

Co-Occurring Disorders

A Report To The California Co-Occurring Joint Action Council

October 2007

CO-OCCURRING DISORDERS REPORT

Prepared for
THE CO-OCCURRING JOINT ACTION COUNCIL (COJAC)
by the Alcohol & Drug Policy Institute (ADPI)

Preface:

State Budget language adopted in 1996 mandates that the Departments of Alcohol and Drug Programs (ADP) and Mental Health (DMH) eliminate barriers to the provision of services to persons with the co-occurring disorders (COD) of mental illness and substance use. This mandate became the impetus for the Co-Occurring Disorders State Action Plan. The Co-Occurring Joint Action Council (COJAC) has as one of its tasks the provision of technical assistance and consultation to both Departments as they work in concert to improve outcomes for community members facing the challenges of accessing appropriate and necessary care for COD. To this end, one of the stakeholders, the Alcohol and Drug Policy Institute (ADPI), was commissioned to prepare the following summary of recommendations for consideration by county programs as new and expanded services are being implemented through the Mental Health Services Act and other local initiatives.

Introduction:

According to the Substance Abuse & Mental Health Services Administration (SAMHSA), seven to ten million individuals in the United States have at least one mental disorder as well as an alcohol or other drug use disorder.¹ Numerous studies support this finding, and further indicate that approximately one half of the individuals who have one of these conditions also have the other. In a 1999 report on mental health, the U.S. Surgeon General stated that “forty-one to sixty-five percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder.”² This proportion is believed to be even higher for adolescent populations. For the purposes of this paper, the term “co-occurring disorders” is used to describe individuals who experience these disorders simultaneously. These individuals have particular difficulty seeking and receiving diagnostic and treatment services, even though separately these disorders are as treatable as other chronic illnesses.

A diagnosis of COD is usually made when at least one disorder of each type can be established independent of the other, and is not simply a cluster of symptoms resulting from one disorder.³ The four-quadrant model, a conceptual framework developed by the

National Association of State Mental Health Program Directors and the National Association of State Alcohol & Drug Abuse Directors, recognizes the full range of persons with COD, and acknowledges that such persons vary in the severity of their mental health (MH) and alcohol and other drug (AOD) disorders. This model is helpful in advancing the continuum of care for individuals with COD. (See Attachment A)

The prevalence of COD in our communities poses significant public policy challenges for California, including the public health effects of inappropriate and/or inadequate diagnosis, and unavailable treatment. Untreated COD drives many of the costs and caseloads in other systems, including Corrections, Child Welfare and Foster Care, Homelessness and Supportive Housing, and Public Health. Yet in spite of the high prevalence and consequences of untreated COD, coordinated, integrated treatment programs remain largely unavailable. In part, the stigma still associated with substance abuse and mental disorders stands between many people with COD and successful treatment and recovery. The difficulty is further compounded by the existence of restrictive funding for two separate service systems.

Proposition 36, the AOD treatment in-lieu-of incarceration ballot initiative passed by the voters in 2000, makes provision for “ancillary services” that could include treatment for COD. Likewise, Proposition 63, the Mental Health Services Act (MHSA) approved by the voters in 2004, provides that effective services for individuals with severe mental illnesses (SMI) must include “whatever it takes” for recovery, which potentially can include such services as supportive housing, prevention and early intervention (PEI) services, and treatment for COD. However, individuals with SMI comprise only a portion of those with COD, and the identified service populations include more than just individuals with COD. Both initiatives have interdependent relationships with federal, state, and local program requirements which limit how funding may be used. As a result of the many factors listed above, there remains a very significant gap between available funding and the needed capacity to serve those with COD.

Public Policy Implications:

COD is a significant policy issue for California for four primary reasons: (1) First, the need for coordination between the health, mental health, and AOD service delivery systems challenges counties to meet the needs of clients with appropriate treatment for COD. (2) Second, both the MH and the AOD fields are under-funded. (3) Third, where treatment is available, the methods and delivery are not always culturally-competent. (4) Fourth, a large portion of the homeless population is comprised of individuals with COD, which makes administering treatment difficult.

Given the lack of coordinated, culturally-competent methods for identification and treatment of COD, individuals with these disorders have special difficulty accessing and receiving services. Race, culture, ethnicity, gender, and sexuality are all associated with differences in the prevalence, diagnosis and treatment of AOD and MH disorders. The culture from which a person comes influences many aspects of care, including whether or not the individual thinks care is even needed. Culture influences what a person brings to the clinical setting, what language is used to express concerns or ask questions, and what coping styles are adopted. Culture also influences where a person goes for help, whether one starts with a primary care doctor, a mental health program, a substance abuse program, etc. Finally, culture affects how much stigma someone attaches to MH or AOD problems, and how much trust is placed in the

hands of providers. All of these complex issues necessitate an individualized approach to COD services and an understanding of cultural identity.

Limited funding also restricts care for persons with COD, even among those who have sought and found appropriate treatment settings. According to estimates from the National Survey on Drug Use & Health, California has the largest “treatment gap” of any state – 2.7% of the population needs substance abuse treatment but does not receive it.⁴ Although local MH and AOD agencies depend on similar sources of revenue, the proportion of funds available for both systems varies widely.

Studies of treatment rates vary, but a significant majority of individuals with COD do not receive any treatment for either disorder, and fewer still receive treatment for both disorders. In 2002, of the adults with COD, 34% received MH treatment only, 2% received specialty AOD treatment only, and 12% received both MH and AOD treatment.⁵ These individuals’ access to effective diagnosis and treatment is limited not only by stigma and high rates of serious medical needs, but also by their inability to find the “right” treatment setting. Many of these individuals who do seek treatment cycle in and out of costly and often inappropriate treatment settings, such as hospital emergency rooms, where their condition is not effectively identified and therefore not appropriately treated. Likewise, those who end up in the criminal justice system have difficulty accessing adequate diagnosis and treatment, given the lack of resources made available to these individuals.

With regard to the homeless population, the federal government defines chronic homelessness as: “*An unaccompanied homeless individual with a disabling condition who has either a) been continuously homeless for a year or more, or b) has had at least 4 episodes of homelessness in the past three years.*” According to a draft report entitled *Characteristics and Interventions for People Who Experience Long-Term Homelessness*, developed for the National Symposium on Homelessness Research, “disabling conditions” often include severe and persistent mental illness, severe and persistent alcohol and drug abuse problems, and HIV/AIDS. Lifetime mental health problems have been found in over 60 percent of chronically homeless people, and greater than 80 percent have experienced lifetime alcohol and/or drug problems.⁶ Without supportive housing, these individuals continue to cycle through the shelter system, hospitals and emergency rooms. They have low rates of engagement and retention in outpatient MH and AOD treatment services, but significant involvement with the criminal justice system.

Advancing the Continuum of Care for Persons with Co-Occurring Disorders:

Use of the four-quadrant model or framework in considering the severity of disorders and the location of care can greatly help our systems of care decide how to best direct and integrate MH and AOD services. Integration at the level of services would improve the clients’ ability to access care, as it will increase the likelihood that at any point-of-entry into treatment, the clients will be able to access the “right” setting to effectively address their needs. Service providers would better be able to place and treat each client, and clients will no longer be inappropriately released without the care needed for their level of severity. Such integration of services will also ensure that both mental illness and AOD disorders are adequately addressed, especially with regard to identification, engagement, prevention and early intervention.

The four-quadrant model has been adapted for use by California counties. In 2004 the County Alcohol & Drug Program Administrators Association of California (CADPAAC) and the California Mental Health Directors Association (CMHDA) jointly developed a set of guiding principles for addressing COD. The *Guiding Principles for California* states that both CADPAAC and CMHDA agree to coordinate systems so that “every point of entry into alcohol and other drug and mental health services will conduct a screening for co-occurring disorders in order to assure the provision of necessary assessment, linkage and follow up.”⁷

Effective treatment for persons in all four quadrants of the continuum of severity of COD requires the capacity to provide a set of interventions suited to each individual’s needs, choice, family, culture, and community, based on evidence-based practices, and integrated at the level of clinical intervention. Treatment components could include: staged interventions; assertive outreach; motivational interviewing; simultaneous interventions; risk reduction; tailored mental health treatment and tailored substance abuse treatment; counseling; social support interventions; addressing “real life” issues in relation to treatment; a chronic care model of remission and recovery; and cultural sensitivity and competence.

Moreover, delivery systems must be organized so as to provide these services in settings that include all the “doors” through which a person might enter the system: i.e. MH and AOD programs; Child Welfare system; primary care clinics; emergency rooms; homeless shelters; juvenile detention facilities; jails and prisons. Developing effective treatment also requires creating an infrastructure that can deliver evidence-based tools and practices. This will include screening and assessment tools, clinical and facility licensing and certification, braided funding streams, information systems, training and technical assistance.

Recommendations:

The following recommendations focus on comprehensive strategies that address the needs of California, and best ways to advance the continuum of care for persons suffering from COD:

- 1. Pursue funding alternatives.** COJAC recommends that both the AOD and MH systems look into funding gaps and barriers, in order to identify strategic ways to provide more flexibility in current funding streams for treating COD. The Council further encourages both systems to request that funding stipulations for current mental health and AOD programs – such as the MHSA and the Offender Treatment Program – be modified in order to provide better integrated services for persons with COD. The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program can provide significant funding for treating youth with MH needs, but can also be utilized to treat youth with a primary AOD diagnosis, if the treatment of their substance abuse is necessary to ameliorate the mental illness. Funding opportunities also exist under the Prevention and Early Intervention (PEI) component of the MHSA. The PEI provides funding to help prevent the development of serious emotional disorders and mental illness, and focuses interventions on individuals across the life span prior to the onset of a serious emotional or behavioral disorder. The language of the PEI policies is intentionally and sufficiently broad enough to encompass many diverse factors that contribute to mental health risk, including substance abuse. The significant, evidence-based Prevention work that has been done in the AOD field, as well

as the Screening and Brief Intervention services for AOD abuse, can serve as a valuable model for PEI programs serving individuals with COD.

2. **Identify priority populations** as a strategy to move forward with limited resources. Priority populations could include:
 - Children, adolescents and transitional-age youth with serious emotional disturbances and AOD disorders, especially those in foster care, group homes, juvenile detention, or other high risk environments.
 - Pregnant women, victims of trauma, and parents with co-occurring problems, including those who are involved with the Child Welfare system.
 - Indigent adults and older adults with COD who also experience frequent or long-term health crises, or who are receiving services in other public sector systems of care.
 - Individuals involved with the criminal justice system who have COD, and who are in need of pre- and post-sentencing treatment programs, in-custody treatment, and post-release services.
 - Individuals who suffer from chronic homelessness.

3. **Promote county plans for MH and AOD services that include a strategy and approach for addressing COD.** COJAC recommends that treatment for COD be an overarching principle in implementing our public systems of care. The Council further recommends that MH and AOD programs with enrolled populations, such as the MHSA Full-Services Partnership and Proposition 36, always consider persons with COD a priority population for receiving services. In addition, there is an existing body of knowledge from providers that have piloted programs in the public sector – i.e. Prototypes, Tarzana, Shield for Families, Phoenix Academy, Behavioral Health Services – integrating treatment for both adults and adolescents with COD with services supported by a patchwork of funding streams. These programs can serve as models for the public systems of care.

4. **Enhance system accountability**, by encouraging both the AOD and MH systems to become accountable for delivering treatment services to individuals with COD. The Council encourages the Departments, where possible, to leverage federal and private funds, and to work toward mutual outcomes measures, joint certification of treatment programs, mutually-crafted policies, goals and objectives for treating COD populations.

5. **Identify, promote, and implement best, promising, and evidence-based practices.** COJAC recommends that the Department of Mental Health (DMH) and the Department of Alcohol & Drug Programs (ADP) jointly lead and fund a statewide effort to accomplish this task, to better integrate services for the COD population, and to streamline data collection. The establishment of the COJAC is a positive first step toward implementing this recommendation. While there are few regulations establishing treatment standards for COD, there is a growing body of Evidence-Based Practices in both the MH and AOD fields that are based on a chronic-care model of care requiring continuity, aftercare, and support, that are culturally competent, and that present an encouraging opportunity to develop standards for the treatment of COD.

- 6. Devote more attention and resources to youth treatment.** It is generally acknowledged that adolescents with substance abuse or mental disorders have higher rates of COD than adults with these conditions. In early 2006, a total of almost 3,000 youth at 56 sites across nine California counties were screened using the Massachusetts Youth Screening Instrument (MAYSI), in order to identify adolescents 12-17 years old who have AOD problems and MH issues. The results showed that between 65% and 70% of youth in juvenile detention or other high-risk environments (i.e. foster care, group homes) are harmfully involved with AOD abuse, and that, on average, nearly 60% display some type of mental disorders. The report concluded that “there is a great need among at-risk youth for substance abuse and mental health interventions.”⁸ The California Blue Ribbon Commission on Children in Foster Care, sponsored by the Administrative Office of the Courts, has found that, with increasing frequency, children are coming into foster care because their parents are addicted to alcohol or drugs, and many of these youth subsequently abuse alcohol or drugs themselves.⁹ Despite these findings, there are precious few resources or programs specifically for youth treatment anywhere in California. These youth are clearly a public responsibility, and COJAC recommends that there be an adequate public response to provide them with basic medical and health care service, including treatment for COD. Counties that are able to invest in youth treatment will see a reduction in the numbers of youth who end up in the adult criminal justice system, a reduction in many of the problems associated with successful transition to adulthood, and a reduction in public costs associated with untreated youth in our systems.
- 7. Develop a standardized approach to screening and assessment.** Since the results of such screening and assessment will be used for the purposes of data reporting and analysis, COJAC recommends that this approach require some minimum number of common data elements captured by both the AOD and MH fields. Ideally, persons in each of the four quadrants would receive appropriate services from “one team with one plan” for each person.
- 8. Form and support partnerships to promote integrated services.** This is another area where establishing formal linkages not only between ADP and DMH, but also with public safety agencies, Health Services, Social Services and Child Welfare, would allow counties to more effectively address and resolve systemic barriers to clients’ receiving services.
- 9. Counties should support local systems to treat persons with COD.** Such local settings could include primary health care, school-based clinics, pre-and post-sentencing treatment programs, post-release services, and community programs that can make referrals for MH or AOD treatment according to treatment matching principles. COJAC also supports and encourages programs to pursue the co-location of MH and AOD clinics in local communities.
- 10. Develop and implement local system transformation efforts,** including implementing needed MH and AOD infrastructure and service-delivery changes in order to improve services to individuals with COD. The MHSAs provide opportunities for system transformation by creating Full Service Partnerships that will focus on unserved and underserved populations, including those with COD. Improving data collection systems is another transformation effort supported by both the County Alcohol and Drug Program

Administrators and the Mental Health Directors. The AOD and MH fields currently have different ways of collecting and reporting data, which hinders development of shared data sets and the exchange of information. These associations encourage the funding of needed technology, training, and staff for both AOD and MH to address data issues, and have formed a joint Information Technology Committee as a first step toward achieving this goal.

- 11. Increase workforce competency.** A recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA) examined the current status of the AOD and MH workforce, and found “overwhelming evidence that the workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population.”¹⁰ One of these emerging needs is integrated treatment for COD. COJAC recommends that leaders from both the AOD and MH fields implement a combined state and local effort to train professionals from both systems in evidence-based practices, so that they become more proficient in addressing issues related to COD. The Council further recommends that both systems jointly implement a program of cross training and skill development activities to enhance core competencies in serving clients with COD.
- 12. Expand Housing Opportunities for the COD Population.** Due to the high rates of COD among the homeless population, the treatment needs of these individuals cannot be adequately addressed without also meeting their needs for stable and supportive housing. Providing housing in conjunction with treatment significantly increases client retention and improves treatment outcomes.

REFERENCES

- ¹ SAMHSA (2002), *Report to Congress on the Treatment and Prevention of Co-Occurring Substance Abuse and Mental Disorders*, Substance Abuse and Mental Health Services Administration.
- ² U.S. Public Health Service (1999), *Mental Health: A Report of the Surgeon General*, Washington, DC.
- ³ Center for Substance Abuse Treatment (2005), *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Treatment Improvement Protocol Series 42, Rockville, MD: Substance Abuse Treatment and Mental Health Services Administration.
- ⁴ SAMHSA (2004), *National Survey on Drug Use and Health*, SAMHSA Office of Applied Studies, Rockville, MD.
- ⁵ Freese, Thomas (2005 June), PSATTC Surveys Southwest Substance Abuse Treatment Staff, *UCLA Integrated Substance Abuse Programs News*, 3,2.
- ⁶ Caton, C.L.M., Wilkins, C., & Anderson, J., *Characteristics and Interventions for People Who Experience Long-Term Homelessness*, 2007.
- ⁷ County Mental Health Directors Association (CMHDA) and County Alcohol and Drug Program Administrators Association of California (CADPAAC), *Guiding Principles for California*, 2004.
- ⁸ Shulman, E., Cauffman, E., *Description of Alcohol/Drug Use & Mental Health Symptoms Among Youth as Identified by the Massachusetts Youth Screening Instrument*, University of California, Irvine, 2006.
- ⁹ California Blue Ribbon Commission on Children in Foster Care, Administrative Office of the Courts, 2006.
- ¹⁰ SAMHSA *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*, Substance Abuse and Mental Health Services Administration, Nov. 2002.

ATTACHMENT A:

Four-Quadrant Model of Co-Occurring Disorders by Severity

