Serving Individuals with Co-Occurring Mental Health and Substance Use Disorders: Systems and Practice Issues

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Presentation Outline

- Co-Occurring Disorders
- CT Jail Diversion Programs
- DMHAS Co-Occurring Disorders Initiative Overview
  - Measuring Co-Occurring Capability in the Treatment System and Improving Services

Why Focus on Co-Occurring Disorders?

- Co-Occurring Disorders (COD) are common.
- There are 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 may be jeopardized.*

National Initiatives

- Significant attention to Co-Occurring Disorders
  - 1999: Surgeon General's Report on Mental Health
  - 2002: Report to Congress on Co-Occurring Disorders
  - 2003: President's New Freedom Commission Report
  - 2003: SAMHSA begins Co-Occurring State Incentive Grant awards (COSIGs); 19 states
  - 2004: National Policy Academy on COD
  - 2005: SAMHSA's Treatment Improvement Protocol (TIP) #42 – Substance Abuse Treatment For Persons With Co-Occurring Disorders

Subgroups of the Population with Co-Occurring Disorders

Quadrant III **High Severity SUD** **Low Severity MI**	Quadrant IV **High Severity MI** **High Severity SUD**
Quadrant I **Low Severity MI** **Low Severity SUD**	Quadrant II **High Severity MI** **Low Severity SUD**

COD Epidemiology

- Studies conducted in mental health settings found 20 to 50 percent of clients had a lifetime co-occurring substance use disorder

- Studies conducted in substance abuse treatment agencies found 50 to 75 percent of clients had a lifetime co-occurring mental disorder

COCE, 2007

LIFETIME RISK OF ANY MENTAL HEALTH DISORDER BY SUBSTANCE USE DISORDER

Cocaine	76.1%
Barbiturates	74.7%
Hallucinogens	69.2%
Opiates	65.2%
Alcohol	36.6%

Regier DA et al. JAMA. 1990(Nov 21);264(19):2511-2518

Jail Diversion Program in Connecticut*

History

- Larger courts in several cities have had staff present from the local mental health center for over 10 years. Serve adults with serious mental illnesses.
- SAMHSA-funded study of CT JD showed improvements for clients and cost benefit of treatment services vs incarceration.
- State funding for a state-wide Jail Diversion program began in 2001 for all 20 arraignment courts.

*Loel Meckel, LCSW, Assistant Director, Forensic Services Division, DMHAS

1 - Jail Diversion Program in Connecticut

Function of JD Programs in Court

- Role is consultant to court – impartial re legal disposition
- Clinical evaluation of defendants in court lock-up
- Provide treatment proposal to court for adults with serious mental illnesses
- **Refer to treatment**
- Support client in community
- Monitor and report compliance with treatment

*Loel Meckel, LCSW, Assistant Director, Forensic Services Division, DMHAS

Jail Diversion Program in Connecticut

Lessons Learned

- Gaps in CT service system are highlighted, including:
  - **Insufficient dual diagnosis service capacity and options (70-80% have COD)**
  - Insufficient housing that is safe and affordable
  - **Near absence of treatment designed for women**
  - A significant number of defendants have mental health needs but diagnoses are not severe enough to qualify for many community services (e.g. case management, outreach, vocational, ACT)

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2 - Women's Treatment and Support Diversion Program (WTSD)

Target Population

- Adult women (age 18+)
- Pretrial or Probation
- History of abuse/neglect
- Psychiatric symptoms of trauma
- Substance abuse/dependence
- No severe psychiatric symptoms

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Why Treat for Trauma?

- Individuals involved with the correctional system, especially female offenders, are particularly likely to have had trauma exposure (Harlow, 1999; Kassebaum, 1999)
- In 1999, 57% of women in state prisons reported a history of physical and/or sexual abuse (Greenfeld & Snell, 1999)
- Nationally, one in four women in state prisons is receiving medication for psychiatric disorders
- 22.3 percent of women in jail have been diagnosed with PTSD, and 13.7 percent have been diagnosed with a current episode of depression (U.S. Department of Justice)

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WTSD Client Profile

Mental Health/Substance Abuse Treatment

- In past, identified as "substance abuser" only
- Had prior substance abuse treatment but did not engage with treatment or did not sustain sobriety after treatment
- Impact of trauma not identified and/or treated
- Mental health needs have not been clearly identified
- Mental health needs have not been properly treated
- Posttraumatic Stress Disorder-spectrum (PTSD) symptoms
  - Always on guard (hyper arousal)
  - Re-experience abuse
  - Avoid reminders of abuse

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WTSD Client Profile

Legal

- Multiple prior arrests and convictions – cycling in/out of Criminal Justice System
- High risk of probation violation or failing court requirements
- Current/past involvement with CT Department of Children and Families

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Connecticut Women's Treatment And Support Diversion Program

Program Services

- Groups
  - Trauma education and symptom management
  - Integrated mental health and substance abuse treatment
  - Life skills
  - Spirituality
- Individual sessions and home visits as needed
- Medication Management

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Connecticut Women's Treatment And Support Diversion Program

Program Services - continued

- Off-site assistance with medical needs, entitlements, DCF, transportation, shopping, support, employment, court, probation
- Limited funds for basic needs – shelter bed, clothes, toiletries, home items, emergency medications
- Link to other community services – medical, methadone, battered women's services, education, vocational, etc.
- Informal contacts with women in office and in community

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Women's Treatment And Support Diversion Program

Models

- TARGET - Trauma Adaptive Recovery Group Education and Therapy , Julian Ford, Ph.D
- Helping Women Recover, Stephanie Covington, PH.D, LCSW
- TREM – Trauma Recovery and Empowerment Model, Maxine Harris, Ph.D.
- DBT – Dialectical Behavior Therapy, Marsha Linehan, Ph.D.
- MI/MET – Motivational Interviewing/Motivational Enhancement Therapy
- Harm Reduction
- Relational Cultural Theory

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Program Design

Ineffective	Effective
Mixed groups - men and women	Women-only groups
Mixed staff – men and women	Women-only staff
Program time is minimal or intensive; no in-between	Flex services to meet individual needs
Contact duration is fixed	Contact duration is flexible
Group only, no individual sessions	Group, individual, home visits, informal contacts as needed
No community services (case mgmt)	Whatever is needed for success
Funded by insurance payments	Funded by grant

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Program Design

Ineffective	Effective
Sobriety first then treat mental health	**Integrated treatment**
Abstinence required –policy, clinical belief, referral requirement	Abstinence desirable but not required
Get sober and stay sober	Sobriety and relapse cycle is the reality
Avoid dealing with trauma, it will trigger alcohol/drug use	**Educate about trauma effects, teach symptom management.**
Effects of trauma do not inform program design	All behavior and experience is seen as influenced by the effects of trauma
Alcohol/drug use = “not ready for treatment”, “not motivated”, “not getting it”, etc – assume an able but unwilling client	Alcohol/drug use is a coping skill to be replaced with healthy skills – assume a willing but unable client

Program Design

Ineffective	Effective
Missed appointments lead to discharge	Missed appointment leads to intensive outreach, problem-solving, tenacious engagement efforts
“Failure” is due to client issues	“Failure” is due to inability of program to meet client’s perceived needs
Give client what the program decides that they need	Give client what they decide that they want (with limitations) then help them to change what they want

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Department of Mental Health and Addiction Services (DMHAS)

Single State Authority that has responsibility for adult mental health and addiction services.

System-Level COD Activities

- 1995 – Department combined; COD Initiatives began
- 2002 – Partnership with Dartmouth Medical School/Psychiatric Research Center began
- 2004 – SAMHSA COD Policy Academy
- 2005 – 5-year COSIG Award
- 2007 – Commissioner's Policy Statement

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

Workforce Development

Build competencies and skills

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

Workforce Development Priorities

- To increase competencies and skills, five areas were established as priorities for the development of a co-occurring capable workforce:
  - Education: Co-Occurring Academy
  - Training, consultation, implementation support
    - Co-Occurring Practice Improvement Collaborative
  - Clinical supervision
  - Developed "Competencies for Providing Services to People with Co-Occurring Mental Health and Substance Use Disorders"
  - Partnering with Higher Education

Enhancing Services for People with COD

- Standardized MH/SA Screening
- Integrated Dual Disorder Treatment (IDDT) model
  - For "mental health" agencies serving people with severe mental illnesses and co-occurring substance use disorders
- Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index
  - For "addiction treatment" agencies serving people with substance use disorders and co-occurring moderate mental health disorders

Standardized Screening Measures Required

- Effective July 1, 2007 all DMHAS operated and funded providers are required to use a standardized mental health screen and a standardized substance use screen; menu of 4.
- Contract language added to all the funded providers.
- Data collection implemented.

Screening 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)

- http://www.ct.gov/dmhas/cosig/screening

Integrated Services Models and Program Assessment Measures

- Integrated Dual Disorders Treatment (IDDT) model
  - Evidence-based model
  - Developed by Faculty at Dartmouth Medical School (Drs. Mueser, Drake, et al.)
- Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index
  - More than 20 states currently using the DDCAT
  - Developed by Dr. McGovern at Dartmouth Medical School

IDDT and DDCAT Summarized

- **All elements with a focus on co-occurring disorders
- Program structure/milieu
- Stage-Wise Interventions
- Motivational Interviewing, CBT
- Family Psychoeducation/Support
- Pharmacological Treatment
- 12 Step Self-Help Groups
- Continuity of Care
- Staffing

CT's Use of the DDCAT Index

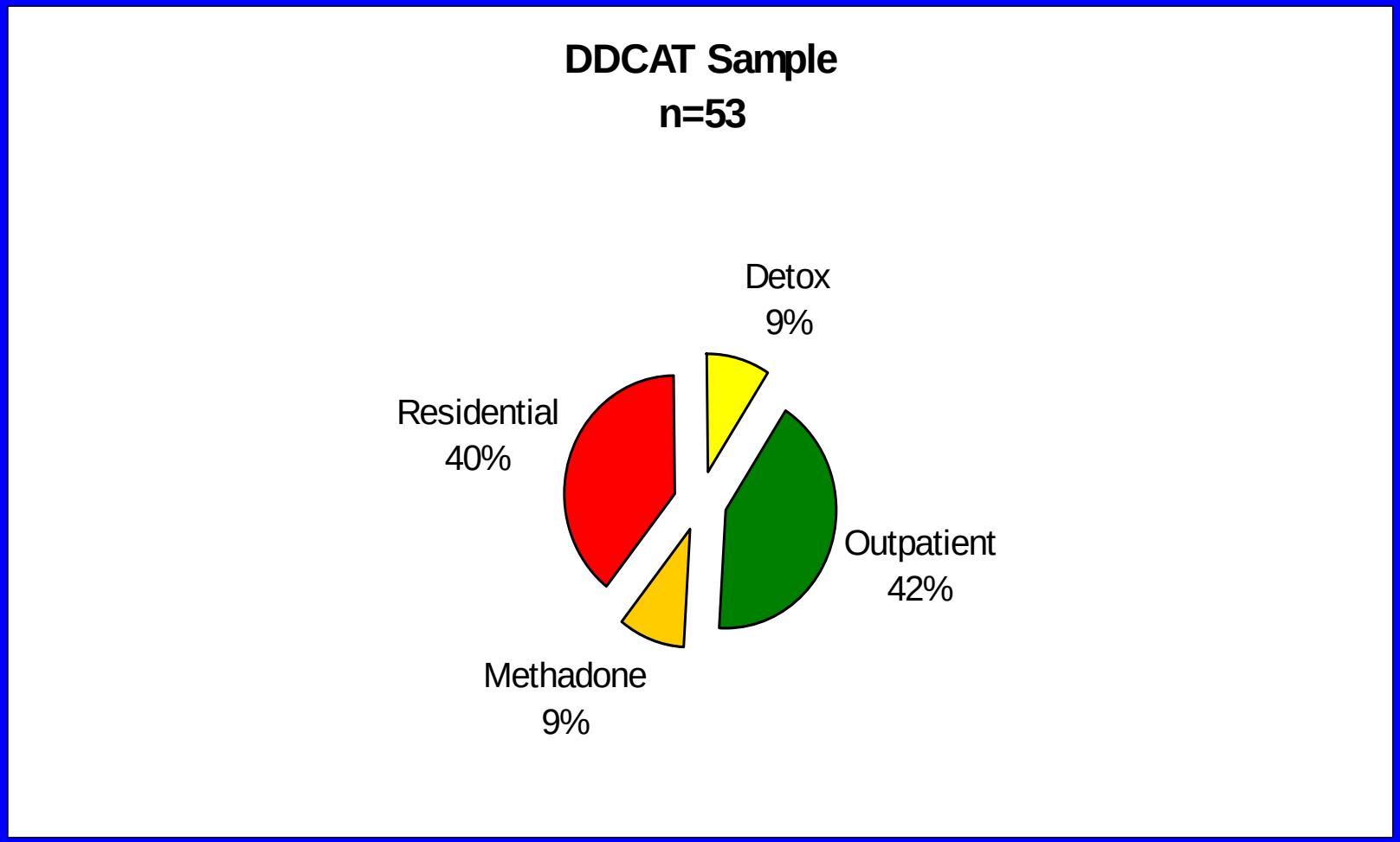
- Systematically assessed a 30% sample of all DMHAS-operated and funded addiction treatment programs;
- Assessed pre and post co-occurring capability in nine addiction treatment programs that participated in a change process designed to increase their capacity to serve individuals with co-occurring disorders;

- All DDCAT assessments were done using a site visit methodology including multiple sources of data.

Co-Occurring Practice Improvement Collaborative

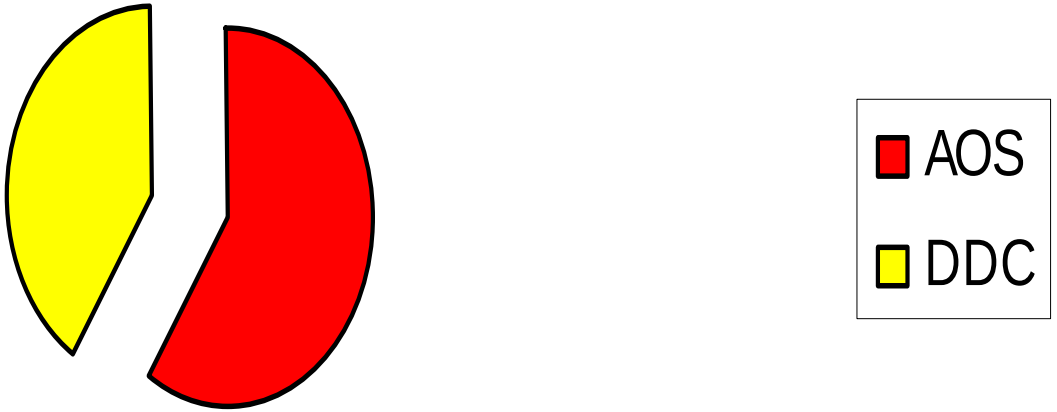
- With technical assistance, agencies developed implementation plans based on their baseline DDCAT assessment findings;
- The DDCAT Toolkit and 2-days of onsite, expert training and consultation provided to each program over 9 months;
- During the intervention period, programs met together bimonthly as a Learning Collaborative including the trainer and project manager;
- $2,000 to offset staff time to participate.

Statewide DDCAT Sample

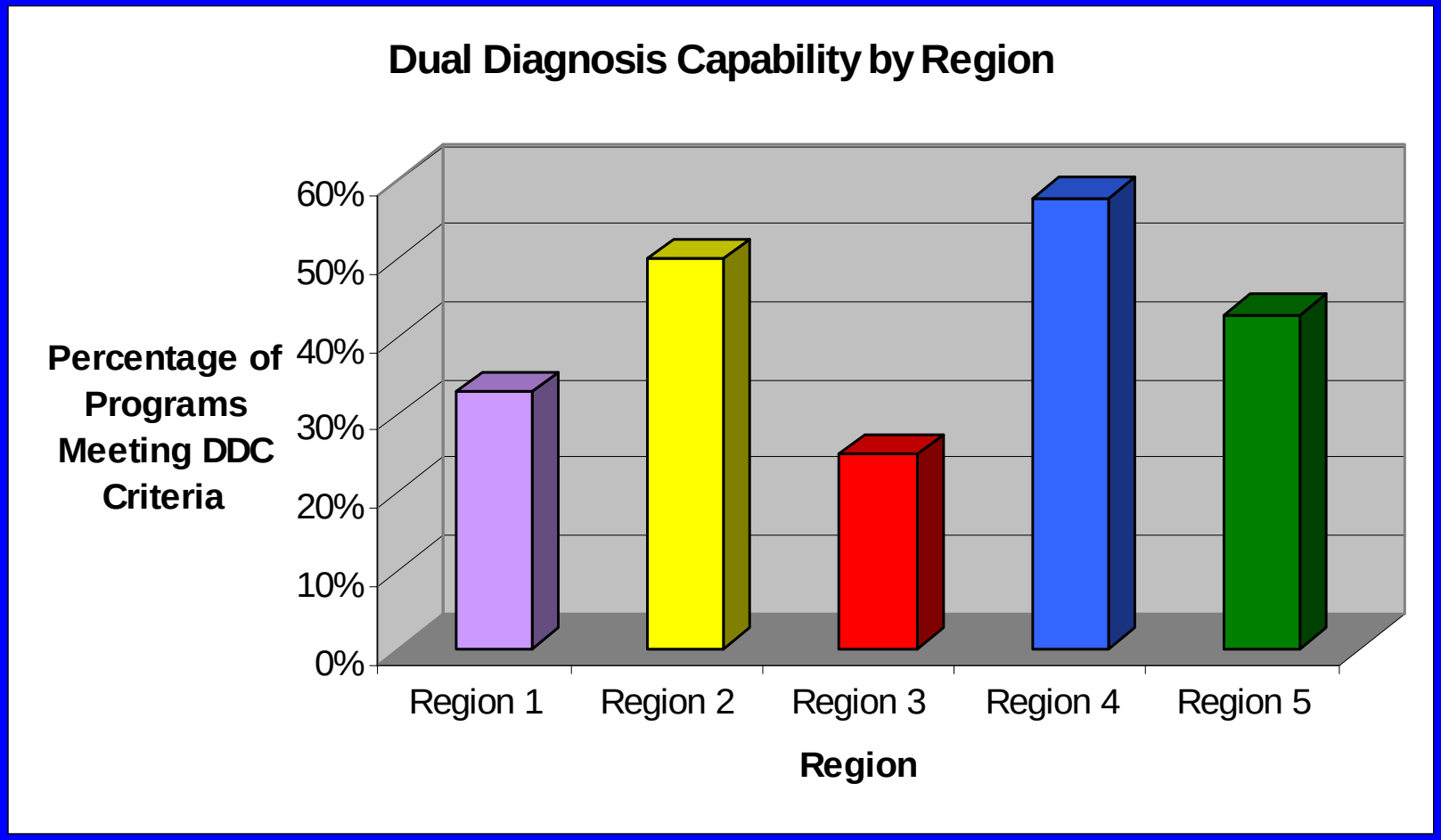


Results: Statewide Sample

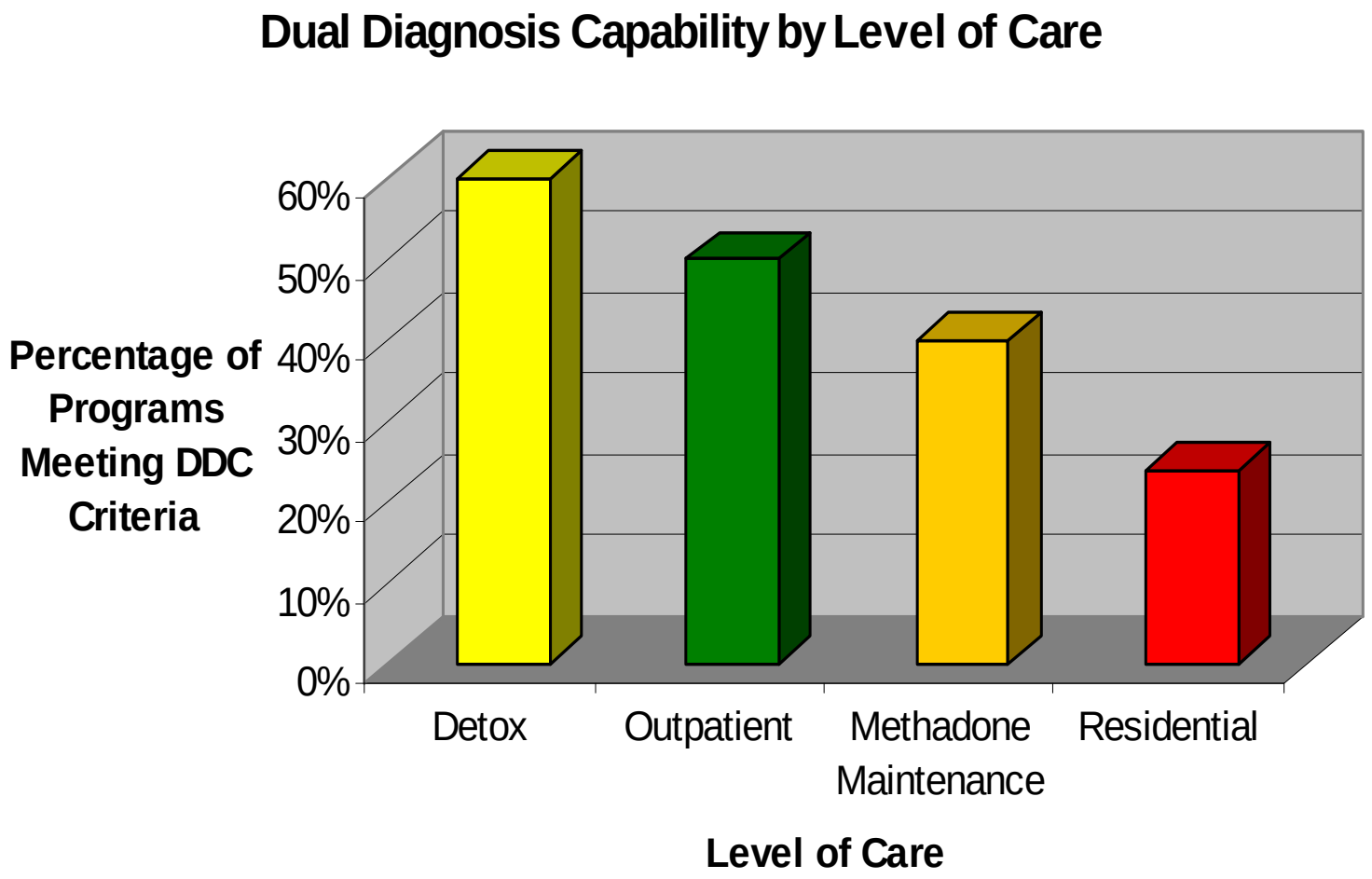
Dual diagnosis capability of programs(n=53):
AOS=31 (58.5%); DDC= 22 (41.5%)



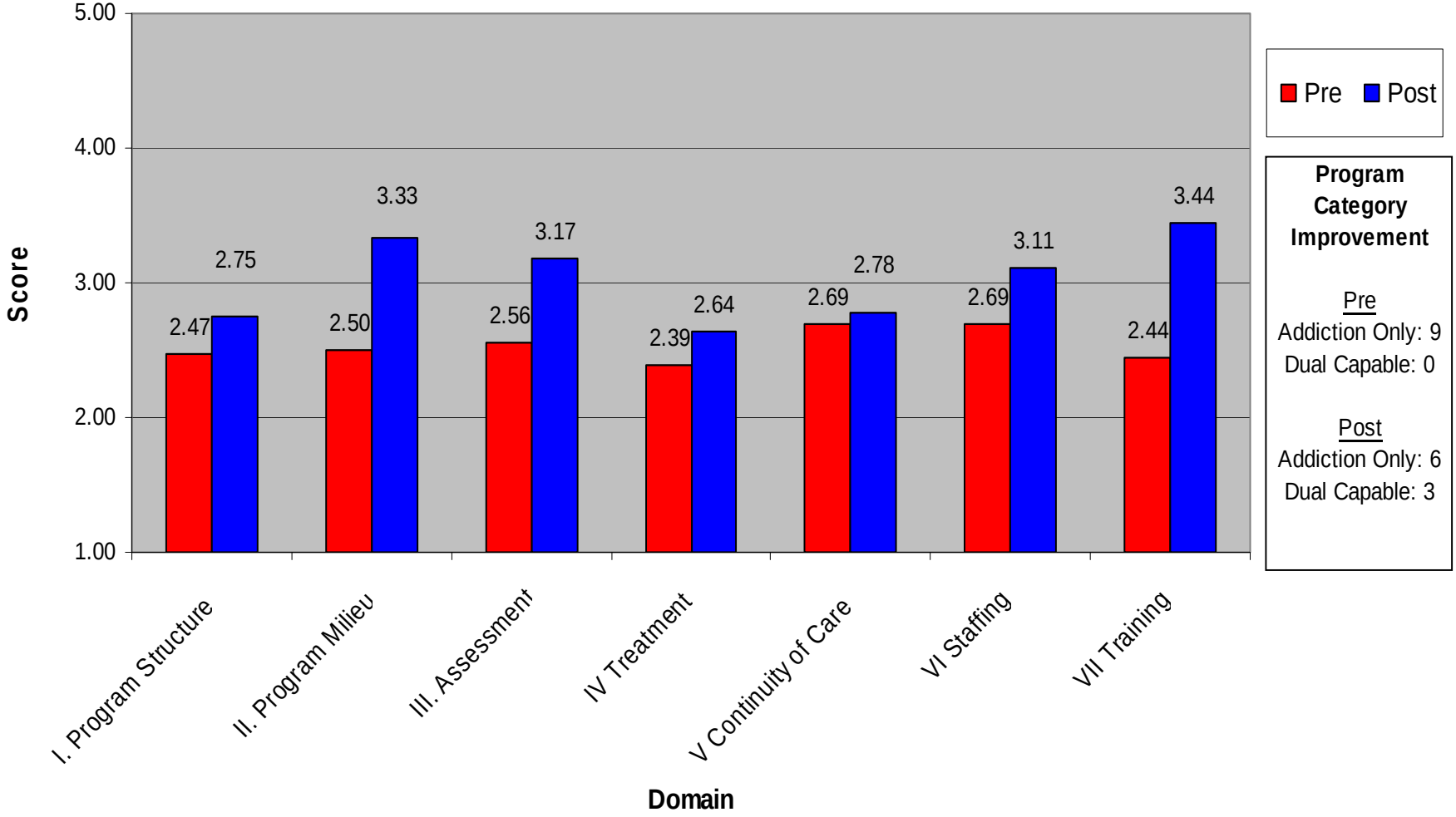
Results by Region



Results by Level of Care



Results for Collaborative Process



Next Steps: Systems/Practice

- Statewide sample of DDCAT assessments informed workforce development activities;
- DDCAT domains and items being used to develop the DMHAS Co-Occurring Enhanced Program Guidelines;
- These Guidelines are being implemented with Intensive Outpatient Programs, using a 25% rate increase incentive through CT's Access to Recovery Grant, and with residential treatment programs;
- Other levels of care and more programs may be targeted for further development using these Guidelines;
- Co-Occurring Capable Program Guidelines are being developed based on the DDCAT and may be used as the minimum standard of care.

Integrated Treatment Tools

- Practitioner level
  - Attitude Scales
  - EBP Scale
  - IDDT Knowledge Quiz
  - MI/CBT Checklists - observation, audiotapes
  - Stages of Change algorithms: matched interventions
  - COD Group Curricula

  - http://www.ct.gov/dmhas/cosig/integratedtreatmenttools

Aligning

- Fiscal Resources
  - 25% rate increase for COD enhanced IOPs (through CT Access to Recovery Program)
  - 2 New State-funded Co-Occurring Enhanced Residential Treatment Programs
  - Anticipated development of additional COD enhanced services

- Administrative Policies
  - ASO billing procedure adjustments

COD Data / Outcomes

- Outcomes - Measuring Inputs and Outputs
  - Fidelity to integrated service models
  - Screening results
  - Identifying people with COD using diagnoses, within existing management information systems (MIS)
  - Identifying outcomes for people with COD
    - Statewide and provider levels

The Focus

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

Co-Occurring Disorders Resources

- Co-Occurring Center for Excellence (COCE)

http://coce.samhsa.gov/

- Dartmouth Addiction Treatment Services Research

http://dms.dartmouth.edu/prc/dual/atsr/

- Ohio SAMI CCOE

http://www.ohiosamiccoe.case.edu/index.html

- SAMHSA Co-Occurring Disorders Website

http://www.samhsa.gov/Matrix/Matrix_cooc.aspx

Contact Information

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Co-Occurring Disorders Initiative
http://www.ct.gov/dmhas/cosig

Division of Forensic Services
http://www.ct.gov/DMHAS/cwp/view.asp?a=2900&q=334746