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

New England Association of Drug Court Professionals
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CT Department of Mental Health and Addiction Services
Presentation Outline

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

- Co-Occurring Disorders (COD) are common.

- There are typically poor treatment outcomes for people with co-occurring disorders in the absence of integrated care.

- *If both conditions are not recognized and treated, recovery may be jeopardized.*
National Initiatives

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

<table>
<thead>
<tr>
<th>Quadrant III</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Severity SUD</td>
<td>High Severity MI</td>
</tr>
<tr>
<td>Low Severity MI</td>
<td>High Severity SUD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Severity MI</td>
<td>High Severity MI</td>
</tr>
<tr>
<td>Low Severity SUD</td>
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</table>
COD Epidemiology

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

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

COCE, 2007
LIFETIME RISK OF ANY MENTAL HEALTH DISORDER BY SUBSTANCE USE DISORDER

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

Regier DA et al. JAMA. 1990(Nov 21);264(19):2511-2518
Jail Diversion Program in Connecticut*

**History**

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

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1 - Jail Diversion Program in Connecticut

**Function of JD Programs in Court**

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

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Jail Diversion Program in Connecticut

Lessons Learned

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

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Women’s Treatment and Support Diversion Program (WTSD)

Target Population

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

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Why Treat for Trauma?

• Individuals involved with the correctional system, especially female offenders, are particularly likely to have had trauma exposure (Harlow, 1999; Kassebaum, 1999)

• In 1999, 57% of women in state prisons reported a history of physical and/or sexual abuse (Greenfeld & Snell, 1999)

• Nationally, one in four women in state prisons is receiving medication for psychiatric disorders

• 22.3 percent of women in jail have been diagnosed with PTSD, and 13.7 percent have been diagnosed with a current episode of depression (U.S. Department of Justice)

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WTSD Client Profile

Mental Health/Substance Abuse Treatment

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

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WTSD Client Profile

**Legal**

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

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Connecticut Women’s Treatment And Support Diversion Program

Program Services

• Groups
  – Trauma education and symptom management
  – Integrated mental health and substance abuse treatment
  – Life skills
  – Spirituality

• Individual sessions and home visits as needed

• Medication Management

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Connecticut Women’s Treatment And Support Diversion Program

**Program Services - continued**

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

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Women’s Treatment And Support Diversion Program

**Models**

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

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## Program Design

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

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

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

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Department of Mental Health and Addiction Services (DMHAS)

Single State Authority that has responsibility for adult mental health and addiction services.
System-Level COD Activities

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

- Establish conceptual and policy framework
- Build competencies and skills
- Enhance programs and service structures
- Align fiscal resources and administrative policies in support of integrated care
- Monitor, evaluate and adjust
Workforce Development

*Build competencies and skills*

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

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

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

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

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

http://www.ct.gov/dmhas/cosig/screening
Integrated Services Models and Program Assessment Measures

– Integrated Dual Disorders Treatment (IDDT) model
  • Evidence-based model
  • Developed by Faculty at Dartmouth Medical School (Drs. Mueser, Drake, et al.)

– Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index
  • More than 20 states currently using the DDCAT
  • Developed by Dr. McGovern at Dartmouth Medical School
IDDT and DDCAT Summarized

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

• Systematically assessed a **30% sample** of all DMHAS-operated and funded addiction treatment programs;

• Assessed pre and post co-occurring capability in **nine addiction treatment programs** that participated in a change process designed to increase their capacity to serve individuals with co-occurring disorders;

• All DDCAT assessments were done using a **site visit methodology** including multiple sources of data.
Co-Occurring Practice Improvement Collaborative

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

DDCAT Sample
n=53

- Detox: 9%
- Residential: 40%
- Outpatient: 42%
- Methadone: 9%
Results: Statewide Sample

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

Dual Diagnosis Capability by Region

Percentage of Programs Meeting DDC Criteria

Region 1  Region 2  Region 3  Region 4  Region 5

Region
Results by Level of Care

Dual Diagnosis Capability by Level of Care

Percentage of Programs Meeting DDC Criteria

- Detox: 60%
- Outpatient: 50%
- Methadone Maintenance: 40%
- Residential: 10%

Level of Care
Results for Collaborative Process

Collaborative DDCAT Pre and Post

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre Score</th>
<th>Post Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Program Structure</td>
<td>2.47</td>
<td>2.75</td>
</tr>
<tr>
<td>II. Program Milieu</td>
<td>2.50</td>
<td>3.33</td>
</tr>
<tr>
<td>III. Assessment</td>
<td>2.66</td>
<td>3.17</td>
</tr>
<tr>
<td>IV. Treatment</td>
<td>2.39</td>
<td>2.64</td>
</tr>
<tr>
<td>V. Continuity of Care</td>
<td>2.69</td>
<td>2.78</td>
</tr>
<tr>
<td>VI. Staffing</td>
<td>2.69</td>
<td>3.11</td>
</tr>
<tr>
<td>VII. Training</td>
<td>2.44</td>
<td>3.44</td>
</tr>
</tbody>
</table>

Program Category Improvement
- Pre
  - Addiction Only: 9
  - Dual Capable: 0
- Post
  - Addiction Only: 6
  - Dual Capable: 3
Next Steps: Systems/Practice

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

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

Aligning

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

• Administrative Policies
  – ASO billing procedure adjustments
COD Data / Outcomes

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

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

- Co-Occurring Center for Excellence (COCE)
- Dartmouth Addiction Treatment Services Research
- Ohio SAMI CCOE
  [http://www.ohiosamiccoecase.edu/index.html](http://www.ohiosamiccoecase.edu/index.html)
- SAMHSA Co-Occurring Disorders Website
  [http://www.samhsa.gov/Matrix/Matrix_cooc.aspx](http://www.samhsa.gov/Matrix/Matrix_cooc.aspx)
Contact Information

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Division of Forensic Services