Update on Treating Persons with Co-Occurring Disorders in the Community

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Overview

- Prevalence of Co-Occurring Disorders
- Elements of a Comprehensive Assessment
- Models for Integrating Care
- Recent Innovations in Care
- Accessing Resources on the Web

What are Co-occurring Disorders?

A non-addictive mental disorder occurring simultaneously and independently with an addictive disorder

In early writing this combination was referred to having a ‘dual diagnosis’ – this term is still used, but it is acknowledged that persons often meet criteria for more than two diagnoses

Overview: Common Acronyms

- COD = Co-Occurring Disorders
- DDC = Dual Diagnosis Capable
- DDE = Dual Diagnosis Enhanced
- MH = Mental Health
- SA = Substance Abuse

Overview: Common Acronyms

- CCISC: Minkoff / Cline Model encouraging Comprehensive, Continuous, Integrated System of Care for Persons with COD
- ICOPSD = Individuals with Co-occurring Psychiatric and Substance Use Disorders
- MOU = Memorandum of Understanding
- SAMHSA = Federal Substance Abuse, Mental Health Services Administration

Overview: Common Acronyms

- COCE = Co-Occurring Center for Excellence / SAMHSA initiative
- CODI = Co-Occurring Disorders Initiative
- IDDT = Mueser et al. / Integrated Dual Disorders Treatment

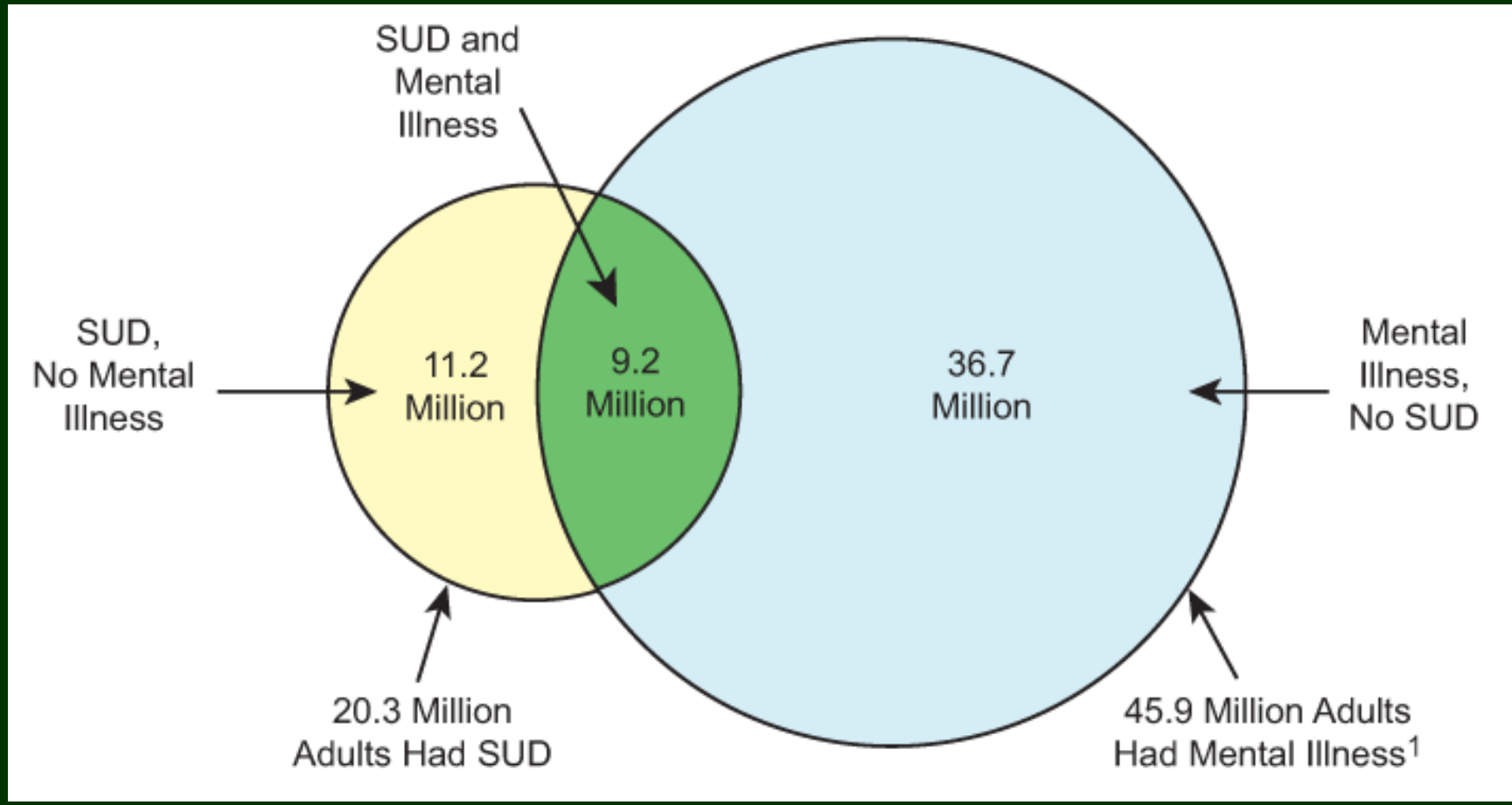
Studies Documenting Rates of Co-Occurring Disorders

- ECA
- NCS
- NLAES
- NCS-R
- NESARC

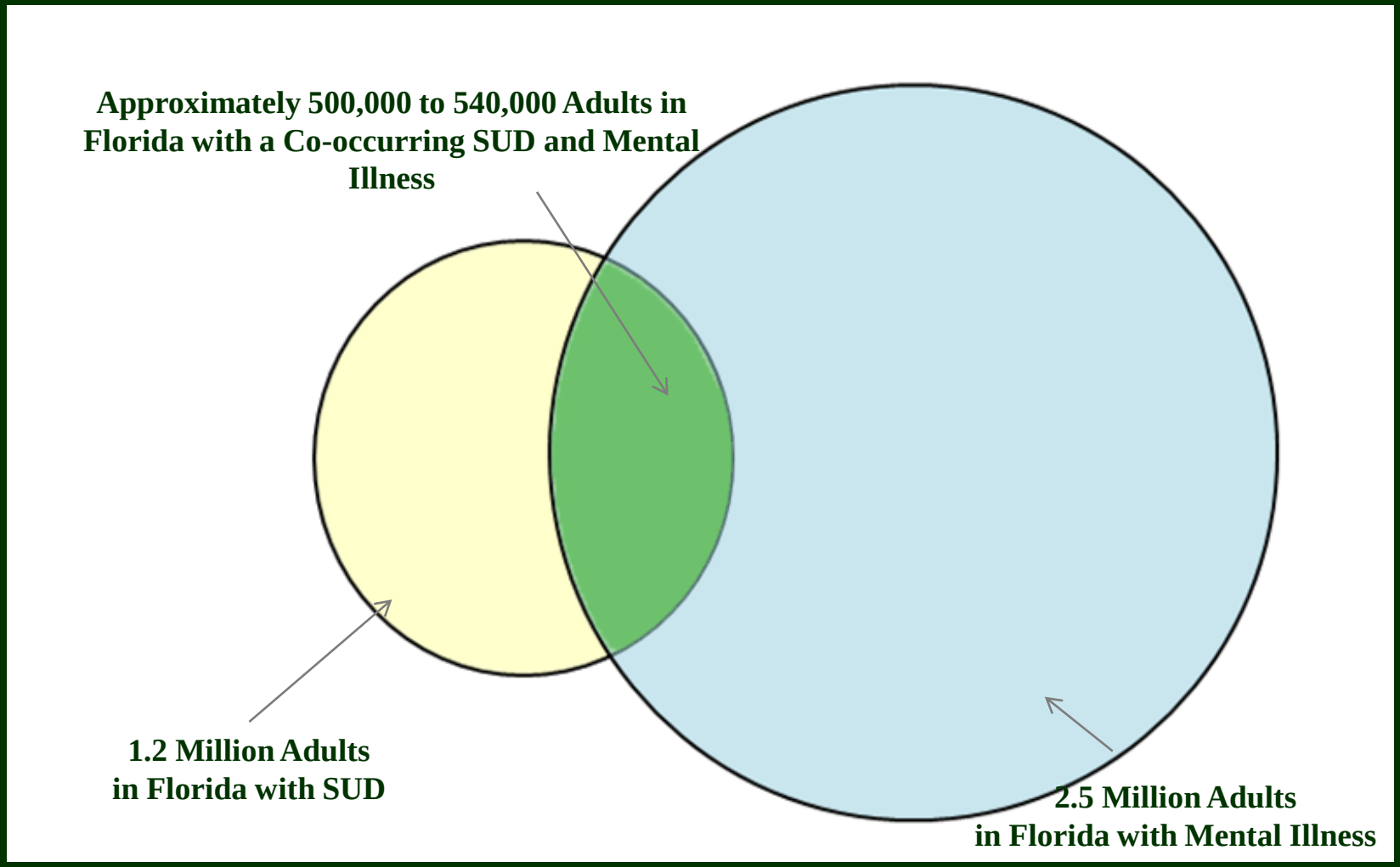
National Survey on Drug Use and Health (NSDUH)

- A representative sample of the civilian, noninstitutionalized population aged 12 or older
- Face-to-face, computer-assisted interviews
- NSDUH excludes:
  - Persons with no fixed household address (homeless people who do not use shelters)
  - Residents of institutional group quarters (correctional facilities, nursing homes, mental institutions, and long-term hospitals)

Past Year Substance Use Disorders (SUD) and Mental Illness Among Adults in the U.S. (2010)



Past Year Substance Use Disorders (SUD) and Mental Illness Among Adults in Florida (2008-2009)



Co-Occurring Disorders: Prevalence

- Literature Summary:
  - Samples drawn from clients in MH or SA settings in the 80s – 90s, found 20 – 50% of those in MH settings had a lifetime prevalence of SA disorders, and 50-75% of those in SA settings had a lifetime prevalence of MH disorders (COCE/ SAMHSA, 2007)

Co-Occurring Disorders: Prevalence

- Why focus on Epidemiological Data?
  - Keeps you ‘vigilant’ for persons who may need COD services
  - COCE concludes that there is a ‘high prevalence in all populations’ and that this expectation should be incorporated into all screening, assessment, and treatment related activities (Overview Paper #8; COCE/SAMHSA, 2007)

Co-Occurring Disorders: Prevalence

- National Co-Morbidity Survey (NCS):
  - 59% of those with other drug disorders at some point in their lifetime also had a history of at least one mental disorder
  - Of those with lifetime co-occurrence, 84% reported that their mental illness symptoms preceded their substance use disorder (Kessler et al., 1994)
  - For most, adolescence marks the onset of their primary MH disorder, with the SA disorders occurring 5-10 years later (Kessler, 2004)

Co-Occurring Disorders: Prevalence

- Prevalence of co-occurring disorders is even higher in public service systems (substance abuse treatment, mental health treatment, criminal justice, homeless shelters,etc.) than in general population

- Individuals with co-occurring disorders need to be thought of as the “expectation, not the exception” in such settings

Co-Occurring Disorders: Risk Factors

- Presence of a substance use disorder quadruples the risk of having a co-occurring mental disorder

- Presence of a mental disorder triples the risk of having a co-occurring substance use disorder (ECA study, 1980-84)

- Persons with any one substance use disorder have an increased risk for another substance disorder

What Explains Co-occurring Disorders?

Four General Models:

- Common Factors
- Secondary Psychiatric Disorder Models
- Secondary Substance Abuse Models
- Bidirectional Models

Common Factors

- While MH and SA runs in families, no clear genetic link between the categories of disorder could be established
- Other common factors could include comorbid ASP, low socioeconomic status, poor cognitive functioning
- Multivariate models also exist….family history of psychopathology, combined with inheritance of deviant personality traits could lead to both the development of Borderline PD and Substance Abuse

Secondary Psychiatric

- These models suggest the SA causes psychopathology
- Strongest relationship may be between unipolar depression and alcohol dependence

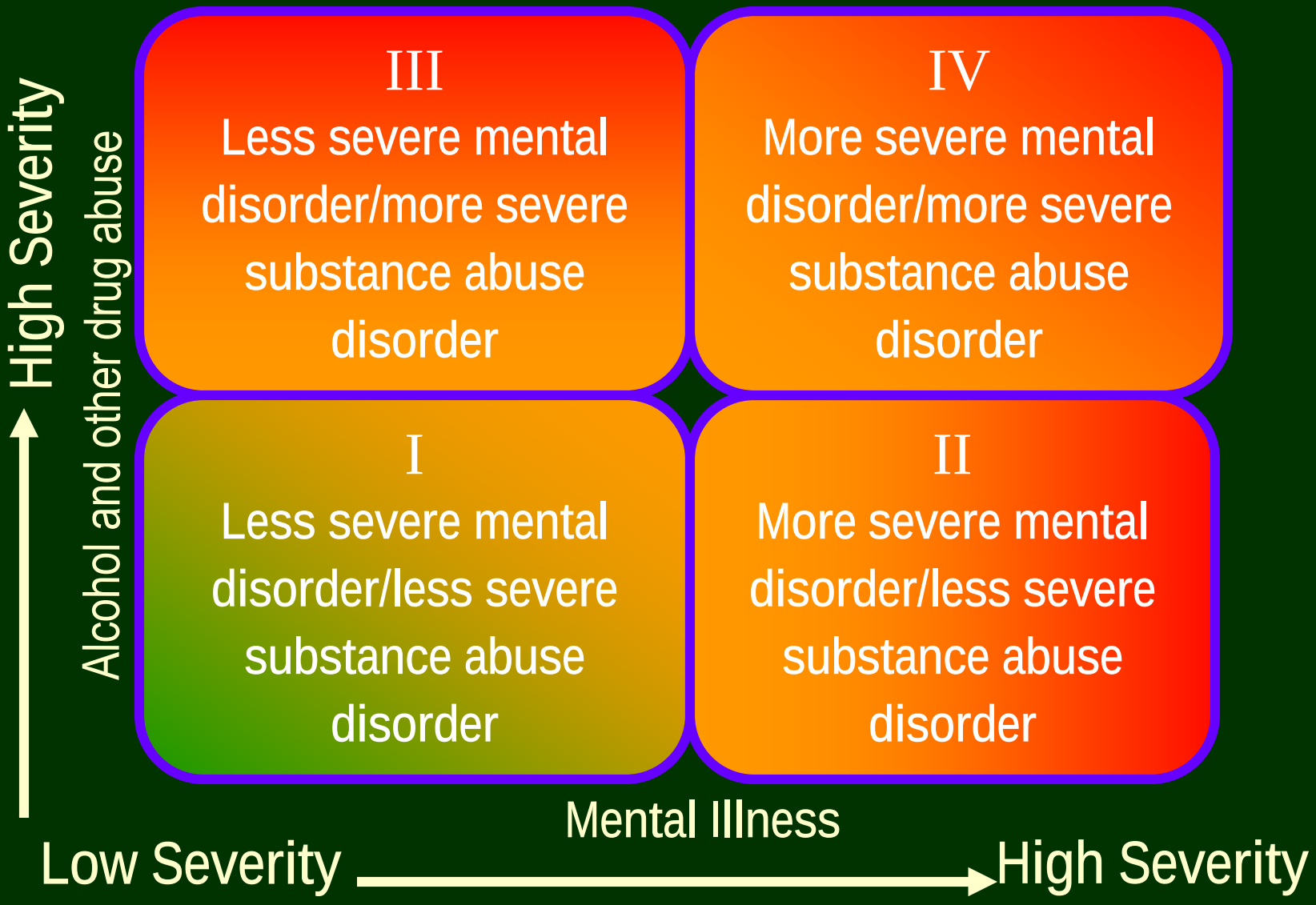
Secondary Substance Abuse

- Mental illness increase vulnerability to Substance Use disorders
- Self medication – is an example of this
- Age of onset, level of symptoms /level of use, subjective reasons for using, types of drugs chosen

Bi-directional Model

- This theory proposes that ongoing interactional effects account for increase rates of comorbidity

- Strongest body of evidence for this may be around anxiety and alcohol dependence



Adapted from Substance Abuse Treatment for Persons With Co-Occurring Disorders, TIP #42 (2005)

SAMHSA / CMHS:

Co-Occurring Disorders Panel (1997)
Chair – Ken Minkoff, MD

- Welcoming
- Accessible
- Integrated
- Continuous
- Comprehensive
- Consumer / Family Oriented

SAMHSA / CMHS: Co-Occurring Disorders Panel (1997)

Philosophy of Service:

- Comorbidity is the Expectation
- Both disorders are considered as primary
- Both are chronic relapsing illnesses
- Acknowledge that readiness will vary
- Need treatment to be lead by ‘integrated’ staff
- Need to have continuous relationship with providers

Challenges in Addressing CODs

- At risk for relapse
- Often have Criminal Justice Involvement
- Housing needs
- Transportation needs
- Family reunification
- Need a continuum of care
- Job skills deficits
- Educational deficits
- Face stigma related to their criminal history, SA and MH disorders
- Scarce prevention and treatment resources – most are not ‘integrated’

Systemic or Organizational Variables that Impact Who May be Served

- "Priority" Populations
- Primary Diagnosis
- Assessment Skills / Capacity
- Staffing Patterns / Job Classifications
- Access to Psychotropic Medications
- Capacity for Longitudinal Care

Where to Begin?

Many Agencies Start with Improved Assessments.

Twelve Steps in the Assessment Process (from SAMHSA's TIP42)

- **Identify collaterals**
  - May be unwilling or unable to report their history accurately, obviously must be done with permission

- **Screen for COD**
  - Safety issues related to acute intoxication and withdrawal
  - Present and past SU, related problems and disorders
  - Screen for MH safety issues (suicidality, violence, self-care, risk behaviors for HIV, Hep C or victimization)
  - Past and present MH disorders
  - Cognitive / Learning Deficits
  - Past and present victimization and trauma

- **Determine Quadrant**
  - Quad I: Less severe MH and SA; Quad IV: More severe MH and SU disorders
  - Severity of mental disorders are typically determined by diagnosis, severity of disability and duration of disability (6 mos+)
  - Substance Abuse clinicians should be familiar with what criteria eligibility is established to be a MH ‘priority’ client, may be eligible for services
  - Severity may be determined by using ASAM PPC-2R Dimension 3 or LOCUS
- **Level of care**
  - ASAM ranges from ‘1. Acute intoxication’ to ‘6. Recovery’
  - MH rated on Dimension 3. -- covering five areas – suicide potential, interference with addiction recovery efforts, social functioning, ability for self care, and course of illness

- **Diagnosis**
  - Determine history of past or current treatment of MH disorder; existing stabilizing treatments should be maintained; should accept this diagnosis presumptively, confirming with collaterals; most important is to tie symptoms to specific life periods
  - Can use M.I.N.I. Plus, Timeline Follow Back, or SCID
  - Can use outlines of common DSM-IV disorders and inquire whether the symptoms were ever met, how treated, and success

- **Disabilities and Impairments**
  - Cognitive capacities, social skills, need for special education

- Disabilities and Impairments
  - Capable of living independently?
  - Capable of supporting self financially?
  - Can engage in social relationships? Has social supports?
  - Level of intelligence? Memory impairments, learning disabilities, limited ability to read, write, understand? Problems with concentration, completing tasks?
  - Ability to use transportation, budgeting, self-care, ability to participate in treatment

- Strengths and supports
  - Current strengths, skills, support in relation to managing their disorders
  - May focus on talents or interests, vocational skills, creative self expression
  - Areas connected to motivation for change
  - Important relationships, family or treatment staff
  - Previous treatment successes, what has worked?
  - Current successful attempts to manage symptoms

- Cultural and linguistic needs
  - Not substantially different for the COD population but should consider
    - Fit in the treatment culture, conflicts in treatment
    - Cultural / linguistic service barriers
    - Literacy

- Problem Domains
  - Medical, legal, social, vocational, family, social that impact treatment engagement and outcomes; ASI does this
  - Identify contingencies that promote treatment adherence

- Stage of Change
  - Interventions must be matched to stage of change
    - No problem / interest in change (precontemplation)
    - Might have a problem, may consider some change (contemplation)
    - Definitely believes they have a problem; getting ready to change (preparation)
    - Working on changing actively, though perhaps slowly (action)
    - Achieved stability in this area – trying to maintain status (maintenance)
    - Measures include SOCRATES, URICA
    - SATS is a case manager rated scale determining engagement in treatment (eight categories); covered in TIP 35

- Plan Treatment
  - Treatment placement should be matched to the needs of the individual client
  - Concept of dual primary treatment
  - Focus is on integrated treatment planning,where intervention choices for each disorder are matched
  - Must take into account impact of other disorder on ability to comply with recommendations

What Are Evidence-Based Practices?

(from the SAMHSA toolkit)

- Services that have consistently demonstrated their *effectiveness* in helping people with mental illnesses achieve their desired goals

- Effectiveness was established by different people who conducted rigorous studies and obtained similar outcomes

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Examples of Evidence-Based Practices

(from the SAMHSA toolkit)

- Integrated Treatment for Co-Occurring Disorders
- Supported Employment
- Assertive Community Treatment
- Family Psychoeducation
- Illness Management and Recovery

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What Is Integrated Treatment for Co-Occurring Disorders? *(from the SAMHSA toolkit)*

- Integrated Treatment is a research-proven model of treatment for people with serious mental illnesses and co-occurring substance use disorders

- Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery

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Practice Principles for Integrated Treatment for Co-Occurring Disorders *(from the SAMHSA toolkit)*

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders
- Integrated treatment specialists are trained to treat both substance use and serious mental illnesses
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage

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Practice Principles for Integrated Treatment for Co-Occurring Disorders

- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages

- **Multiple formats for services are available, including individual, group, self-help, and family**

- **Medication services are integrated and coordinated with psychosocial services**

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Treatment is Integrated

- Mental health and substance abuse treatment are evaluated and addressed
  - Same team
  - Same location
  - Same time

- Treatment targets the individual needs of people with co-occurring disorders and is integrated on organizational and clinical levels

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Treatment is in a Stage-Wise Fashion (from the SAMHSA toolkit)

Precontemplation — Engagement

•Assertive outreach, practical help (housing, entitlements, other), and an introduction to individual, family, group, and self-help treatment formats

Contemplation and Preparation — Persuasion

•Education, goal setting, and building awareness of problem through motivational counseling

Action — Active treatment

Counseling and treatment based on cognitive-behavioral techniques, skills training, and support from families and self-help groups

Maintenance — Relapse prevention

Continued counseling and treatment based on relapse prevention techniques, skill building, and ongoing support to promote recovery

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Integrated Treatment Recovery Model

(*from the SAMHSA toolkit*)

- Hope is critical
- Services and treatment goals are consumer-driven
- Unconditional respect and compassion for consumers is essential
- Integrated treatment specialists are responsible for engaging consumers and supporting their recovery

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Integrated Treatment Recovery Model

(from the SAMHSA toolkit)

- Focus on consumers' goals and functioning, not on adhering to treatment

- Consumer choice, shared decision making, and consumer/family education are important

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Integrated Treatment Recovery Model

(from Drake et al., 2001 / SAMHSA toolkit)

Integrated treatment is associated with the following positive outcomes:

- Reduced substance use
- Improvement in psychiatric symptoms and functioning
- Fewer arrests
- Improved quality of life
- Increased housing stability

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Moving Toward Integrated Treatment (from SAMHS /COCE):

- **Integrated treatment refers broadly to any mechanism by which treatment interventions for COD are combined within the context of a primary treatment or service setting.**

- **Integrated treatment is a means of coordinating substance abuse and mental health interventions to treat the whole person more effectively.**

Why Integrated Treatment?

- Traditional, non-integrated approaches result in poorer outcomes (no treatment / sequential / parallel)

- An integrated, multidisciplinary approach is needed:
  - To achieve client retention and reduce burden
  - Focus is on person in a holistic sense

- Communities increasingly recognize that a large proportion of those served have co-occurring disorders – Integrating care is a path to better service and greater effectiveness / improved outcomes

Why Traditional MH Programs are not Effective for Persons with CODs

- **Unaddressed and ongoing SA interferes** with individuals' ability to follow MH treatment recommendations
- Active substance use **interferes with effectiveness** of MH treatment (i.e., medications, etc.)
- MH treatment may not focus on **changing substance use** and other maladaptive behaviors

Why Traditional SA Programs are not Effective for Persons with CODs

- **Absence of accurate MH diagnosis** prevents effective treatment
- **Cognitive impairment** detracts from understanding and processing information
- **Confrontational approaches** used in SA treatment are not well tolerated
- **Frustration and dropout** may result from requirements of abstinence

What does it mean to become Dual Diagnosis Capable?

Considered an ‘evolving concept’ (Minkoff & Cline, 2006) in which all agencies and programs that serve persons with MH or SA disorders develop a core capacity to provide appropriate services to persons with co-occurring disorders.

History of DDC and DDE

- In 2001, American Society of Addiction Medicine in the "Patient Placement Criteria" (ASAM PPC-2R) described programs that sought to address co-occurring disorders

- They described Dual Diagnosis Capable (DDC) programs as those that

  – Address CODs across policies, procedures, assessment, treatment planning, program content
  – Employ staff that are able to address CODs in the context of their recovery environment, addressing readiness to change and in the teaching of relapse skills

What does it mean to become Dual Diagnosis Capable?

This ‘capacity’ is achieved through modifying elements of infrastructure including

- Policies and procedures
- Clinical practices and standards
- Clinician competencies and expectations

What does it mean to become Dual Diagnosis Capable?

Developing this capacity is intended to better serve those clients who are

→ *Already being served in community settings*

What does it mean to become Dual Diagnosis Enhanced?

As its name indicates….

- This is an enhanced capacity of programs to deliver (even) more integrated treatment to persons with (even) more specialized needs (Minkoff & Cline, 2006)
- *Generally speaking – you have to get to DDC to get to DDE in your organization*

What does it mean to become Dual Diagnosis Capable Clinician?

- Chris Cline (2005) describes it this way….”you are able to provide what you are licensed or trained to provide to people who have co-occurring disorders, and that you are able to provide treatment in an appropriate way”.

What does it mean to become Dual Diagnosis Capable Clinician?

- Further…..” you should be able to identify who has COD, to know how to get them the help that they need, to be able to advocate for them when needed and to know how to help them achieve a stable dual recovery.”

History of DDC and DDE

Dual Diagnosis Enhanced (DDE) Programs are described as those that

- in addition to their DDC capability, are able to work with persons who are “more symptomatic and or functionally impaired as a result of their co-occurring mental disorder”

History of DDC and DDE

- As originally conceptualized – DDC and DDE designations described modifications to substance abuse treatment programs
- This conceptualization has broadened over the past decade

Planning for DDC and DDE Programs

- When thinking about all service delivery within a system you will need to
  - Routinely deliver DDC services across your service array
  - Offer some DDE service components

Planning for DDC and DDE Programs

- The premise of ‘all versus some’ (DDC v. DDE) relies on the proportional severity of the client population served
- Persons with Mild to Moderate symptoms of the ‘other’ category of disorder are able to be routinely served within DDC
- DDE programs serve persons who are “more symptomatic and or functionally impaired as a result of their co-occurring mental disorder”
- So, public MH and SA systems have to clearly evaluate who they are serving

Planning for DDC and DDE Programs

- Across the country – programs are working on the incorporation of DDC services within their administrative and clinical infrastructure
- Now many are beginning to work on what DDE services will look like within their service system

Planning for DDC and DDE Programs

- The premise has been that the DDC programs can be created within ‘base funding and base staffing’ (Minkoff, 2008)
- DDE programs – are considered by many ‘implementers’ as requiring
  - Additional funding
  - More highly trained staff
  - ….but not all agree with this conceptualization

Planning for DDC and DDE Programs

- DDE-CD programs should be designed to serve
  - Clients with moderate to severe active psychiatric symptomatology
  - Or ‘baseline psychiatric disability’
  - At any level of care (Minkoff, 2008)

Planning for DDC and DDE Programs

DDE Programs: Implications for Service Delivery

- Greater on-site access to MH / SA expertise
- More program modifications
- Smaller groups

Planning for DDC and DDE Programs

DDC programs may

- Can often accommodate the occasional individual who has higher needs
- But cannot be expected to ‘manage a full cohort of such clients without the full range of accommodations mentioned’ (Minkoff, 2008)

Planning for DDC and DDE Programs

Creating DDE programs

- Isn’t solely about hiring more staff
- Hiring more highly trained staff

Creating DDE Programs

- Programs must be designed ‘at every level’ to match the ‘functional needs’ of individuals that have greater impairment

Creating DDE Programs

- Generally, the program content between DDC and DDE programs will be fairly similar
  - Addiction treatment groups
  - MH symptom management
  - Skill building courses

Creating DDE Programs

- Higher staff ratios are focused on
  - Providing greater structure
  - Providing greater support
  - More frequent contacts and monitoring

Planning for DDC and DDE Programs

DDE – MH Programs

- Likely will involve staff with addiction backgrounds, but this is not sufficient
- Built on a DDC-MH paradigm
- Focused on the integration of addiction treatment content within the MH program

Distinction between DDC and DDE

- May be clearer between DDC and DDE programs when the content of a program is highly structured
- Will be less clear when looking at programs like ACT
- ACT programs that are DDE – likely will be focused more exclusively on the severely impaired COD population
- Not a ‘linear continuum’ in which DDC is the ‘halfway mark’ to DDE

Innovations in Service Delivery

Dartmouth DDC / DDE Conceptualization

(DDCAT / DDCMHT / Mark McGovern and colleauges)

Innovations in Service Delivery

DDCAT / DDCMHT / Mark McGovern and colleauges)

Program Structure

- Focus is on CODs
- Licensure / Certification for both Categories
- Billing is done for both
- Most services are ‘integrated’

Program Milieu

- Clinicians treat both disorders – and document it
- Literature discusses the COD interactions

Innovations in Service Delivery

Assessment

- Standardized, valid instruments evaluate both categories of disorder
- Clear diagnoses of both are made and documented
- Chronology of both categories is documented
- Moderate to severe acuity in disorders are admitted to program
- Motivation for treatment of both disorders is evaluated and documented

Innovations in Service Delivery

Treatment

- Both disorders are considered primary
- Changing motivation for each category of disorder are evaluated
- Stage-wise interventions are delivered for both
- Full access to medication prescribers and they are members of the treatment team
- Specific content on comorbidities is incorporated
- Clients are treated and maintained within the same program, unless acute service is warranted
- Evidence-based practices are incorporated

Innovations in Service Delivery

Continuity of Care

- Plan includes ongoing, indefinite treatment for both categories of disorder
- Focus is on both mental health illness management and addiction recovery

Innovations in Service Delivery

Staffing

- Equivalent / balanced representation of staff from both disciplines
- Clinical supervision / case reviews / utilization reviews are focused on CODs

Training

- Training plan explicitly addresses cross training
- Almost all are crossed trained, and have had advanced specialized training

Elements of Change

- Clinical
  - Changes in Terminology
  - Administrative policies
  - Admission Criteria
  - Record Keeping
  - Screening and Assessment
  - Treatment Engagement
  - Treatment Content
  - Adoption of Evidence-based Practices
  - Workforce Buy-in and Training

Elements of Change

- Systemic or Infrastructure
  - Licensure and Certification
  - Funding
  - Oversight and Monitoring
  - Administrative Integration

Addressing the Whole Person

- Essential Service System Components
- Other Essential Services

Essential Service System Components

- Outreach and Engagement
- Housing with Supports
- Intensive Case Management
- Integrated Treatment for CODs
- Focus on Stages of Change
- Modified Therapeutic Communities
- Active Consumer Involvement
- Prevention – in all things

Other Essential Services

- Integration / Focus on Primary Health Care
- Comprehensive, Timely Service Access (MH / SA)
- Income Support and Entitlement Assistance
- Focus on Employment (Skills / Support / Training)
- Specialized Trauma Services / Focus

NREPP – National Registry of Evidence-based Programs and Practices

- 26 interventions are identified as having a focus on co-occurring disorders (Nov ‘12) and have undergone experimental evaluation

http://www.nrepp.samhsa.gov/AdvancedSearch.aspx

NREPP – National Registry of Evidence-based Programs and Practices

Adolescents

- Adolescent Community Reinforcement Approach
- Multidimensional Family Therapy
- Family Behavior Therapy

NREPP – National Registry of Evidence-based Programs and Practices

Adults

- Modified Therapeutic Community for Persons with Co-Occurring Disorders
- Seeking Safety
- Dialectical Behavior Therapy

Features of Successful Change Processes

- Buy-in and engaged participation at high levels of organizations
- Early engagement of direct care staff
- Dedicated ‘change agent’ assigned full time to move initiative forward
- Development of Consensus vote and strategic plan
- System level orientation

Resources

- SAMHSA
  - Integrated Treatment for Co-occurring Disorders Evidence-based Practice Toolkit
    - www.samhsa.gov/co-occurring
    - http://store.samhsa.gov/product/SMA08-4367
    - http://store.samhsa.gov/shin/content//SMA08-4367/TheEvidence-ITC.pdf

Resources: SAMHSA's TIP 42

Chapter 1—Introduction

Chapter 2—Definitions, Terms, and Classification Systems

Chapter 3—Keys to Successful Programming

Chapter 4—Assessment

Chapter 5—Strategies for Working With Clients With CODs

Chapter 6—Traditional Settings and Models

Chapter 7—Special Settings and Special Populations

Chapter 8—A Brief Overview of Specific Mental Disorders

Chapter 9—Substance Induced Disorders

http://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA12-3992

Resources

Assessment Resources

- SAMHSA TIP 42

Training and Informational Resources

- COD training modules: www.fmhi.usf.edu follow the links for web-based training on co-occurring disorders
- Ken Minkoff's Website: www.kenminkoff.com