

Florida Department of Children and Families Policy Paper on Co-occurring Mental Health and Substance Abuse Disorders



Jeb Bush, Governor

Jerry Regier, Secretary

LETTER FROM THE DIRECTORS

In its endeavor to treat the whole person and ensure the comprehensiveness and continuity of services to the people we serve, the Substance Abuse and Mental Health Program Offices of the Florida Department of Children and Families (DCF) are taking the initiative to improve the system of care for people with co-occurring mental health and substance abuse disorders. The goal is to foster a framework that is coordinated, integrated, and supportive to prevent a person from falling through the cracks of separate "parallel" systems of care. This document is an important step towards achieving this goal of a coordinated and integrated policy framework because both the Mental Health and Substance Abuse Programs are identifying joint issues, system goals and outcomes, and recommendations to implement the necessary action steps. Also, it identifies critical strategic action steps necessary to implement its vision of how the service delivery system should be organized in order to provide high quality, evidence-based services to the co-occurring disorders population in Florida. Most importantly, it draws on the research literature and the experience of other states and national experts.

The growing need for more effective treatment for those with co-occurring disorders prompt a rethinking of the current "parallel" systems. Therefore, this policy paper searched for and incorporated input from a diverse group of key stakeholders in Florida including trade associations, consumers and their family members, and advocacy groups. Several research findings underscored the importance of restructuring Florida's substance abuse and mental health systems of care including:

š At least 10 million people in the U.S. have co-occurring substance abuse and mental health disorders.

Š Up to 65.5% of those with a substance dependence disorder had at least one mental disorder and 51% of those with a mental disorder had at least one substance dependence disorder.

Š The majority of people with co-occurring disorders typically receive treatment that only addresses one type of disorder which has been found to be less effective than integrated treatment of both types of disorders at the same time in the same setting.

Š Individuals with co-occurring disorders typically have multiple co-occurring disorders and problems, and as a group have high rates of physical illness, death, unemployment, homelessness, and criminal justice involvement that often lead to greater costs for public services.

Š Clients with co-occurring disorders are more likely to drop out of outpatient mental health and substance abuse treatment programs and have poorer outcomes in these systems than clients with a single type of disorder. They are often high users of expensive hospital and inpatient services due to the severity of their disorders and the frequency of their crises that leads to increase public costs. It is our hope that the Florida Department of Children and Families' Policy Paper on Co-occurring Mental Health and Substance Abuse Disorders is used as an impetus to carry out the suggested strategic action steps and promote continued cooperation among all stakeholders towards an improved service delivery system to those with co-occurring disorders. We pledge our leadership to advance this important work.

Sincerely,

Kenneth A. DeCerchio, MSW, CAP Director Substance Abuse Program Celeste Putnam, MS Director Mental Health Program

Acknowledgement

The authors would like to thank the joint Workgroup on Co-occurring Disorders of the Florida Alcohol and Drug Abuse Association (FADAA) and the Florida Council on Community Mental Health (FCCMH) for reviewing the document and offering their useful suggestions, especially the following individuals: Mark Engelhardt of the Louis de la Parte Florida Mental Health Institute/University of South Florida; John Daigle, Executive Director of the Florida Alcohol and Drug Abuse Association; Randy Wilcox and Karen Koch of the Florida Council on Community Mental Health; Mary Ruiz, CEO of Manatee Glens and Chair of the Workgroup, and Deborah Orr of the Center for Drug Free Living. We would also like to thank Phil Emenheiser of the DCF Substance Abuse

Table of Contents

Purpose	1
Background	1

The National Perspective on

Florida Department of Children and Families (DCF) Policy Paper on Co-occurring Mental Health and Substance Abuse Disorders

GUIDING QUESTION: "If I were an individual with co-occurring mental health and substance abuse disorders in Florida, what type of service delivery system would best meet my needs?"

PURPOSE

The overall purpose of this initiative is to achieve the following goal: to better serve persons with co-occurring mental health and substance abuse disorders so that they can continue to recover and achieve satisfying, productive lives. This document is an important step towards achieving this goal because it provides a coordinated and integrated policy framework, as well as a strategic vision, for the Mental Health and Substance Abuse Programs of the Florida Department of Children and Families (DCF) to implement the necessary action steps towards achieving this goal. Both the Substance Abuse and Mental Health Programs of DCF are in the process of identifying joint issues, system goals and outcomes, and recommendations focused on improving services for individuals with co-occurring disorders. This policy paper includes input from a diverse group of key stakeholders in Florida, with a focus on consensus development. These stakeholders include trade associations such as the Florida Alcohol and Drug Abuse Association (FADAA), the Florida Council of Community Mental Health, consumers and family members of consumers, and advocacy groups such as the Florida branch of the National Alliance for the Mentally III (NAMI). This paper identifies critical strategic action steps necessary to implement our vision of how the service delivery system should be organized in order to provide high quality, evidence-based services to the cooccurring disorders population in Florida. This paper also draws on the research literature and the experience of other states and national experts in developing high guality, evidence-based services for individuals with co-occurring disorders.

BACKGROUND

Why is the co-occurring disorders¹ population important and why does the service system for this population need to be restructured?

- S At least 10 million people in the U.S. have co-occurring substance abuse and mental health disorders (SAMHSA, 1997). This group is defined as individuals with at least one substance use disorder in the presence of at least one Axis I major mental disorder, such as major depression, bipolar disorder, and schizophrenia (Matthews, 2001).
- S The best study to date documenting the extent of co-occurring disorders (the National Co-Morbidity Survey; Kessler et al., 1994) substantiates the need for restructuring. The study found that, among a representative national sample of community respondents, up to 65.5% of those with a substance dependence disorder had at least one mental disorder, and 51% of those with a mental disorder had at least one substance

¹ Note: The term "co-occurring disorders" is used here instead of the terms "dual diagnosis" or "dual disorders" because people in this population often have more than two disorders.

dependence disorder. These percentages tend to be even higher in clinical treatment settings, especially in public mental health and substance abuse treatment settings.

- š Such statistics have led a number of experts to declare that **clients with co-occurring disorders should be the "expectation, not the exception,"** for treatment providers in the public substance abuse and mental health treatment systems (Matthews, 2001).
- S The majority of people with co-occurring disorders receive no treatment (SAMHSA, 1997). Treatment that is received typically only addresses one type of disorder, which has been found to be less effective than integrated treatment of both types of disorders at the same time in the same setting. Successful and cost effective treatment for these complicated conditions must be continuous, comprehensive, integrated and individually tailored to meet the consumer's changing needs and motivation (Minkoff, 2000).
- S Individuals with co-occurring disorders typically have multiple co-occurring disorders and problems, and as a group have high rates of physical illness, death, unemployment, homelessness, and criminal justice involvement, which often lead to greater costs for public services (Matthews, 2001). Post-traumatic stress disorder (PTSD), often from previous or ongoing physical and/or sexual abuse, also tends to be a problem for this group of people, especially among females (NASMHPD/NASADAD, 1998).
- S While clients with co-occurring disorders are more likely to drop out of outpatient mental health and substance abuse treatment programs and have poorer outcomes in these systems than clients with a single type of disorder, they are often high users of expensive hospital and inpatient services due to the severity of their disorders and the frequency of their crises, **leading to increased public costs** (Matthews, 2001). More effective and cost-effective strategies focused on continuity of treatment in community settings have been developed and need to be made more widely available.
- S Additionally, many substance abuse and mental health programs use criteria that exclude people with co-occurring disorders from their programs. Such exclusions lead to people "falling through the cracks" caused by service gaps, or being sent back and forth between the mental health and substance abuse systems. These types of system problems contribute to poor outcomes and higher rates of repeatedly cycling through higher-cost services, including arrest, incarceration and emergency admissions to hospitals, crisis stabilization units and detoxification units, none of which are effective long-term solutions for keeping this population stable and functional in the community (Matthews, 2001).
- S The public mental health and substance abuse service systems are typically separate in most states, have little cross-training for staff, and limited availability of integrated treatment for co-occurring disorders (Matthews, 2001). Substance abuse and mental health treatment systems typically have different philosophies, administrative structures, and funding mechanisms. This level of separation prevents consumers and providers from moving easily among service settings. Such barriers are a crucial deficit, because the

primary cause of relapse into mental illness is untreated substance abuse, and the primary cause of relapse into substance abuse is untreated mental illness (SAMHSA 1997). Clearly, the co-occurring disorders population needs to be a priority for both public health and economic reasons, as many agencies are beginning to recognize (Matthews, 2001).

š The Connection Between Addictive and Mental Disorders

People with mental disorders are typically much more susceptible to the negative effects of substance abuse. Even using a small amount of drugs or alcohol can rapidly destabilize someone who has a mental illness and make their symptoms much worse. Additionally, when someone has a mental disorder, that can also make it more difficult for them to maintain abstinence or comply with treatment due to associated cognitive impairments. Such impairments associated with mental disorders include increased confusion, impaired judgment, impulse problems, memory problems, limited attention span or problems concentrating, and difficulty planning ahead. In addition to making mental disorders worse, substance abuse and withdrawal can also mimic or induce symptoms of mental disorders (Matthews, 2001).

THE NATIONAL PERSPECTIVE ON CO-OCCURRING DISORDERS

Over the last ten years, the concept of integrated service provision for individuals with cooccurring mental and substance use disorders has been gaining increasing support at the national level as evidenced by the following initiatives:

- š In June of 1998, a panel consisting of state mental health and substance abuse commissioners, alcohol and drug abuse directors, experts in the field of mental health and substance abuse, and federal officials met for the National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders. This panel was sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). It was also supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and two of its centers - the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT). Through a collective effort the panel published a comprehensive report that not only defined the population and barriers to care, but also outlined and described a model conceptual framework for a comprehensive system of care (NASMHPD/NASADAD, 1998). This system of care is based on three forms of service coordination: (1) consultation, (2) collaboration and (3) integration. In addition, the framework for the system of care is based on the four-quadrant model that classifies individuals with co-occurring disorders based on high or low severity of mental disorders and substance use disorders. The report also outlined desirable system characteristics and recommendations for the future at both the national and state levels.
- š In June of 1999denced by the feors, ex

and su09 NASADAD, 1998). This system of 0.00

National Dialogue. This meeting, co-sponsored by NASMHPD and NASADAD, was also supported by CMHS and CSAT and included representatives from the National Association for County Behavioral Health Directors (NACBHD) and the National Council for Community Behavioral Healthcare (NCCBH). One outcome of this second National Dialogue resulted in publication of **Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders**. This document not only supports the original conceptual framework but also highlights financial solutions in implementation of quality services for co-occurring disorders. This paper also outlines general marketing principles and specific recommendations to push the national agenda forward.

S In February of 1999, SAMHSA developed the SAMHSA Position Statement on Use of Substance Abuse Prevention and Treatment Block Grants (SAPTBG) and Community Mental Health Services Block Grant (CMHSBG) Funds to Treat People with Co-Occurring Disorders. In sum, this paper stated that <u>SAPTBG and CMHSBG</u> funds can be used to treat individuals with co-occurring disorders in a variety of treatment

- š Develop common performance measures and methods for data collection, including integrated data systems.
- š Develop funding streams that may permit the most effective response to consumers and that will allow providers to be reimbursed.
- š Develop and implement integrated treatment models for individuals with co-occurring disorders in both the mental health and substance abuse service systems.

During the 2001 session, the Florida legislature passed SB 1258 (Chapter 2001-191, Laws of Florida). This legislation provided several additional initiatives that relate to co-occurring disorders, and which are included in the 2002 update to the State Mental Health and Substance Abuse Services Master Plan. These initiatives are described as follows:

- S DCF was provided with the authority to pilot programs that integrate children's mental health Crisis Stabilization Units (CSUs) with children's Addiction Receiving Facilities (ARF) in Fort Myers, Sarasota, and Naples. Thus far, a 10-bed combined CSU/ARF was opened in Fort Myers on October 1, 2001. Additionally, in Sarasota an existing children's CSU was converted to a 10-bed children's CSU/ARF in May of 2002. Both programs are currently undergoing a program evaluation, as mandated by SB 1258.
- S Chapter 2001-191 also provided for the establishment of a Behavioral Health Services Integration workgroup, for the purpose of assessing the barriers to the effective and efficient integration of mental health and substance abuse treatment services across various service systems and to propose solutions to those barriers.

This workgroup includes representatives from the following groups in Florida:

- The Department of Children and Families
- The Department of Juvenile Justice
- The Department of Health
- The Department of Corrections
- The Department of Elder Affairs
- The Department of Education
- The Office of Drug Control Policy
- The Agency for Health Care Administration (AHCA)
- The Louis de la Parte Florida Mental Health Institute
- County jail systems, homeless coalitions, county government
- Public and private Baker Act receiving facilities
- Assisted living facilities serving behavioral health clients
- Providers of behavioral health services and child protection services
- Consumers of behavioral health services and their families
- š Additionally, Chapter 2001-191 permitted DCF and AHCA to establish two behavioral health service delivery strategies that will test methods and techniques for coordinating, integrating, and managing the delivery of mental health and substance abuse treatment

- "Develop motivation for decreasing substance use" (p.66).
- "Develop coping skills and alternatives to reduce or minimize substance use" (p.66).
- "Achieve periods of abstinence and stability" (p.66).

Other initiatives related to co-occurring disorders in Florida include the following:

- š The Tampa-Hillsborough County Community Action Grant on Co-occurring Disorders -This Center for Mental Health Services (CMHS) funded Community Action Grant is intended to provide resources for technical assistance and community consensus-building in order to implement effective services for co-occurring disorders in Hillsborough County. Representatives from the majority of key community stakeholders met throughout 2001-2003 and achieved consensus to use Minkoff's Comprehensive Continuous Integrated System of Care (CCISC) Model as the basis for evidence-based systems change in improving services for individuals with co-occurring disorders. This working group has developed and is implementing a strategic action plan based on this model in mental health and substance abuse provider agencies in Hillsborough County, and applied for and received a renewal grant under the leadership of the Louis de la Parte Florida Mental Health Institute (FMHI). An additional project that emerged out of this effort was the development by FMHI, under contract with the DCF ADM Suncoast Region, of a ninemodule, online training series on co-occurring disorders (e.g., "Evidence-based Treatment Models for Co-occurring Disorders", Matthews, 2002; available online at http://mhlp.fmhi.usf.edu/Training/ole/mhlpole.htm).
- S The Florida Alcohol and Drug Abuse Association (FADAA) and the Florida Council for Community Mental Health (Florida Council) have established a joint Workgroup on Cooccurring Disorders, which meets several times per year with representatives from these two trade associations and other interested parties from around the state. This workgroup has formed two sub-committees, one focused on Policy and Finance, the other on Clinical Services. Both sub-committees have begun to identify barriers to improving services for co-occurring disorders and are developing initial action plans and recommendations for how to overcome these barriers. The Workgroup agreed to review and make suggestions and recommendations for the ongoing development of this policy paper. Additionally, Florida's new Center for Substance Abuse Treatment (CSAT)-funded Southern Coast Addiction Technology Transfer Center (SCATTC; www.scattc.org) has been involved in sponsoring, along with FADAA and FCCMH, trainings on co-occurring disorders around the state.
- Suncoast Practice and Research Collaborative (SPARC)/Tampa Practice Improvement Collaborative (PIC). The Florida Mental Health Institute applied for and received ongoing grants from SAMHSA's Center for Substance Abuse Treatment (CSAT) to form SPARC, which is a collaboration between FMHI, local substance abuse community providers, and policy makers to improve services for substance-involved offenders. Projects related to cooccurring disorders to date have included the development and implementation in local

agencies of a co-occurring disorders group treatment manual and client workbook (Moore, Matthews, and Hunt, 2001; available online http://www.fmhi.usf.edu/mhlp/sparc), and the implementation of a gender-specific treatment manual for women with PTSD and Substance Abuse (Najavits, 2002; available online at www.seekingsafety.org). An additional project developed by SPARC, in collaboration with DCF and FADAA and interested researchers, policy makers, and providers from around the stat23.mf

- S Universal screening of both types of disorders (mental disorders and substance use disorders) in both mental health and substance abuse agencies needs to be implemented. This does not necessarily mean that all settings need to use the same instruments, since different settings may require different instruments specifically developed for their treatment populations.
- S Mental health and substance abuse staff and programs need to develop basic minimum competencies to serve persons with co-occurring disorders, who already make up the majority of their clients in most settings. "This will be especially important for staff in crisis stabilization and detoxification units as well as inpatient and intensive residential programs in both systems" (DCF, 2001, p. 143).
- š After defining "the competencies necessary for assessment and treatment of individuals with co-occurring disorders within each system" (DCF, 2001, p. 143), appropriate training and consultation will need to be made available to both mental health and substance abuse administrators and staff.
- S "Specific funding mechanisms are necessary to support the philosophy of consultation, collaboration, and integration. State and local planners need to develop funding mechanisms that allow such partnership activities (work groups, task forces, networks, etc.) to be reimbursed" (DCF, 2001, p. 143).

While both the mental health and substance abuse systems have many of the necessary pieces to begin integrating and improving treatment services there is still much to be done.

GUIDING PRINCIPLES OF EFFECTIVE SERVICES FOR CO-OCCURRING DISORDERS

Desirable Co-occurring Treatment System Characteristics (adapted in part from NASMHPD/NASADAD, 1998)

"An effective system of care for people with co-occurring disorders [is] one that encourages and allows for consultation, collaboration and integration" (NASMHPD/NASADAD, 1998, p. 19), and will have addressed issues related to co-occurring disorders in such key areas as philosophy, service delivery, staffing and funding.

Philosophy

S Ongoing Commitment and Consensus Building – "Any service system that can effectively care for people with co-occurring disorders must be built on a strong foundation of shared principles and values. There must be agreement among all key stakeholders, including federal, state and community officials, policy makers, mental health and substance abuse treatment and primary health providers, consumers, and advocates about the need for and the value of treatment systems working together to improve consumer outcomes" (NASMHPD/NASADAD, 1998, p. 19). Whenever possible, such agreements should be formalized in memoranda of understanding, and there should be "ongoing and shared commitments to address the needs of this group. It should be clear to all parties that

provide consultation, collaboration and integration are not only allowed, but are encouraged and programmatically supported" (NASMHPD/NASADAD, 1998, p. 19), based on the needs of the individual.

S Person-centered - Any successful service system must be person-centered as well as culturally competent. A person-centered system "is one in which people with mental health and substance abuse problems and their families are actively involved not only in treatment decisions but also in program design, administration, evaluation" (NASMHPD/NASADAD, 1998, p. 19), quality assurance and quality improvement.

Service Delivery System

- S "No Wrong Door" The service delivery system for people with co-occurring disorders "must be available and accessible, wherever and whenever the person enters [the] system"_(NASMHPD/NASADAD, 1998, p. 19-20). Often referred to as "no-wrong door", this approach ensures that an individual will receive treatment (even if this includes referral), "whether he or she seeks help for a mental health problem, a substance abuse problem or a general medical condition. This eliminates unnecessary duplication of services and reduces the likelihood that an individual will fall through the cracks of an uncoordinated system of care" (NASMHPD/NASADAD, 1998, p. 19-20).
- š Comprehensive, Long Term Care "Because of the chronic and severe nature of many co-occurring conditions, treatment for such individuals must be comprehensive, longitudinal" (NASMHPD/NASADAD, 1998, p. 20) and appropriate to the consumer's changing needs and motivation.
- S Engagement Because many individuals with co-occurring disorders are not currently receiving any treatment, [it is recommended] that providers [also] focus on engaging those [persons] who are not currently in the mental health or substance abuse treatment systems. Special efforts should be made to reach out to children and adolescents at risk for developing mental health and substance abuse disorders, many of whom are present in primary care settings or school-based clinics. In addition, individuals with co-occurring disorders are found in jails and prisons, hospital emergency rooms and living in shelters or on the streets" (NASMHPD/NASADAD, 1998, p. 20). Some individuals who are already receiving treatment in one system or the other, and who are identified as having co-occurring disorders, may need persuasion and motivational interventions in order to become engaged in treatment for both types of disorders.
- S Integrated Service Delivery "While service delivery for some individuals with co-occurring disorders should be [fully] integrated" (NASMHPD/NASADAD, 1998, p. 20) (i.e., Dual Diagnosis Enhanced settings for those persons with the most severe disorders), this does not mean that all settings need to be integrated to that degree. "Because both the mental health and substance abuse systems have unique characteristics... their efforts should be combined, but it may not be either practical or desirable to [completely] merge the systems themselves" (NASMHPD/NASADAD, 1998, p. 20). Rather, each setting should develop and maintain a minimum standard (i.e., Dual Diagnosis Capable) to serve their clients with co-occurring disorders effectively.

- š Universal Screening All clients should be screened for both mental and substance use disorders, regardless of where they present for services.
- Š Aftercare In keeping with the need for comprehensive and long term care, a critical element in the treatment continuum for people with co-occurring disorders should be aftercare/follow-up services for those who complete primary treatment episodes. Individuals with co-occurring disorders are at a greater risk for relapse or return to the problems of their pre-treatment state. This means that they need additional supports and services to help them maintain their treatment gains.
- š Integrated Data Systems Integrated data systems should facilitate and enhance access to and movement between the mental health and substance abuse systems, as well as help to identify ways in which the system could be further improved.
- Shared Performance Indicators With shared performance indicators to assess treatment for co-occurring disorders, the people served by either system or both systems, as well as family members, advocates and funding sources can better determine whether outcomes are met.
- Special Populations and Co-occurring Disorders- Prevention, treatment, and other services also need to be made available to special populations with (or at risk of developing) co-occurring disorders, including the following (1) children and adolescents

<u>Funding</u>

- S Flexible Funding Streams "Flexible funding is a necessary tool [for] mental health and substance abuse providers... to meet the needs of individuals whose disorders don't fall neatly into one or another categorical funding stream. Maintenance of separate funding streams at the [national] and state levels [should] ensure that the mental health and substance abuse systems remain viable and able to complement [each] other... In the final analysis, coordination and [integration] of those funding streams at the local level by community providers may permit the most effective response to... needs of consumers with co-occurring disorders" (NASMHPD/NASADAD, 1998, p. 21).
- Specific Funding Mechanisms "To support [the] philosophy of consultation, collaboration, and integration, state and local planners may need to develop... funding mechanisms that allow such partnership activities (e.g., work groups, task forces, [networks], etc.) to be reimbursed" (NASMHPD/NASADAD, 1998, p. 21).

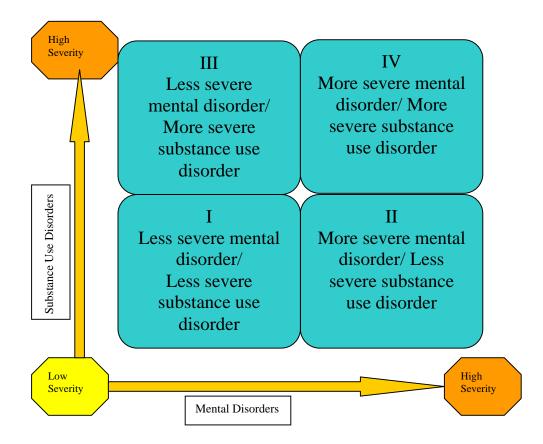
Four Quadrant Model: Co-occurring Disorders by Severity (Figure 1)

Commonly called the "Four Quadrant Model" or "New York Model" (NASMHPD/NASADAD, 1998), the framework outlined in Figure 1 is based on the assumption that persons with cooccurring disorders vary in the degree of severity of their co-occurring mental health and substance use disorders. Some persons will be affected by mental disorders to a greater degree than their co-occurring substance use disorders. Others may be affected by their substance use disorders to a greater degree than by their mental disorders and still others may be greatly affected by both. The present model places individuals in four major categories based on severity:

- S Quadrant I Less severe mental disorder/Less severe substance use disorder. Persons in Quadrant I are those individuals who may or may not already be involved in the mental health or substance abuse service systems. Those who are involved may generally be found in outpatient settings with problems such as anxiety, depression, or family problems or in substance abuse treatment programs with substance abuse problems (not usually clear cut substance dependence). In many instances, the problems may not be severe enough to bring them to the attention of either system. This category may include children, adolescents and adults at-risk for developing mental or substance use disorders who will frequently be found in primary health care settings, school or community programs or receiving no care at all. Programs may have the greatest impact on this group by minimizing the future impact of these disorders through prevention and early intervention programs.
- Š Quadrant II More severe mental disorder/Less severe substance abuse disorder. Persons in Quadrant II are likely to be or have been involved with the mental health system due to a more readily apparent mental disorder. This group often includes persons with a severe mental illness complicated by substance abuse (whether or not the person sees their use as a problem).

- S Quadrant III- Less severe mental disorder/More severe substance use disorder. Persons in Quadrant III are more likely to be or have been involved with the substance abuse system due to a more readily apparent substance use disorder. Individuals in this group are more likely to have a diagnosis of substance dependence with psychiatric symptoms but do not have a severe and persistent mental illness. Included within this group will be persons with substance-induced and substance exacerbated psychiatric disorders.
- Š Quadrant IV More severe mental disorder/More severe substance abuse disorder. Persons in Quadrant IV are those with a severe and persistent mental illness who have an accompanying problem of substance dependence. These individuals typically need integrated treatment for both disorders. Individuals in this group often are found in settings that are largely inappropriate for their needs (e.g., jails, prisons, homeless shelters, the streets, state hospitals). This group tends to be the most chronic and severe, uses the most resources, is the most difficult to serve, and tends to have the worst outcomes in fragmented systems of care. However, integrated, comprehensive, continuous services provided to this group can improve long-term outcomes for these individuals.

Figure 1



Co-occurring Disorders by Severity

(2) Similarly, substance abuse funding should be able to support services for an individual's co-occurring mental disorder(s), in addition to their substance use disorder(s).

Case Mix and Risk Adjustment, Including Adjustment of Performance Outcome Standards and Service Rates for Co-occurring Disorders

Performance outcome standards should be adjusted based on severity of population served. Individuals with co-occurring disorders are typically more severe, complicated, and difficult to serve than those with "single disorders" and show more gradual improvement. Thus, because outcomes for individuals with co-occurring disorders are reasonably expected to be lower compared to those with "single disorders", service rates should be enhanced to reflect the need for greater intensity, comprehensiveness, and length of services for the co-occurring disorders population. As much as possible, performance outcome standards for providers should be based on research evidence and the experience of other states, and should be guided by consensus among national and Florida experts and constituents, including FMHI, FADAA, FL Council, and Florida providers and consumers. This is not to suggest that new statewide performance measures be established for the co-occurring disorders population at this time, because more experience and system development needs to occur before

STRATEGIC IMPLEMENTATION PLAN

In addition to the need for development of work groups and action plans for the Targeted High Priority Goals (as described in above section), the following section outlines needed and ongoing action steps to implement improved services for persons with co-occurring disorders in Florida.

Action Step 1: Develop an Integrated System Planning Process and Structure

The first step for Florida to improve its service system for the co-occurring disorders population as outlined in the preceding document is to develop an integrated system planning process and structure. This is also the first step in Minkoff's 12-steps of implementation of his CCISC model (see Attachment A).

S Florida Work Group on Co-occurring Disorders - The Florida Alcohol and Drug Abuse Association (FADAA) and the Florida Council on Community Mental Health have developed a joint Workgroup on Co-occurring Disorders. In addition to representatives from FADAA and the Florida Council, current membership includes interested parties from the Florida Behavioral Health Services Integration Workgroup, community substance abuse and mental health treatment providers, the Tampa-Hillsborough Community Action Grant on Co-occurring Disorders, and the Louis de la Parte Florida Mental Health Institute. It is recommended that this committee expand its membership to include additional key stakeholders from around the st

- S Expert Consultation and Review This type of review should also be included in the planning process to provide strategic guidance at key points. Individuals such as Dr. Kenneth Minkoff and Dr. Robert Drake, two of the top experts in the area of co-occurring disorders, are possible candidates for reviewing strategic implementation plans and providing ongoing consultation to Florida's effort to improve services for persons with Cooccurring Disorders.
- S Regional, District and Local Planning Groups These groups should be convened to build consensus and support regarding how to improve services for co-occurring disorders in local communities. These groups should also include all key stakeholders and should develop their own consensus documents, including Memoranda of Understanding, as well as their own Strategic Implementation Plans. These local efforts should coordinate with the overall vision outlined in the statewide planning process.
- CCISC Model Planning Process The following is a brief description of this planning Š process from the CCISC model (Minkoff, 2002; see attachment B): "Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funding sources, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of (individuals with cooccurring disorders) and their families."

Action Step 2: Continue to Implement Current Projects in Florida Related to Improving Services for Co-occurring Disorders

S District 1 DCF/ADM Activity Related to Co-occurring Disorders and Integrated Services -Florida Senate Bill 1258 authorized AHCA and the Alcohol Drug Abuse, and Mental Health (ADM) office to integrate Medicaid and ADM-funded mental health and substance abuse data systems, funding and services in at least two parts of the state, Districts 1 and 8. In District 1 this is being done through a pilot Medicaid waiver for a pre-paid mental health plan (PMHP) that was implemented by AHCA 11/1/01 and through integrated ADM services. AHCA and ADM are contracting on a prepaid basis with the same managing entity, Lakeview Center.

Since September of 2001, District 1 workgroups, including local providers, have been redesigning the data system to make it flexible and user-friendly in order to capture data in real-time, and to make it completely web-based to allow providers to easily and quickly report their data. Under the old system still in use in other parts of the state, if a client has not already been "enrolled" as a substance abuse client, any subsequent substance abuse

services provided are not accepted by the database, even if they were previously enrolled in the mental health service system. Similarly, if a client has not been "enrolled" as a mental health client, any subsequent mental health services are not accepted by the database, even if they were previously enrolled in the substance abuse service system. Additionally, under the old system, enrollment in the substance abuse and mental health systems each required their own separate enrollment forms. All of the above have created barriers to providing integrated services and data management of clients with co-occurring disorders.

District 1's pilot data system, which began its first data uploads in approximately July of 2002, has eliminated the need for either mental health or substance abuse "enrollment forms". This means that clients are automatically enrolled when data from their first services (either mental health or substance abuse) are entered. Furthermore, once data from a client's first service are entered, the system will automaticaservdlrvicacceptesubsequent m

sources, and regulations. Additionally, local providers (e.g., Lakeview Center), in collaboration with Dr. Paul Rollings and other ADM staff, have endorsed Minkoff's Comprehensive Continuous, Integrated System of Care (CCISC) model, and have periodically utilized his services as a consultant and trainer. Adoption of the CCISC model in District 1 is further guiding the development of integrated mental health and substance abuse services for persons with co-occurring disorders, as in other parts of the state (e.g., Hillsborough County).

- S Evaluation and Implementation of Integrated Acute Care Units As noted earlier, there are currently two pilot integrated children's Crisis Stabilization Units/Addiction Receiving Facilities operating in Ft. Myers and Sarasota. These pilot programs are currently undergoing an independent evaluation as mandated by SB 1258. The evaluation report is due to legislature by December 2003, and is mandated to address the following questions:
 - (1) Number of clients served by the CSU/ARF's.
 - (2) Quality of services provided by the CSU/ARF's.
 - (3) Performance outcomes for the CSU/ARF's.
 - (4) Feasibility of continuing or expanding the CSU/ARF demonstration models (to other parts of the state).
 - (5) In addition to the above specific areas, the evaluation should "identify the most effective ways to provide integrated CSU/ARF services to children".

In addition, program evaluation of the co-located secure detoxification and crisis stabilization unit in District 4 may also be useful and inform the potential expansion of integrated acute care services. Recommendations for this type of expansion should also be informed by the ongoing DCF-funded, FMHI focus-group study and analysis of the acute care system in several DCF Districts as part of the Behavioral Health Integration Workgroup created by S.B. 1258, as well as the separate analysis of the Sarasota County acute care system currently being developed by FMHI.

S Other Florida initiatives related to Co-occurring Disorders - As outlined earlier in this paper under the "Florida Situation", there are a number of other initiatives related to co-occurring disorders in the state. It will be important to continue to support these projects as well, and to bring key stakeholders from these different projects together at strategic points in order to facilitate more effective system planning, and to facilitate the sharing of information regarding lessons learned, solutions obtained, and possible barriers to overcome.

Additional Action Steps- Minkoff's 12 Steps of Implementation of CCISC Model

Minkoff outlines 12 broad steps in order to implement his CCISC Model in any size system (see Attachment A on following pages). Action Step 1 for Florida, <u>Developing an Integrated</u> <u>System Planning Process and Structure</u> (see above), is only the first of these 12 steps. The additional 11 steps of implementation will need to be developed over time in a collaborative,

consensus building process by the Florida Work Group on Co-occurring Disorders. These additional steps can then be included in revisions of this Policy Paper on Co-occurring Disorders, or in other documents, as needed. In brief, these steps are listed below (see Attachment A for a detailed description of what each entails).

Attachment A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE (CCISC) MODEL

Principles

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. Dual diagnosis is an expectation, not an exception. Epidemiological data defining the high prevalence of co-morbidity, along with clinical outcome data associating ICOPSD with poor outcomes and high costs in multiple systems imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level. In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH - high CD (Quadrant III), high MH - low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.

3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties. The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting. Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community-based reinforcements to make incremental progress within the context of continuing treatment.

5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual

6.

funding sources, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families.

2. Formal Consensus on CCISC Model

The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

3. Formal Consensus on Funding the CCISC Model

CCISC implementation involves a formal commitment that each funding source will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.

4. Identify Priority Populations and Focus of Responsibility for Each

Using the national consensus four-quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

5. Develop and Implement Program Standards

A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stage wise implementation. Program competency assessment tools (e.g., COMPASS; Minkoff & Cline, 2001) can be helpful in both development and implementation of DDC standards.

6. Structures for Intersystem and Inter-Program Care Coordination

CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross-traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

7. Develop and Implement Practice Guidelines

CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (Minkoff, 1998; Arizona DHS, 2001) are available to facilitate this process. Practice guideline implementation must be

pranddniter/P30gramCCatellCatesplin007cTcOc0029eEveffin12n6psill0cee)dihTg0Uy8BEc0,285859ans

10. Develop Basic Dual Diagnosis Capable Competencies for all Clinicians

Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT, Minkoff & Cline, 2001) can be utilized to facilitate this process.

11. Implement a System Wide Training Plan

In the CCISC model, training must be ongoing, and tied to expectable competencies in the

3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities.

4. Consumer - choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness

d. Continuum of levels of care: All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization.

CCISC implementation requires a plan that includes attention to each of these areas in a comprehensive service array.

Attachment B

AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRY (AACP) POSITION STATEMENT ON PROGRAM COMPETENCIES IN A COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth Minkoff, MD 12 Jefferson Drive Acton, MA 01720

June 18, 2001

Introduction

In June, 2000, AACP released a consensus position statement entitled Principles of Treatment for Individuals with Co-occurring Psychiatric and Substance Disorders, indicating the need for welcoming, accessible, integrated, continuous, and comprehensive treatment interventions and treatment programs, organized into a comprehensive, continuous, integrated system of care (CCISC).

The current document builds upon that position statement, by indicating AACP support for

DDC-CD: The concept of Dual Diagnosis Capability in CD programs is incorporated in the ASAM PPC2R (ASAM, 2001), in which DDC is described as a standard of care for ALL addiction treatment programs, based on the high prevalence of expected co-morbidity among individuals seeking addiction treatment.

DDC-CD represents a measurable basic standard of care, which can be implemented within the context of existing program requirements, with additional technical assistance and training support, but without additional clinical operational cost, and can be reliably assessed through routine program audit, such as would occur during licensure review.

DDC-CD applies to any and all levels of care in the addiction treatment system, and implies that the program routinely admits individuals with co-occurring disorders, provided that the symptomatology and disability associated with those disorders is not severe enough to substantially interfere with participation in routine program functions or require substantially increased levels of staff support in order to sustain such functioning.

Thus, an individual may have baseline psychotic symptoms or suicidal ideation, but these symptoms are sufficiently limited or controllable that the individual can participate in groups, complete assignments, perform independent ADLs, etc.

The measurable criteria that define DDC status are as follows:

1. Mission and Philosophy

The program's mission, philosophy, and admission policies specifically welcome individuals with co-occurring disorders, and create no barriers to admission based solely on psychiatric history, diagnosis, or non-addictive prescribed medication. Assessment of motivation and functional capacity to participate in treatment are assessed for this purpose, as they would be for anyone seeking admission. (Note that individuals with psychiatric presentations or medication regimes that are more complex or controversial will ordinarily require DDE-CD programs for addiction treatment.)

2. Screening for Co-morbidity

There are specific screening procedures for the presence of psychiatric disorders and

4. Diagnosis and Treatment Planning

Psychiatric diagnoses are identified in the treatment record, and, where current treatment is required, listed as problems on the treatment plan. Specific goals and objectives are identified for each such problem.

Ex. Problem: Major Depression, on meds, currently minimal symptoms. **Goal:** Maintain stability and prevent interference with addiction rx. **Objective:** Patient demonstrates competency in taking meds as prescribed. Patient identifies techniques for addressing med issues in Twelve-Step meetings.

5. Documentation

Progress notes document monitoring of the psychiatric disorder in relation to the treatment plan.

6. Programming

Treatment programming (at least one group per week) addresses issues related to cooccurring mental illness directly and openly, educating ALL clients about basic symptoms of mental illness, the possibility of co-morbidity, and the need for continued medication compliance while working an addiction recovery program. **DDE-CD:** DDE-CD programs are psychiatrically enhanced programs at any level of care or type of treatment in the addiction system, in which additional resources and capabilities are added to an existing addiction program model in order to accommodate individuals with psychiatric disorders who have moderate levels of acute symptomatology or psychiatric disability. This type of program may include individuals who are motivated for addiction treatment, but also have active symptoms of PTSD which may include intermittent flashbacks and/or suicidal ideas, or who also have stable schizophrenia with persistent disability that may interfere with usual functioning required in a DDC addiction program.

DDE-CD programs are more costly than usual DDC addiction programs, and require additional funding, often through braiding or blending MH funding into the addiction program funding base. The ASAM recommendation is that within each system of care, at each level of care in the addiction system, there is a plan for DDE-CD capacity. This may involve distinct programs, or it may involve a component of an existing DDC program.

The specific characteristics of DDE programs are as follows:

- 1. Meets all DDC criteria, plus;
- 2. Increased staffing levels, with more staff with MH training;
- 3. Direct psychopharmacology presence on site;
- 4. On site availability of MH supervision/consultation;
- 5. Smaller group size, with more flexible expectations, and more specific MH symptom

Capacity for medically-monitored detoxification is dependent upon the availability of medical and nursing care comparable to that found in an ASAM Level III detoxification program, but intoxicated individuals who do not require medical detoxification can be routinely stabilized in appropriately staffed settings.

Like DDC-CD, DDC-MH is evaluated through routine program audit procedures, through chart review of specific, measurable criteria.

Specific characteristics of DDC-MH programs include:

1. Mission and Philosophy

Mission statement and philosophy clearly welcome individuals with active substance use, and promote continued mental health treatment of such individuals even when actively using.

2. Screening for Co-morbidity

Specific screening for substance use disorders documented, with evidence that such screening is performed competently.

3. Assessment

For individuals who are screened positively for past or present disorder, there is documentation of substance assessment, incorporating types and amounts of use, patterns of use, problems associated with use, specific substance diagnoses, past successful interventions, characteristic MH symptoms during previous sobriety periods, current treatment if any, and specific documentation of stage of change. In addition, proactive linkage is provided to ensure access to substance disorder treatment for those individuals who need substance disorder services beyond the capabilities of the program.

4. Treatment Planning

Substance diagnoses are routinely recorded in the clinical record, and identified as problems in the treatment plan, with specific goals, objectives, and interventions.

5. Substance Disorder Consultation

Documentation of access to consultation with CADAC or another clinician with documented substance expertise, and integration of this input into progress notes and treatment plans.

6. Continuity

In programs responsible for continuity of care, no denial of access or continuity based on continuing substance use for individuals who require treatment for continuing psychiatric disorders, and program policies specify that primary clinicians provide integrated continuous treatment relationships.

7. Stage-Specific Treatment

Availability of stage-specific treatment interventions including a range of group interventions within programs that offer groups.

8. Competencies

Human resource policies incorporate basic competencies in substance use disorders consistent with job requirements, and supervision and training policies include continuing education plans to support and enhance those competencies.

9. Collaboration with CD Clinicians

Documentation of coordination of care with collaborative substance providers integrated into treatment record.

10. Discharge Planning

Discharge or transition planning incorporates specific attention to continuity of phase-specific treatment for co-occurring substance disorder.

DDE-MH: Dual diagnosis enhanced mental health programs incorporate increased capacity to address co-occurring substance disorders in a variety of mental health settings. In general, in any mental health system, at each level of care, there needs to be a plan for appropriate availability of DDE-MH services. In almost every level of care in the MH system, a DDE service is no more costly than a comparable DDC service. Creation of appropriate DDE services in a system with adequate baseline capacity often involves designating some of those services as DDC, and the remainder as DDE, in the planning process.

Characteristics of DDE-MH programs vary according to the type of program. All programs meet DDC criteria, plus additional criteria as follows.

- 1. One type of program involves provision of an active addiction treatment program in a mental health environment such as an inpatient psychiatric unit, partial hospitalization program, or mental health group residential setting.
 - a. The program staff has increased training in addiction with available supervision by credentialed addiction staff.
 - b. Program content includes substantial addiction focus (approximately half time as a minimum.), with strong connections to standard (e.g., 12-Step) and dual recovery programs.
 - c. Program policies address abstinence expectations, and make provisions for transfer to a setting with lower expectations if the individual lapses.
- 2. The second type of program emphasizes motivational enhancement interventions for individuals with active substance disorders and severe psychiatric illnesses that are very disengaged: e.g., continuous treatment teams, "wet" housing programs.
 - a. Program staff has increased training and experience in working with actively using individuals with severe substance disorders.
 - b. Programs incorporate motivational interventions, along with contingency management (e.g., payee-ships), and intensive case management, maintaining continuity with clients who are very disengaged.

- **3.** The third type of program incorporates a range of phase-specific treatment options into a comprehensive program setting that emphasizes working with individuals with co-occurring disorders. Examples include: dual diagnosis specialized continuing day treatment, dual diagnosis specialized damp housing, as well as combinations of services in a comprehensive continuum.
 - a. Program staff members have increased training and access to supervision, as above.
 - b. Programs have a full range of phase-specific interventions, including connection to dual recovery programs.
 - c. Programs have substance use policies that clarify consequences for various types of behavior in each phase of treatment, and procedures for connecting

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring disorder) who need housing assistance due to

Attachment C

Adapted, with permission from the author, from: Matthews, C. O. (2001). <u>Principles of care for</u> <u>persons with co-occurring addictive and mental disorders</u>. (Suncoast Practice and Research Collaborative Practice Brief, Vol. 1, # 2). Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Different Treatment Models for Co-occurring Disorders

There are a number of different treatment models for people with co-occurring disorders. These include:

- š **No Treatment** the most common, and least effective model.
- š **Sequential Treatment** the client first goes through the substance abuse treatment system followed by treatment in the mental health system, or vice versa.
- š **Parallel Treatment** the client receives services in both mental health and substance abuse treatment settings at the same time.
- š **Integrated Treatment** the client receives treatment for both types of disorders at the same time and in the same service setting, with staff who are cross-trained to address both mental and substance disorders concurrently.

Which Treatment Model Works Best?

š Although both <u>sequential</u> and <u>parallel</u> treatment models work better than no treatment, they tend to be largely ineffective, especially for mseTw(for .gat the)Tj-23.6Tf8.675 0 TD-0.0004r⁻ mental illness stop their psychiatric medications without consulting their doctor, this puts them at a much higher risk for relapsing into both mental illness and substance abuse.

S As described in a review by Drake, Mercer-McFadden, Mueser, McHugo, and Bond (1998), clients with co-occurring disorders who receive traditional non-integrated treatment often have high drop-out rates and achieve little to no reduction in substance use. Their research indicates that <u>integrated, long-term, comprehensive treatment programs,</u> which include assertive outreach and motivational interventions, are most likely to The level of monitoring may be able to be reduced as a client improves and moves through the stages of treatment, or conversely, it may need to be increased if the client has a relapse.

- S Longitudinal Perspective like diabetes and heart disease, co-occurring disorders are typically chronic, relapsing illnesses requiring long-term treatment. Additionally, over time mental and substance-related symptoms present increases and decreases in severity, and not necessarily at the same time.
- Stable Living Situation in order for integrated substance and mental treatment to be effective, people with co-occurring disorders must first have a stable living situation. Some people with co-occurring disorders who have not yet stopped using substances may need to first be housed in "wet" housing, in which there is no prohibition against use, but which has minimal rules with treatment outreach. The next stage of housing can be classified as "damp" housing, in which residents are prohibited against use or intoxication at home, with continued treatment outreach. Once a patient is able to maintain abstinence, then they can be placed in "dry" housing, which accepts only complete abstinence. The problem with having no wet or damp housing in a community is that it keeps potential co-occurring disorders clients homeless, which keeps them from being able to be engaged in effective treatment, thus continuing the cycle of addiction and homelessness.
- S Harm Reduction Strategies Rather than expecting immediate and complete abstinence, which is often unrealistic for people with co-occurring disorders who are living in the community, it is often more effective to persuade them to gradually cut back on the types and amounts of drug use. For instance, if a client cuts out cocaine but continues to use alcohol, this can be seen as a partial success on the road to recovery, rather than a failure of abstinence.
- Stages of Treatment Osher's phasic model of treatment acknowledges that people who have co-occurring disorders may initially have little motivation to receive treatment, and uses motivational enhancement techniques (e.g., Miller and Rollnick, 1991; 2002) as part of treatment. Clients typically do not go through these in an orderly progression, but the stages do give clinicians a guiding framework to know what kind of treatment is needed based on level of motivation for recovery, with the goal of eventually moving clients to the next stage. The stages of treatment include:

A. <u>Engagement</u> – establishing a relationship with people with co-occurring disorders in the community through outreach and letting them see that you have some benefit to offer them, such as housing, financial assistance, etc.

B. <u>Persuasion</u> – once a relationship is established, motivational interviewing techniques are used to help clients identify why they wish to enter treatment and help them persuade and motivate themselves to enter treatment

C. Active Treatment - entering an integrated treatm

D. <u>Relapse Prevention</u> – maintaining abstinence and keeping mental illness symptoms manageable after active treatment. Relapse prevention includes training to help people limit the damage of a slip in abstinence to keep it from becoming a full-blown relapse, by being prepared for a slip or an increase in mental illness symptoms if it happens.

- S Cultural Competency and Consumer Centeredness –the clinician tries to see things from the client's perspective, and actively seeks to get help from the client to understand their perspective. This is particularly important because clinicians and clients with cooccurring disorders are often of different cultural or ethnic groups. When clinicians are culturally sensitive, they are better able to truly understand a client's needs, allowing them to help the client learn more adaptive ways of meeting those needs.
- š Optimism and Recovery clinicians, researchers, trainees, clients, and policy makers all

References

American Society of Addiction Medicine. (2001). <u>Patient Placement Criteria 2R</u>. Washington, DC: Author.

Arizona DHS. (2001). State of Arizona Service Planning Guidelines: Co-occurring Psychiatric and Substance Disorders.

Department of Children and Families (2000). <u>State Mental Health and Substance</u> <u>Abuse Plan: 2000-2003: A Report to the Governor and the Legislature</u>. Tallahassee, FL: Author.

Department of Children and Families (2001). <u>State Mental Health and Substance</u> <u>Abuse Plan: 2002 - Update</u>. Tallahassee, FL: Author.

Department of Children and Families (2001). <u>Florida Supplement to the American</u> <u>Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance</u> <u>Related Disorders</u> (ASAM-PPC-2-R). Tallahassee, FL: Author.

Drake, R., Bartels, S., Teague, G., Noordsy, D., & Clark, R. (1993). Treatment of substance abuse in severely mentally ill patients. <u>Journal of Nervous and Mental Disorder</u>, <u>181</u>,606-611.

Drake, R., Mercer-McFadden, C., Mueser, K., McHugo, G., & Bond, G. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. <u>Schizophrenia Bulletin, 24(4)</u>, 589-608.

Drake, RE, Essock, SM, et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. <u>Psychiatric Services, 52(4)</u>.

Florida Commission on Mental Health and Substance Abuse (2001). Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida. Available online at http://www.fmhi.usf.edu/fcmhsa/finalreports.html

Kessler, R., McGonagle, K., Zhao, S., et al. (1994). Lifetime and 12 month prevalence of DSM-II-R psychiatric disorders in the United States. <u>Archives of General Psychiatry, 51</u>, 8-19.

Matthews, C. O. (2001). <u>Principles of care for persons with co-occurring addictive and</u> <u>mental disorders</u>. (Suncoast Practice and Research Collaborative Practice Brief, Vol. 1, # 2). Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Matthews, C.O. (2002). <u>Evidence-Based Treatment Models for Co-occurring Disorders</u>. Florida Department of Children and Families Training Manual. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute. Available online at <u>http://mhlp.fmhi.usf.edu/Training/ole/mhlpole.htm</u>

SAMHSA. (2002). <u>Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders</u>. Rockville, MD: Authors. Available online at <u>http://www.samhsa.gov/news/cl_congress2002.html</u>

U.S. Department of Health and Human Services. (1999). <u>Mental Health: A Report of the Surgeon General</u>. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. <u>http://www.nimh.nih.gov/research/sgreports.cfm</u>