

Clinical Perspective on Continuum of Care in Co-Occurring Addiction and Severe Mental Illness

Oleg D. Tarkovsky, MA, LCPC

SAMHSA Definition

“Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). There are no specific combinations of....disorders that are defined uniquely as co-occurring disorders.”

In “A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders”

Examples of Psychiatric Disorders Associated with Co-Occurring Disorders

- Schizophrenia
- Other psychotic conditions
- PTSD
- Mild depressive disorders
- Closed head injuries
- Anti-social personality D/O
- Bipolar Affective D/O
- Major depression
- Other Anxiety Disorders
- Mild organic syndromes
- Eating Disorders
- Borderline personality D/O

Examples of Addiction Disorders Associated with Co-Occurring Disorders

- Alcohol Abuse/Depen
- Cocaine/ Amphet
- Opiates
- Marijuana
- Polysubstance combinations
- Prescription drugs

Naming Addiction and Mental Health Problems

- Dual Diagnosis/Dual Disorders
- MICA - mentally ill chemical abusers
- MISA - mentally ill substance abusers
- SAMI - substance abusing mentally ill
- CAMI - chemical abusing mentally ill
- 3-D patients: drinking, drugged, disturbed
- Comorbid Disorders
- Combined Disorders
- Co-occurring Disorders
- Concurrent Disorders

Impact of Co-occurring Disorders:

- **Increase risk of violence**
- **Psychotic relapse**
- **Higher cost to services**
- **Treatment non-compliance**
- **HIV and medical problems**
- **Homelessness**
- **Higher rate of re-admission to hospital**
- **More unemployment**
- **Poorer overall functioning**
- **Neurocognitive deficits**

There is no one type of dual diagnosis program or intervention. For each person, the correct treatment intervention must be individualized according to subtype of dual disorder and diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder.

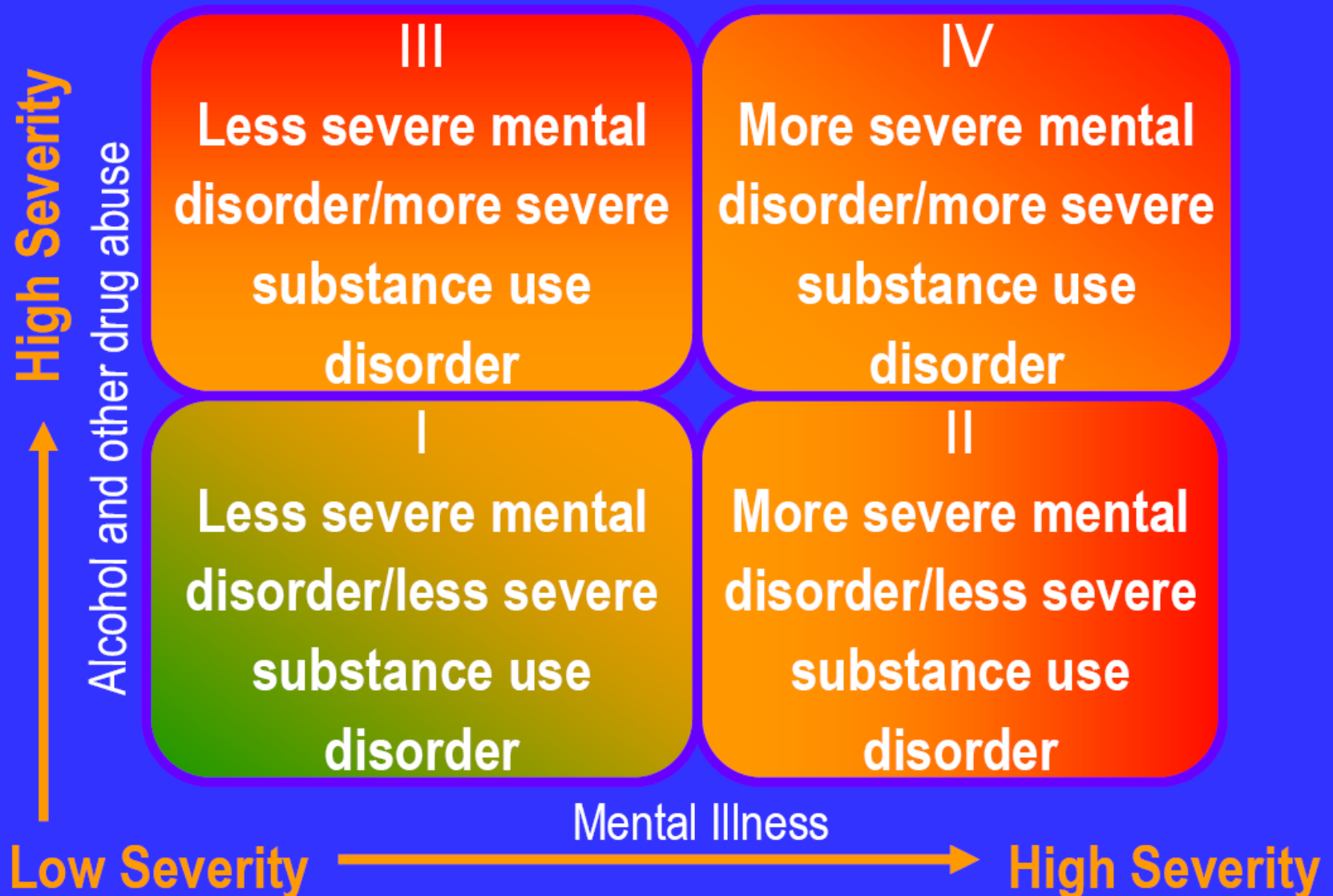
Identification of the Population in Need

- Screen individuals for co-occurring disorders
- Assess the level of severity
- Treat in comprehensive and coordinated manner

CAGE

- **Cut Down** (or stopped)
 - Because symptoms worsened
 - Because doctor or therapist suggested
- **Annoyed when asked drug/alc. use discussed**
 - Annoyed, angry, fights when using
 - Admitted to ER or hospital when using
- **Guilty about use**
 - Guilty, depressed, suicidal when using
 - Ever made a suicide attempt when using
- **Eye opener: taken drink or drug in AM to feel better**
 - Taken drink or drug with meds
 - Not taken meds because of using drug/alc.

Co-Occurring Disorders by Severity



Service Delivery for COD

LOW - HIGH

Collaboration between systems

Eligible for public alcohol/drug services but not mental health services

Low to Moderate Psychiatric Symptoms/Disorders

And

High Severity Substance Issues/Disorders

Services provided in outpatient and inpatient chemical dependency system

HIGH - HIGH

Integration of services

Eligible for public alcohol/drug and mental health services

High Severity Psychiatric Symptoms/Disorders

And

High Severity Substance Issues/Disorders

Services provided in specialized treatment programs with cross-trained staff or multidisciplinary teams

LOW - LOW

Consultation between systems

Generally not eligible for public alcohol/drug or mental health services

Low to Moderate Psychiatric Symptoms/Disorders

And

Low to Moderate Severity Substance Issues/Disorders

Services provided in outpatient chemical dependency or mental health system

HIGH - LOW

Collaboration between systems

Eligible for public mental health services but not alcohol/drug services

High Severity Psychiatric Symptoms/Disorders

And

Low to Moderate Severity Substance Issues/Disorders

Services provided in outpatient and inpatient mental health system

Integrated Co-occurring Services

- Improve quality of life
- Promote hopeful interactions
- Utilize biopsychosocial treatments
- Promote consumer and family involvement in service delivery

Integrated Co-occurring Services

- Promote a recovery concept
- Promote and increase stable housing
- Increase continuity of care
- Promote employment as an expectation
- Increase independent living

Prevalence of Serious Mental Illness

2002 National Survey on Drug Use and Health

- An estimated 17.5 million adults aged 18 or older with SMI
 - This is 8.3% of all adults aged 18 or older
- Rate of SMI by age range
 - 13.2% among persons aged 18-25
 - 9.5% among persons aged 26-49
 - 4.9% among persons aged 50 or older

- Among adults the percentage of females with SMI was higher than for males

- 10.5% for females

- 6.0% for males

Prevalence of Serious Mental Illness 2002 *National Survey on Drug Use and Health*

Illicit Drug Use

2002 National Survey on Drug Use and Health

- 8.3 percent of the population aged 12 years or older
- 19.5 million were current illicit drug users

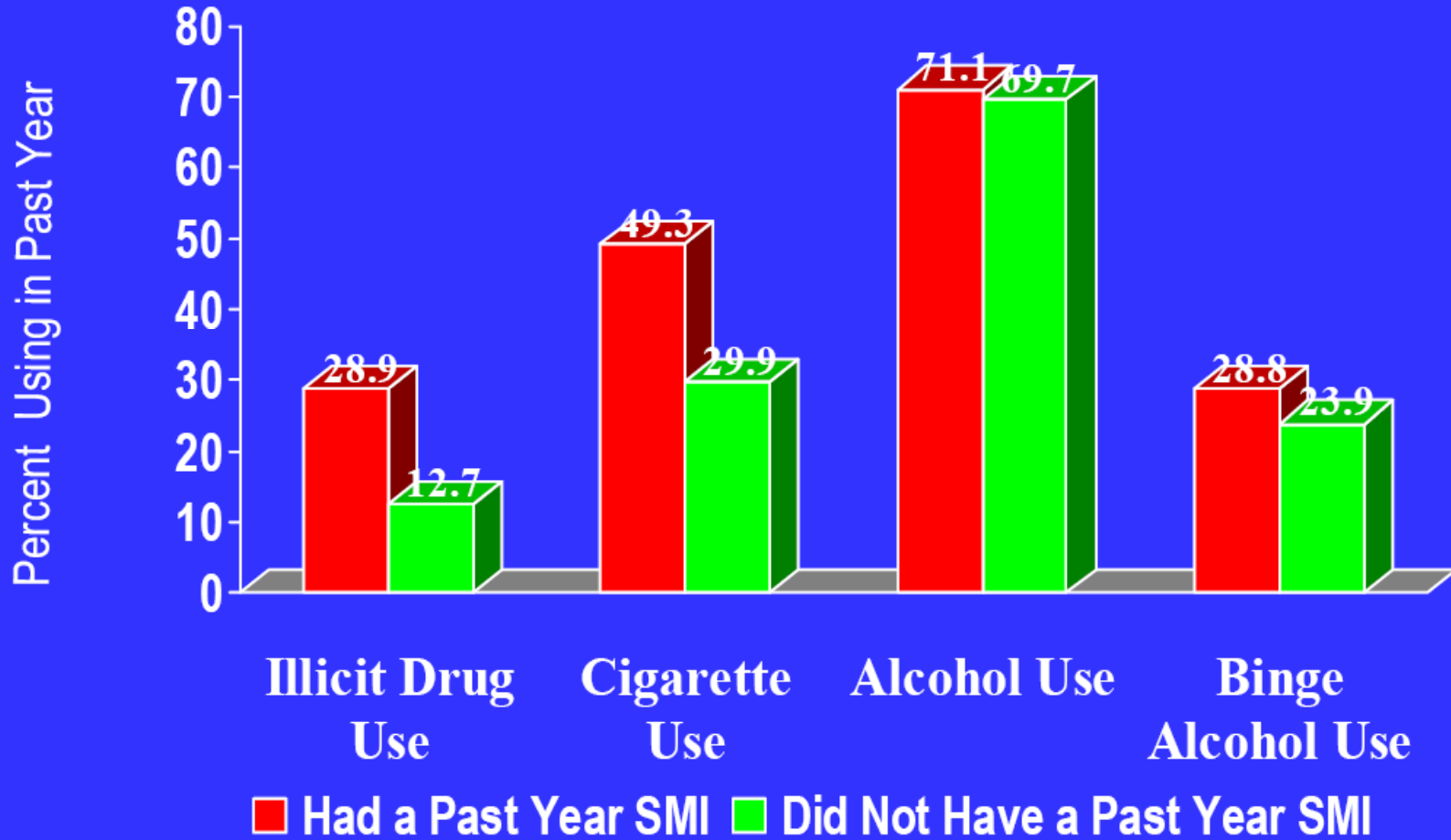
Alcohol Use

2002 National Survey on Drug Use and Health

- 15.9 million aged 12 or older are heavy drinkers
- 6.7 percent of the general population aged 12 or older reported heavy drinking

Past Year Substance Use among Adults Aged 18 or Older, by Serious Mental Illness

2002 National Survey on Drug Use and Health



Co-Occurrence of Serious Mental Illness with Substance Dependence /Abuse

2002 National Survey on Drug Use and Health

- 4.0 million adults had both SMI and SD/A in the past year
- 0.8 million had SMI and dependent/abused alcohol and illicit drugs
- 0.9 million had SMI and dependent/abused only illicit drugs
- 2.4 million had SMI and dependent/abused only alcohol

National Comorbidity Survey

Co-occurring substance use disorders and mental disorders

- 42.7% of individuals with a 12-month addictive disorder had at least one 12-month mental disorder
- 14.7% of individuals with a 12-month mental disorder had at least one 12-month addictive disorder

National Comorbidity Survey

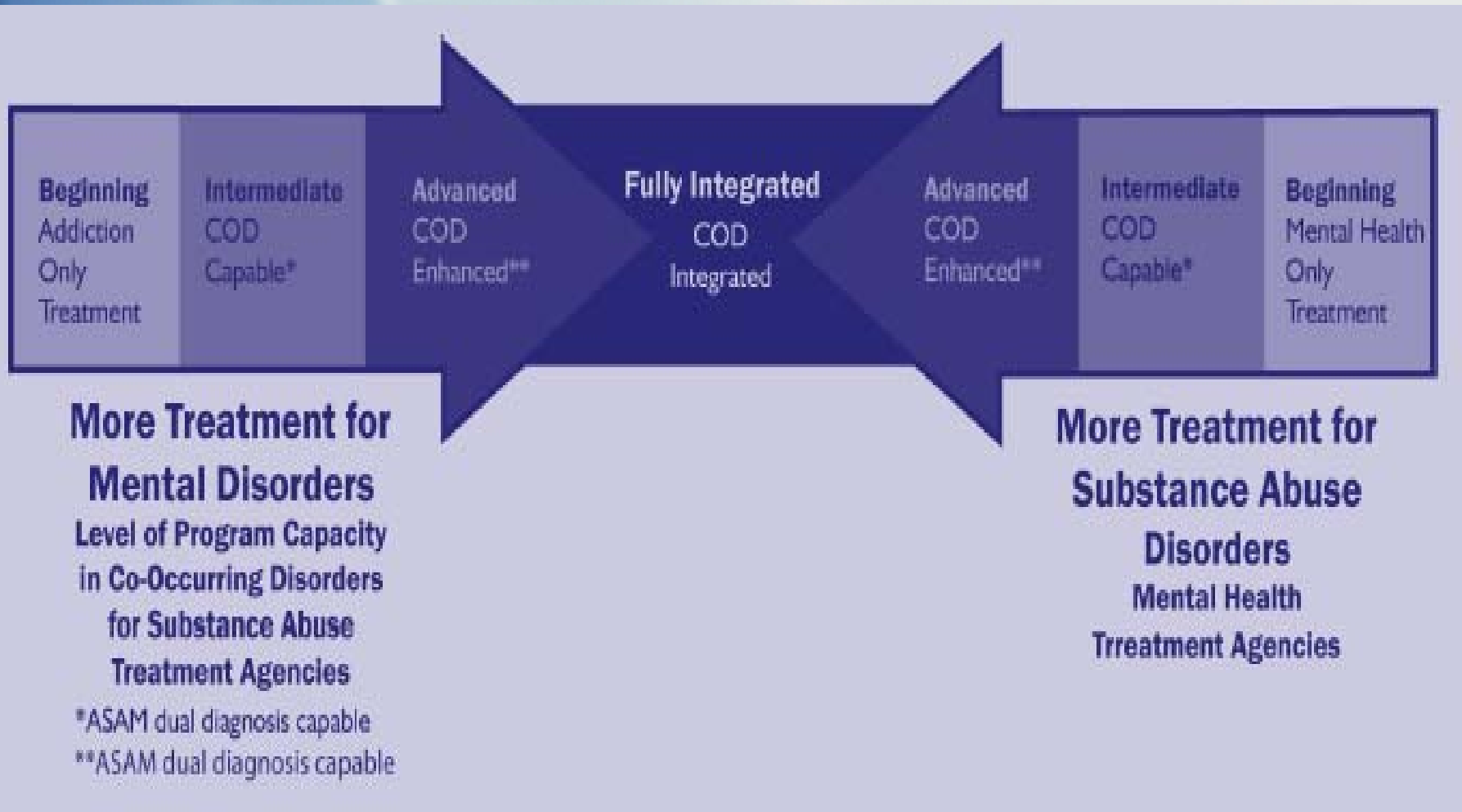
Co-occurring substance use disorders and mental disorders

- 47% of individuals with schizophrenia also had a substance use disorder \approx More than 4 times as likely as general population
- 61% of individuals with bi-polar disorder also had a substance use disorder
- Nearly 43% of youth who receive mental health services have been diagnosed with a co-occurring disorder

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

A model for bringing the mental health and substance abuse treatment systems (and other systems, potentially) into an integrated planning process to develop a comprehensive, integrated system of care

Levels of Program Capacity in Co-Occurring Disorders



CCISC Model

- Four Basic Characteristics
- Eight Principles of Treatment
- Twelve Steps of Implementation

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Four Basic Characteristics of CCISC

1. System Level Change
2. Efficient Use of Existing Resources
3. Incorporation of Best Practices
4. Integrated Treatment Philosophy

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Eight Principles of Treatment CCISC

1. Dual diagnosis is an expectation, not an exception.
2. All people with COD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level.
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 .

Eight Principles of Treatment CCISC

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

5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.

6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery),

Eight Principles of Treatment CCISC

7. There is no single correct intervention for COD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.

8. Clinical outcomes for COD must also be individualized, based on similar parameters for individualizing treatment interventions

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Twelve Steps of Implementation of CCISC

1. Integrated system planning process
2. Formal consensus on CCISC model
3. Formal consensus on funding the CCISC model
4. Identification of priority populations, and locus of responsibility for each
5. Development and implementation of program standards
6. Structures for intersystem and interprogram care coordination

Twelve Steps of Implementation of CCISC

7. Development and implementation of practice guidelines
8. Facilitation of identification, welcoming, and accessibility
9. Implementation of continuous integrated treatment
10. Development of basic dual diagnosis capable competencies for all clinicians
11. Implementation of a system wide training plan
12. Development of a plan for a comprehensive program array

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Evidence-Base for CCISC

- It is important to recognize that CCISC itself is not an evidence based practice, but an exemplary model based on evidence based practices
- This model includes work derived from the Clinical Standards and Workforce Competencies Project developed by CMHS

Evidence-Based Practices for COD

Traditional Definition of Evidence-Based Practice

- **Gold Standard**

- Assessment of research findings from randomized, controlled clinical trials

- **Next Best**

- Quasi-experimental study in which comparison groups are assigned by randomization

- **Weak Design**

- Open Clinical Trials coupled with expert-based clinical observations

**Limited Evidence in the Treatment of
COD “Controlled research on the
treatment of dual diagnosis is limited,
and the results are inconclusive, but
there are some promising findings.”**

Harvard Mental Health Letter, Vol 20: September
2003, See also, Report to Congress (2002)

Guarded Hopefulness for Integrated Treatment for COD

- Drake et al (1998) reviewed 36 research studies on the effectiveness of integrated treatment in mental health settings for people with COD.
- Drake et al concluded:
 - Integrated treatment, especially when delivered for 18 months or longer, resulted in significant reductions in substance abuse, and, in some cases, in substantial rates of remission, as well as in reductions in hospital use and/or improvements in other outcomes.

Drake et al, Schizophrenia Bulletin 24:589-305

“The most significant predictor of treatment success is an empathic, hopeful, continuous treatment relationship, in which integrated treatment and co-ordination of care can take place through multiple treatment episodes.”

-Ken Minkoff

Q & A

References

Evans, K. & Sullivan, J. M. (2001). *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser (2nd Ed.)*. New York: Guilford.

Gibbs, L.E. (2003). *Evidence-based practice for the helping professions: A practical guide with integrated multimedia*. Pacific Grove, CA: Brooks/Cole-Thompson Learning.

Hendrickson, E. L (2006). *Designing, Implementing, and Managing Treatment Services for Individuals with Co-Occurring Mental Health and Substance Use Disorders: Blueprints for Action*. Binghampton, NY: Haworth Press.

References

McGovern, M. P., Giard, J., Brown, J., Comaty, J., & Riise, K. (2006). *The Dual Diagnosis Capability in Addiction Treatment (DDCAT): A Toolkit for Enhancing Addiction Only Service (AOS) Programs and Dual Diagnosis Capable (DDC) Programs*. Unpublished manuscript, Dartmouth Medical School.

McGovern, M.P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). *Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers*. *Journal of Substance Abuse Treatment* (31), 276-275.

References

Minkoff, K., & Cline, C. A. (2004). Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-Occurring Disorders. *Psychiatric Clinics of North America*, 27, 727-743.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). Integrated treatment for dual disorders: A guide to effective practice. New York: Guilford.

Regier, D. A., Farmer, M. E., Rae, D. S., et al. (1990). *Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) Study*. *Journal of American Medical Association*, 264, 2511-2518.

References

http://www.samhsa.gov/reports/co_occur_home.htm

SAMHSA Report to Congress on The Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders