estimates

- Using DMHAS statewide data systems:
 - 12-45% with co-occurring disorders
 - Depending on how you analyze the data: MH vs SA; state operated vs private non-profit providers
 - New data systems being implemented 2010
- Providers routinely report anecdotally higher percentages of people with CODs

Treatment Issues-Historically (we're making progress!)

- Sequential and Parallel treatment of co-occurring disorders is not recommended.
 - RESEARCH INDICATES INTEGRATED TREATMENT IS ESSENTIAL.
- At times, not welcoming to this population
- Lack of assessment/identification of “other” disorder
- Lack of treatment of “other” disorder
- Lack involvement of family in integrated care
- No linkage to 12-step groups
- Lack of staff competent to treat both disorders in the same setting

Environment of Opportunity

DMHAS has been working to integrate services for people with co-occurring disorders for several years

- 1990s: Taskforces, research on co-occurring disorders (COD)
- 2002: CT Integrated Dual Disorders Treatment (IDDT) Initiative (for mental health agencies) began and CT Dual Diagnosis Capability in Addiction Treatment (DDCAT) Initiative (for addiction treatment agencies) began
- 2004: National Co-Occurring Disorders (COD) Policy Academy; State Action Plan.
- 2005: 5-year Co-Occurring State Incentive Grant (COSIG)

DMHAS' Systemic Approach to Integrated Care



- Establish conceptual and policy framework
- Build competencies and skills
- Enhance programs and service structures
- Align fiscal resources and administrative policies in support of integrated care
- Monitor, evaluate and adjust
- Implement co-occurring enhanced program guidelines

Commissioner's Policy Statement # 84

“Serving People with Co-Occurring Mental Health and Substance Use Disorders”

Effective January 11, 2007

- Support DMHAS' overarching goal of promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care
- **Communicate expectations:**
 - Improve processes of care and outcomes for people with co-occurring disorders
 - Implement advances in research and practice related to co-occurring disorders; close the science-to-service gap
 - Transform DMHAS' system of care

Definitions in the Policy Document



- **“Co-Occurring disorders** are defined as the co-existence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one of which is a mental health disorder.”
- **“Integrated treatment** is a means of coordinating both substance use and mental health interventions; it is preferable if this can be done by one clinician, but it can be accomplished by two or more clinicians working together within one program or a network of services. Integrated services must appear seamless to the individual participating in services.”

Policy Statement



“The publicly funded healthcare system in Connecticut will be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout all phases of the recovery process (e.g., engagement, screening, assessment, treatment, rehabilitation, discharge planning, and continuing care).”

Guiding Principles

- People with co-occurring disorders are **the expectation** in our healthcare system, and **not the exception**.
- There is **“no wrong door”** for people with co-occurring disorders entering into the healthcare system.
- Mental health and substance use disorders are **both “primary”**.
- The system of care is committed to integrated treatment with **one plan** for one person.
- Integrated care must be accomplished by **preserving and capitalizing on the values, philosophies, and core technologies of both the mental health and addiction treatment fields.**

CT COD INITIATIVE - STRUCTURE

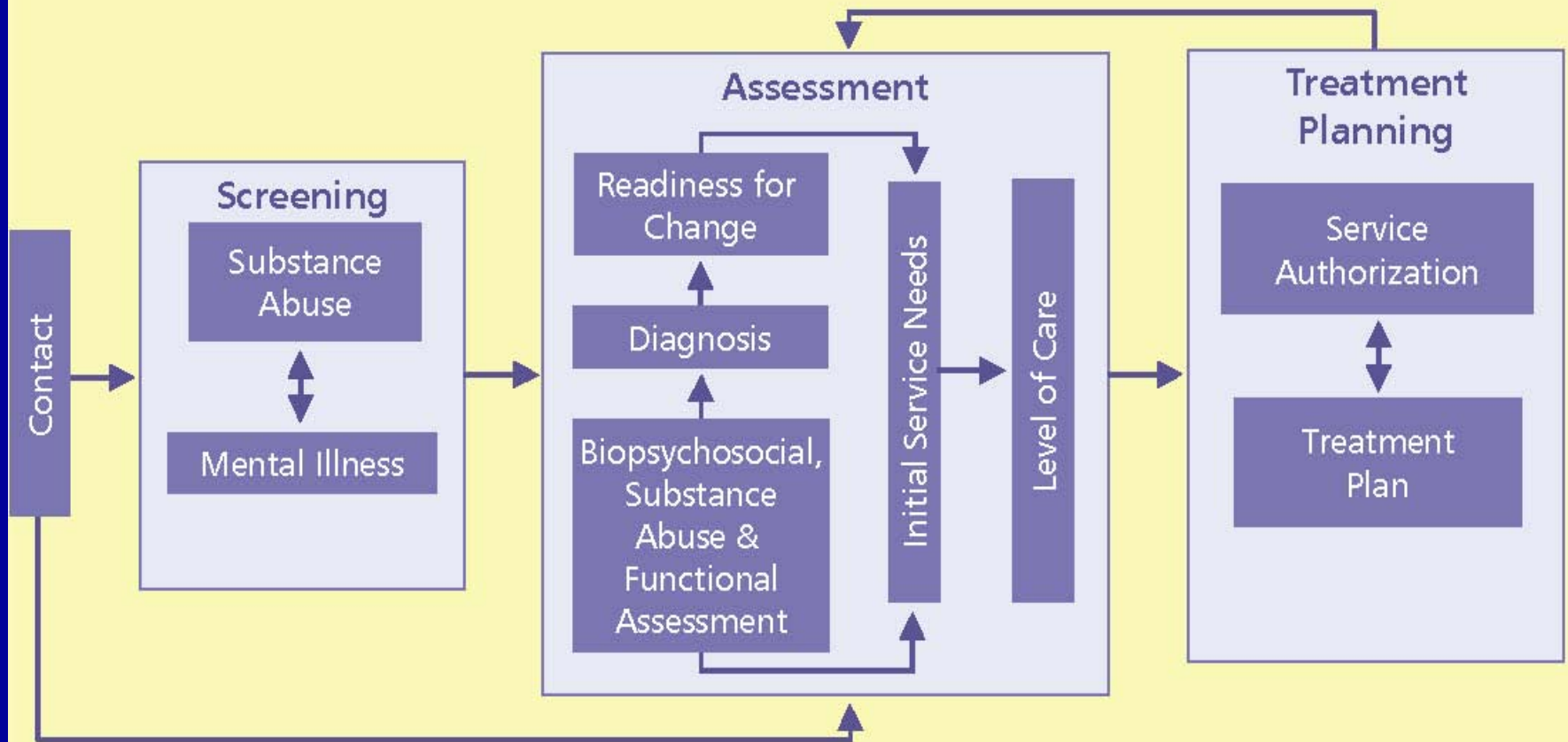
- Steering Committee – Commissioner Kirk, Chair
- Workgroups
 - Screening Workgroup
 - Workforce Development Workgroup
 - Co-Occurring Guidelines/Services Workgroup
 - Co-Occurring Practice Improvement Collaborative
 - State Facilities Workgroup

Four Main Goals

- Statewide Implementation of Standardized Screening Measures
- Integrated Service Delivery
- Information sharing; data-based decision making; using data to inform program development
- Workforce Development

Screening Data and the Assessment and Treatment Planning Process

Figure 1: Relationships Among Screening, Assessment, and Treatment Planning



Screening Pilot: 2006-07

- 30 providers (mental health and addiction, state-operated and private non-profit) participated in the pilot.
- Training, monthly conference calls, provider data feedback reports.
- Pilot began in May 2006 and continued to Spring 2007.
- **Positive Results!**

COD Screening Pilot - 2006

Measures

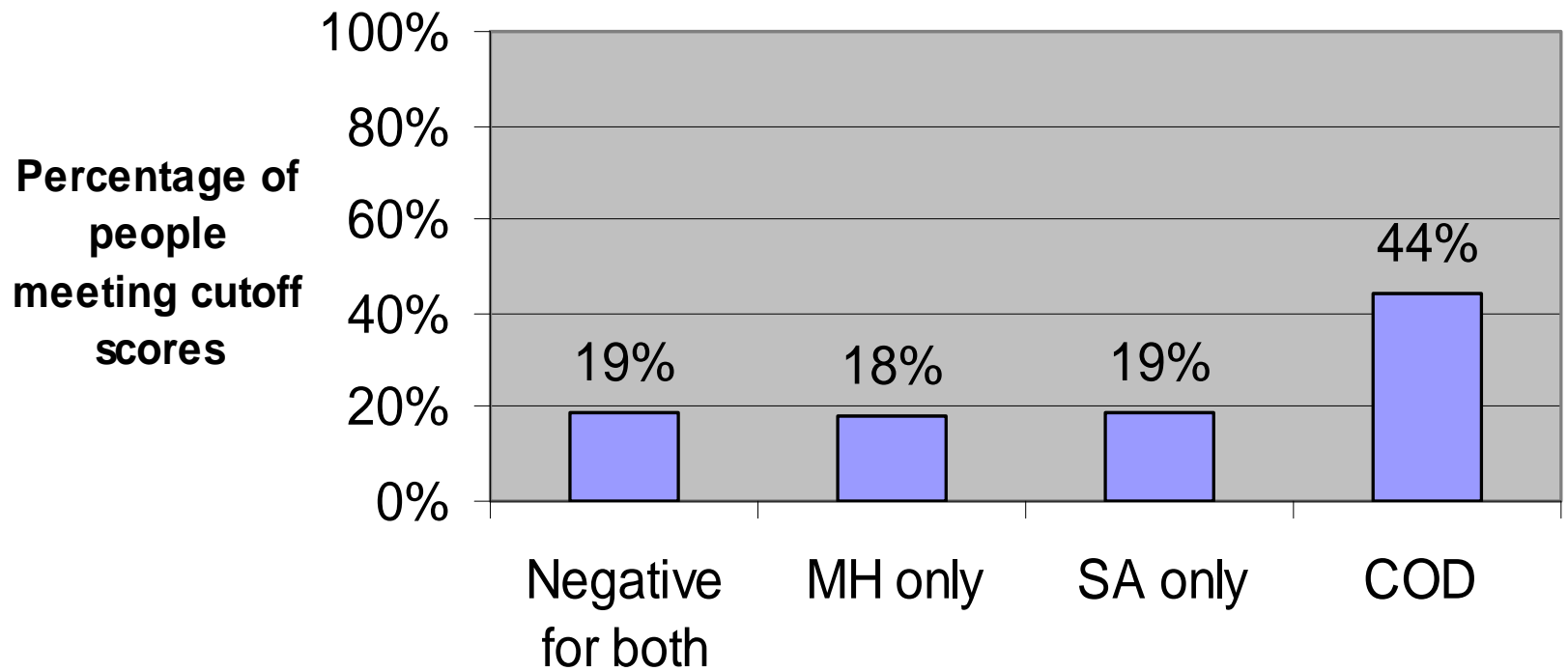
- Mental Health Screening Form-III (MHSF-III).
- Modified Mini International Neuropsychiatric Interview (Modified Mini).
- Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD).
- CAGE-AID (CAGE Adapted to Include Drugs).

Features of Screening Instruments

- High sensitivity (but not high specificity)
- Brief
- Low cost and no cost
- Minimal staff training required
- Consumer friendly

Screening Pilot

Screening Pilot Results



Standardized Screening Measures Required - 2007

- Effective July 1, 2007 all DMHAS operated and funded providers are required to use one of the mental health screens and one of the substance use screens.
- Contract language
- Data collection also being implemented.

IDDT and DDCAT Models Summarized

- Integrated Dual Disorders Treatment Model
- Dual Diagnosis Capability in Addiction Treatment Index
 - Multidisciplinary Teams
 - Stage-Wise Assessment and Treatment (level of motivation; readiness to change)
 - Comprehensive Services
 - Co-Occurring Groups; pharmacology for both disorders
 - Family Psychoeducation
 - Pharmacological Treatment
 - Alcohol & Drug Self-Help Groups
 - Continuity of Care
 - Also: health, program structure/milieu

Integrated Services

- **Implementation Support**
 - Training, ongoing consultation and supervision
 - COSIG Pilot sites (Morris Foundation and Hispanic Clinic)
 - Practice Improvement Collaboratives (PNP and State Operated)
 - Co-Occurring Enhanced Program Guidelines
 - Co-Occurring Competencies

COD Data / Outcomes

- **Outcomes - Measuring Inputs and Outputs**
 - Screening results
 - Identifying people with COD within existing management information systems using diagnosis data
 - Fidelity to integrated service models
 - Identifying outcomes for people with COD
 - **Statewide and provider levels**

Workforce Development

Ensuring a workforce competent to meet the needs of individuals with co-occurring disorders wherever they enter the system of care

Setting Priorities

- Three areas were identified and established as priorities for the development of a co-occurring disorder (COD) competent workforce
 - Education and training curriculum development
 - Clinical supervision
 - Credentialing

Creating COD Training Opportunities

- Trainers/Consultants
- Established the Co-Occurring Academy through the DMHAS Training and Education Division.
- Collaborating with the Community College system to develop COD course offerings. A COD course now exists at Gateway College through the Drug and Alcohol Recovery Counselor (DARC) Program. Collaborating with Southern Connecticut State University's MSW Program.

Clinical Supervision

- Supervision is essential for imbedding, developing and sustaining the practice!
 - Collaborating with the Mental Health Transformation Grant

Credentialing

- **CT Certification Board**. COD credentialing of individuals has been in place in Connecticut since 2000 through the Connecticut Certification Board. Currently 200 individuals in CT.
- **International Certification & Reciprocity Consortium (IC&RC)** for addiction professionals. Recently the IC&RC announced that a national/international COD credential has been adopted (including a written exam), thus standardizing the requirements across states.
- Similar types of COD Certifications are offered by NASW (social workers), APA (psychologists), ASAM and other organizations (physicians).

The Focus

- **Better care and outcomes for persons with co-occurring mental health and substance use disorders**
- Change
- Systems Transformation
- Partnerships
- Continual assessment and communication
- Technology Transfer (science-to-service)
- Sustained focus

Recommended Reading

Free Publications from SAMHSA

- COCE Overview Papers on Co-Occurring Disorders
- TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders
- TIP 48: Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

Resources

- DMHAS' Co-Occurring Academy
www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334766
- SAMHSA's Co-Occurring Center for Excellence (COCE)
coce.samhsa.gov
- Addiction Technology Transfer Center (ATTC)
www.nattc.org/resPubs/cooccurring/attc.html
- University of South Florida: Co-Occurring Disorders Free On-line Training Series
www.fmhi.usf.edu/institute/academic/training.html

For More Information...

The Co-Occurring Disorders Initiative webpages on
the DMHAS website:

www.ct.gov/dmhas/cosig

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