Treatment, Volume 2: Addressing Co-Occurring Disorders in Non-Traditional Service Settings

Overview Paper 5

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment
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The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training delivered through curriculums and materials on-line, by telephone, and through in-person consultation.

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Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

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SUMMARY

Only about half the people with co-occurring disorders (COD) receive any services within substance abuse and mental health (SA/MH) settings. Settings outside the SA/MH system, or settings where service missions do not include a primary focus on COD, are the focus of this overview paper. Primary health, public safety and criminal justice, and social service settings, where persons with COD are likely to be seen, are highlighted. These settings should be prepared to identify and effectively respond to persons with COD. The use of specialized techniques appropriate to these settings can increase the likelihood that the person with COD will access needed treatment.

INTRODUCTION

Persons with COD reside throughout our communities and move through all system and service locales. While significant progress is being made within SA/MH settings to comprehensively address the complex needs of persons with COD in an integrated manner, almost half of all persons with COD do not access any SA/MH services. Unrecognized and untreated COD results in excess morbidity and mortality; unnecessary health and personal expenditures; and frustration for families, intimates, and service providers. However, the disabilities and social consequences associated with COD bring those affected in contact with a number of public health, public safety, and social welfare providers. These contacts, if handled with sensitivity to COD issues, afford unique opportunities for identification, initial engagement, and linkage to appropriate care systems.

LITERATURE HIGHLIGHTS

SA/MH settings have made significant progress in addressing the needs of persons with COD. However, many persons with COD never see a SA/MH provider. The 2003 National Survey on Drug Use and Health shows that 49 percent of persons with a serious mental illness (SMI) and a co-occurring substance use disorder received no treatment in the 12 months preceding the survey (Office of Applied Studies, 2004). Although large numbers of persons with COD are not seen in SA/MH settings, they can be found in several other settings:

- About 70 percent of the U.S. population sees a primary care physician every two years (Fleming et al., 1997). Because of the high frequency of medical conditions that co-occur with COD and the stigma associated with SA/MH disorders that leads those with the disorders to avoid formal treatment, persons with COD often seek medical care in emergency rooms and primary care settings (Jones et al., 2004; Mader et al., 2001; McLellan & Meyers, 2004; Saitz, 2003).
- There has been considerable growth in the number of persons having contact with the criminal justice system over the past decade. More than 13 million "bookings" occur in U.S. jails each year (Bureau of Justice Statistics, 2005), and more than two million people are incarcerated in the Nation's prisons and jails (Harrison & Beck, 2005). The overrepresentation of persons with mental illnesses and substance use disorders in criminal justice settings is well documented (CSAT, 2005b; Teplin, 1994; Teplin et al., 1996), and almost three-quarters of those with mental illnesses have co-occurring substance use disorders, while 15 percent of those with substance use disorders have co-occurring SMI (National GAINS Center, 2002).[1]

Table 1: Key Definitions

Substance abuse and/or mental health (SA/MH) service settings	Agencies, programs, and facilities specifically designed to treat psychiatric and/or addictive disorders.
Non-SA/MH settings	Settings outside of the SA/MH system where persons with COD are likely to be encountered. These can be divided into three categories: • Health settings, including primary care (e.g., community health clinics, HIV/AIDS treatment programs, family practice locales) and acute care (e.g., emergency rooms, intensive care units, trauma centers) settings. • Public safety and criminal justice settings, including police encounters, courts, jails, prisons, and community corrections settings. • Social welfare settings, including income support, entitlement and unemployment offices, homeless shelters (as well as makeshift shelters, parks, and abandoned buildings) and the community (e.g., schools and faith and workplace settings).

[1] According to emerging research, rates of co-occurring disorders among the juvenile justice population are estimated to be as high as 50 to 80 percent (SAMHSA, 2002).

- The Urban Institute estimates that 2.3–3.5 million people experience homelessness each year (Burt & Aron, 2000). Studies suggest that as many as 37 percent of homeless women and 32 percent of homeless men had co-occurring Axis I and substance use disorders in 2000, a marked increase from 1990 figures (North et al., 2004). The settings in which these persons are found include not only homeless shelters, but also streets, parks, and abandoned buildings.
- People with and at risk for COD may also be found in community settings including workplaces, places of worship, and social welfare agencies, while at-risk children and adolescents are found in our schools.

The principle of "No Wrong Door," whereby every point of entry into the healthcare system is seen as an opportunity for outreach, education, and connection to needed services, is embraced by mental health and addiction service systems (U.S. Department of Health and Human Services, 1999). This principle can be extended to a variety of public and private domains such as the non-SA/MH settings highlighted here. While non-SA/MH settings should not be expected to provide comprehensive SA/MH services, they afford important opportunities for identification and engagement of persons with COD and can serve as gateways to integrated systems of care.

KEY QUESTIONS

1. Why be concerned about settings outside the SA/MH system or settings where service missions do not include a primary focus on COD (non-SA/MH settings)?

Given that only half of persons with COD receive any service within SA/MH settings, non-SA/MH settings associated with the health care, public safety and criminal justice, and social welfare systems afford a critical opportunity for identification, initial engagement, and early intervention. Most persons with untreated COD cannot function optimally in school, work, or within their families and communities. This impaired functioning leads to an overrepresentation in acute and high-cost health, public safety and criminal justice, and social welfare settings. The proper identification of SA/MH disorders that contribute to a person's social circumstance or presenting complaint is an important step toward helping that person realize his or her full potential and live a rewarding life in the community.

2. In what non-SA/MH settings are people with untreated COD found?

The simple answer is that persons with untreated COD are found everywhere in our communities. However, the medical, social, and psychological consequences of COD increase the likelihood of their presence in certain locations. In addition, the severity and progression of COD can determine the settings in which untreated persons may initially present, from emergency rooms to homeless camps.

Figure 1 (page 3, adapted from National Association of State Mental Health Program Directors [NASMHPD] & the National Association of State Alcohol and Drug Abuse Directors [NASADAD], 1999) depicts a model that provides a framework for understanding the range of co-occurring conditions and the settings in which people with COD are likely to be found. The model's utility for individual treatment and program planning has not been established, but it provides guidance to communities in determining the settings where persons with COD present, and supports strategies to identify, engage, and respond to their needs. Descriptions of three categories of non-SA/MH settings follow.

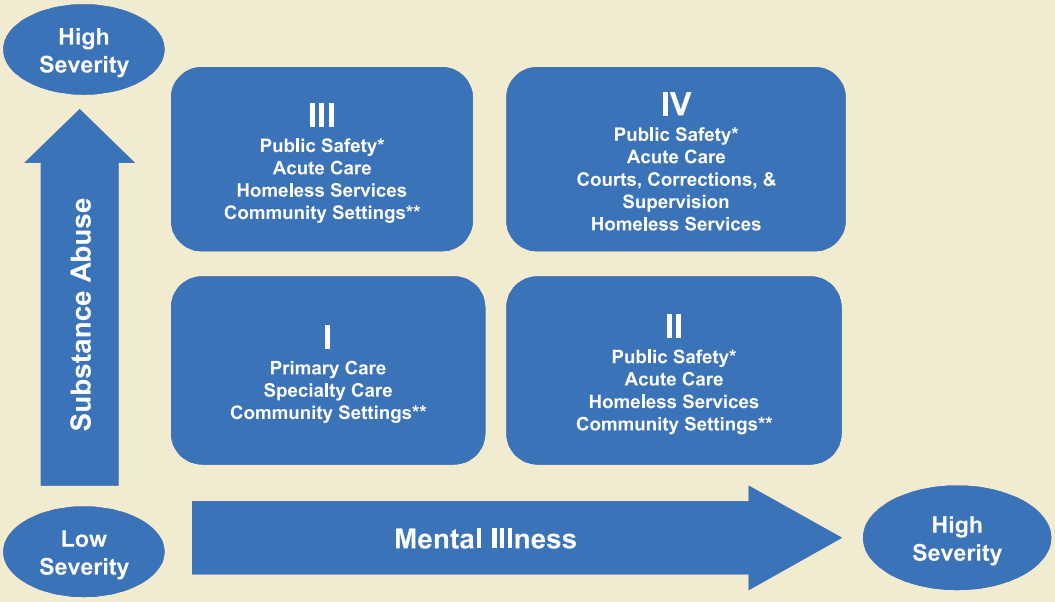
Health Settings

Primary Care: Well before persons with COD come to the attention of SA/MH providers, most will have seen a primary care provider (O'Connor & Schottenfeld, 1998; Simon & VonKorff, 1995). Depression and anxiety disorders frequently present as somatic symptoms such as fatigue, headaches, and pain, which in turn are the leading causes of medical visits (Kroenke, 2003). Substance use disorders frequently complicate the management of many chronic illnesses such as hypertension, diabetes, and asthma (Rehm et al., 2003). Conversely, the association of medical problems with mental illnesses and substance use disorders is also high. In a recent survey of persons with SMI, 74 percent had at least one diagnosed chronic health problem (Jones et al., 2004). Moreover, the effects of substance use on a variety of organ systems and the high rates of infectious disease among persons with substance use disorders ensure that large numbers of these individuals will be seen in primary care settings (Saitz, 2003).

Persons with COD tend to be in poorer physical health than persons without these disorders and in poorer health than persons with either disorder alone (Osher, 1996). Within primary care outpatient settings, it is estimated that 25 percent of patients have a current psychiatric disorder and 20–25 percent have a substance use disorder (Brady, 2002). As gatekeepers to health services, primary care physicians have a powerful opportunity to identify COD early and initiate appropriate treatment—for example, counseling patients on abstinence (National Center on Addiction and Substance Abuse, 2000). While they typically do not have the resources to provide comprehensive care, they can refer patients to SA/MH specialists.

The United States Preventive Services Task Force recommends routine screening for alcohol and drug problems, dementia, depression, and suicide risk (Agency for Healthcare Research and Quality, 2005). These recommendations have not been implemented in most primary care settings (Friedmann et al.,

Figure 1: Special Settings as a Function of COD Severity



2000; Haack & Alemi, 2002; Woolf et al., 1996). Accordingly, opportunities for early identification and treatment of COD are being missed.

Specialty Care: Specialty care combines primary health care with specialized services for persons with chronic physical illnesses, such as HIV/AIDS. The pressing nature of deteriorating physical conditions can motivate a person with COD to seek care and follow up with suggested treatment plans. Specialty healthcare settings may have the staff resources to provide assessment and some treatment services for COD.

Acute Care: Acute care refers to short-term interventions provided in emergency rooms, trauma centers, and intensive care units. Untreated COD has a significant impact on health, and persons with untreated COD will often enter the service system through contact with urgent or acute care settings. Screening and identification of SA/MH disorders in these settings may not be routinely conducted (Kushner et al., 2001; McClellan & Meyers, 2004; O'Connor & Schottenfeld, 1998; Simon & VonKorff, 1995), and given the time constraints, COD treatment beyond brief intervention is unlikely. However, if COD is suspected through screening procedures, counseling and referral can be effective in moving the person to an appropriate treatment setting.

Public Safety and Criminal Justice Settings

Responding to the needs of persons with COD constitutes a major challenge for police and other public safety officials, prosecutors, courts, and corrections and supervision systems.

Police: Persons with COD, particularly those without access to adequate treatment, frequently come in contact with law enforcement. If illegal or criminal activity is observed, such as possession or sale of controlled substances, this contact can begin a series of appearances within criminal justice settings. Significant police manpower is required to respond to persons with SA/MH disorders, many of whom are eventually incarcerated (Reuland, 2004).

Corrections: It has been documented that a considerable number of incarcerated individuals have COD (Abram & Teplin, 1991; Hartwell, 2004; Steadman et al., 1999). As a consequence of their incarceration, persons with COD have legal rights to have access to health care, to receive any care that is ordered, and to have healthcare decisions made by medical personnel (Cohen, 2003; National Commission on Correctional Health Care, 2003). Unless COD is recognized and addressed, recidivism is the likely outcome for incarcerated persons with COD (Hammett et al., 2001).

Jails may offer the first opportunity for problem identification, treatment, and community referral (Peters & Matthews, 2001). Nonetheless, jails are high-volume, highly structured, high-turnover institutions with little time to initiate more than basic assessment of mental health and substance abuse issues with appropriately matched urgent care responses. Prisons are State- or federally operated facilities for inmates with longer sentences (usually exceeding 1 year). As such, they presumably have more opportunities to develop integrated service programs. While the vast majority of

prisons have substance abuse programs, only a small minority of prisoners with substance use disorders get access to any addiction treatment (CSAT, 2005b). The likelihood of access to integrated dual disorder programs is even smaller.

Courts and Supervision: Courts report increasing contact with offenders with COD and drug court judges have found that defendants with COD are among the most difficult to place into treatment (Denckla & Berman, 2001).

Social Welfare Settings That Afford an Opportunity for COD Interventions

Homeless Services: More than two million U.S. citizens will experience homelessness in a calendar year. More than 40 percent of these homeless persons have substance use disorders, with recent estimates as high as 84 percent of men and 58 percent of women (North et al., 2004). Twenty percent of homeless persons have SMI, and 25 percent have some form of disabling health condition (CMHS, 2003). One third of homeless persons have COD (CSAT, 2005a). While integrated care has been cited as important to the recovery of homeless persons with COD, few have access to it (Oakley & Dennis, 1996). Homeless people are disaffiliated and are not often voluntary recipients of any kind of health services. Thus, homeless persons with COD may remain undiagnosed and untreated. This, in turn, can lead to continued homelessness and further deterioration in physical, social, and economic functioning.

Community Settings: Persons at high risk for—or in the early stages of—SA/MH disorders often continue to function and fulfill work, school, and family obligations (Klitzner et al., 1992). The tendency of lay people to "normalize" early signs of deteriorating functioning (Mechanic, 1978), combined with the stigma attached to SA/MH problems and a lack of familiarity with warning signs on the part of teachers, supervisors, clergy, and parents, may lead to missed opportunities for early intervention. Significant levels of deterioration in functioning and/or disruption may lead to punitive actions rather than referral to helping resources.

3. What can be done in primary healthcare settings to help persons with COD?

The Institute of Medicine report *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006) highlights the strong link between mental and substance use disorders and general health care. One of the report's overarching recommendations states, "Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." COCE takes the position that a first step in implementing this recommendation is to identify persons with COD as a routine component of care in each of the health settings discussed above. This position is based on considerations of quality of care as well as cost recovery for care providers and payors. Overview Paper 2, *Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders* (currently available), provides details on the methods and procedures by which this identification can be accomplished.

An efficient screening method for COD in primary care settings is laid out in Figure 2, below. It combines two questions related to depression with the four questions of the CAGE (or CAGE-AID—adapted to include drugs). If these six questions are used for screening on an annual or regular basis, it is likely that the depression screening items will serve as a marker for a wide range of mental health issues and that the CAGE/CAGE-AID items will help identify substance-related problems. Any single positive response should lead to

Figure 2: Screening For COD in Primary Care Settings

Depression

- Over the past two weeks, have you felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

CAGE (CAGE-AID)

1. Have you ever felt you should **C**ut down on your drinking (or drug use)?
2. Have people **A**nnoyed you by criticizing your drinking (or drug use)?
3. Have you ever felt bad or **G**uilty about drinking (or drug use)?
4. Have you ever taken a drink (or a drug) first thing in the morning (Eye-opener) to steady your nerves or get rid of a hangover?

Sources: Agency for Healthcare Research and Quality, 2002, 2004; Fiellin et al., 2000, p.1979.

a thorough assessment by a mental health and/or substance abuse professional. A positive response to both an item from the depression questions and an item from the substance use questions should lead to an assessment by a COD professional.

It is recognized that resources beyond screening and identification are not readily available in most primary health settings, and inadequate financing for these basic services is often a barrier (McLellan & Meyers, 2004). As such, community mental health and substance abuse systems of care must be designed to support public and private health care settings' screening efforts with appropriately matched and readily accessible assessment and treatment services delivered within SA/MH programs.

A continuum of responses to persons with COD who appear in health settings can be identified (NASMHPD & NASADAD, 1999):

- *Identification and Initial Management* is the minimum level of responsibility. It involves screening for COD and providing brief, structured, targeted advice to patients. Referral of those with positive screens or more serious symptoms may be necessary. The health setting retains responsibility for the client's general health care unless or until the client is referred to a treatment facility that offers health care in addition to COD services. Upon discharge from such a facility, responsibility for general health care reverts back to the original, referring setting.
- *Collaboration* is a more formal process of sharing responsibility for treating a person with COD, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different disorders are treated by different providers, yet the roles and responsibilities of the providers are clear.
- *Integration* requires the participation of providers trained in both primary care and SA/MH services to develop a single treatment plan addressing all health conditions. These providers continue their formal interaction and cooperation in the client's ongoing reassessment and treatment.

Several considerations will determine where a given health setting operates on this continuum. While the nature and type of integration will vary by communities, it has been proposed that the SA/MH system take the lead in developing the plan (CSAT, 2000a). Other considerations include resources, funding, clinical interest in COD, and the availability of other COD resources in the community. Treatment Improvement Protocols (TIPs) 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000b) and 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005a), address how providers with specialized training for "triply diagnosed" clients have been successful in addressing COD. For example, the HIV Integration Project of The CORE Center in Chicago, Illinois (CSAT, 2005a) is a good example of a local integrated service response to health and COD needs. There are as yet no data to favor one approach over another; agencies will address COD issues to the extent that their resources allow and can participate in advocating and soliciting additional funding to support enhanced COD interventions.

4. What can be done in other non-SA/MH settings to help persons with COD?

Like primary health settings, other settings can also serve as gatekeepers for the SA/MH system. These settings provide an opportunity to recognize persons who may have COD and to engage them in a process that leads to referral for further assessment and integrated treatment. This recognition, engagement, and referral approach requires strong partnerships with community SA/MH providers. These approaches typically require the oversight of a multidisciplinary community planning group, training for frontline staff, the development of specific referral guidelines, and easy access to welcoming clinical settings.

Public Safety and Criminal Justice Settings

Innovative police responses to persons with COD illustrate a recognition, engagement, and referral approach. Law enforcement is often the initial point of contact for persons with COD who may have violated a public ordinance, committed a crime, or raised the suspicions of other citizens or police through unusual, disruptive, and/or bizarre behavior. During the last 10 years, police-based specialized responses, most notably the Crisis Intervention Team, have been implemented across the country (Reuland, 2004). In these models, police receive intensive training to recognize and engage persons with COD, with the goal of increasing access to treatment and support services and diversion from criminal justice settings.

Problem-solving courts, such as drug courts and, more recently, mental health courts, have developed as a response to the growing influx of persons with COD in the court system. These settings have recognized the need to develop specialized responses to the defendant with COD (Peters & Osher, 2004). Such responses include specialized training for court personnel to help them identify people with SA/MH needs, implementing specialized programming, and championing community alternatives for these individuals. The goals of these initiatives include an increase in public safety, better quality of life for the consumer with COD, and a more effective use of overtaxed criminal justice resources (Council of State Governments [CSG], 2005).

Identification and management of COD within jails and prisons mirror the complexity of providing care within community settings. While the inmate with COD is legally entitled to health care and can be more easily "engaged" in treatment, jail and prison treatment resources are scarce (Fellner & Abramsky, 2003), and integrated care programs are rare. Jails are attempting to improve screening procedures for COD with the use of standardized instruments administered by correctional staff (Steadman et al., 2005).

Opportunities for brief motivational interventions exist, yet the capacity of understaffed jail providers and inmates to develop a strong therapeutic alliance is limited. Such collaborative efforts as the Vermont Departments of Health and Corrections coordinate programming to better identify, assess, and treat offenders with COD in their criminal justice system (CSG, 2005). Sacks and colleagues (2004) describe a modified therapeutic community model that has shown significantly lower reincarceration rates for persons with COD leaving incarcerated settings. Because of the stigma associated with the combination of COD and a criminal record, specialized programming is necessary to ensure successful transition to communities on release (CSAT, 2005a).

Social Welfare Settings

Outreach is often required in order to reach individuals who are marginalized, isolated, alone, or homeless (Federal Task Force on Homelessness and Serious Mental Illness, 1992). A rich history of outreach efforts to marginalized individuals exists in the United States (Lam & Rosenheck, 1999; Tommasello et al., 1999). By starting with what the marginalized person values and desires, it is possible to develop a relationship that can address associated conditions such as mental illness and/or addiction. Once engaged, the individual will benefit from the same integrated interventions associated with positive outcomes in other clinical settings.

Central to the process of outreach and engagement is the establishment of a "helping relationship." Core characteristics of this relationship include mutual trust and respect, tolerance and flexibility, patience and realism, and actually being helpful in the eyes of the consumer (Winarski, 1998). Sacks and associates (2002) have described adaptations of therapeutic communities in shelters that use the peer community and a focus on mutual self-help as a starting point to engage homeless persons with COD. Once engaged, providing access to supportive housing can have a powerful effect on outcomes for homeless persons with COD (CSAT, 2005a).

Community Settings

Schools, workplaces, community groups, families, and friendship networks are the settings in which individuals spend the most time. Signs of COD are likely to manifest in these settings, although they are unlikely to be recognized as such. Student and employee assistance programs, informational kiosks at community events, pastoral counseling, and other similar intervention methods offer the potential for early identification and referral of high-risk individuals before serious COD-related problems emerge (Klitzner et al., 1992).

FUTURE DIRECTIONS

For a variety of reasons, COD is currently neither widely recognized nor well addressed in the settings discussed in this paper. Wider dissemination on the use of screening and identification techniques appropriate to these settings could encourage programs to develop efficient referral mechanisms and/or more onsite COD interventions. Demonstration programs have shown that identification and effective care are possible, but access to these innovations is not widespread. The activities that staff in these settings need to perform—recognizing signs and symptoms, making referrals, and the like—can be learned, although training would need to be expanded to include primary care practitioners, justice staff, and social welfare personnel. Excellent models, some of which are cited in this paper, are available for community-level adoption. Future work should address issues of dissemination and implementation of these models.

Realizing the goal of "No Wrong Door" requires increased awareness of COD in non-SA/MH settings, fostering enlightened self-interest in COD issues, and establishing the community networks, teamwork, and systems required to meet the needs of persons with COD. SA/MH providers should take the lead in creating a continuum of COD services to support efforts in non-SA/MH settings.

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National Development & Research Institutes, Inc.

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Stephanie Perry, M.D., *Bureau of Alcohol and Drug Services, State of Tennessee*
Richard K. Ries, M.D., *Dual Disorder Program, Harborview Medical Center*
Linda Rosenberg, M.S.W., CSW, *National Council for Community Behavioral Healthcare*
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