

Chapter 7: Co-occurring Mental Health and Substance Abuse Disorders

The purpose of this chapter is to describe services for adults diagnosed with co-occurring mental health and substance abuse diagnoses, including existing resources, particular strengths of current initiatives, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources

Until quite recently, Oklahoma did not have a plan to assure that individuals with co-occurring mental health and substance abuse disorders had access to integrated mental health and substance abuse treatment. Although some community agencies understood this need and were prepared to respond appropriately, the system overall had little capacity to serve persons with a dual diagnosis. As described below, ODMHSAS has initiated a pilot program with 15 agencies in five counties to change this.

B. Strengths

In 2004, ODMHSAS received a five-year Co-Occurring State Incentive Grant (COSIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The overarching goal of the OK-COSIG project is to develop an Integrated Services Initiative (ISI) to improve the delivery of state-funded services for people in Oklahoma with or at risk for co-occurring mental health and substance abuse disorders. The project will contribute two interventions to promote systemic infrastructure change: 1) a standard protocol for the screening and assessment of mental health and substance abuse problems will be developed, evaluated, and field tested, and 2) a model of integrated treatment will be developed that is accessible, culturally competent, and grounded in evidence-based practices.

During the first year of activity, project participants and staff identified an integrative model and developed a consensus to support the implementation of this model to treat people with co-occurring disorders. The Change Agent concept was adopted; a Change Agent is a clinician or other front-line staff member with additional training in providing integrated services to people with co-occurring disorders who advocates and acts as a consultant to staff and professionals at his or her agency. The training needs, competencies, and curricula were identified and initial training provided, and a training manual developed. Planning was begun to develop three model sites to serve as pilot projects; the model sites came online in the fall of 2005, the beginning of the second grant year.

In December 2004, Oklahoma was invited to attend a Co-occurring Policy Academy sponsored by SAMHSA in Washington, D.C. A 12-member team comprised of staff from ODMHSAS, OHCA, University of Oklahoma Health Sciences Center and provider organizations attended and developed a state plan that supports and broadens the goals of the original COSIG Grant. The state plan highlights the importance of prevention, collaboration with other state agencies, advocacy organizations and the general health care community, as well as blended funding mechanisms and licensure and

credentialing issues. This plan has helped expand the original scope of the COSIG Grant, supported systems integration inside ODMHSAS, and promoted greater integration among partnering agencies and organizations.

The OK-COD Integrative Treatment Screen instrument was developed and made available online as a part of the ODMHSAS Integrated Client Information System (ICIS). The instrument is being tested for reliability, validity, sensitivity and specificity. An ISI Advisory Group of stakeholders was formed, with subcommittees on Training and Workforce Development, Screening and Assessment, Outcome and Evaluation, Financial Issues, and Systems Integration.

A Consensus Document was developed for use among local providers at each model site; it spells out in detail the responsibility of each agency to the other agencies. The document was endorsed by the agencies at each of the model sites involved in the pilot projects, and is considered a major accomplishment. The document describes a consensus plan of action that is consumer-driven and recovery-focused; it also articulates the commitment of co-signers to specific activities and objectives, at all levels of the system.

A cross-training initiative for substance abuse service providers and mental health service providers was implemented in the first year of the project, and cross-training on creating a trauma-informed system was offered in the second year of grant activity. Also during the second year, consensus-building among stakeholders continued, workshops and core trainings were delivered, and agencies for the second cohort of pilot programs were identified. There are currently 15 community providers that have agreed to work toward becoming model dual-diagnosis capable programs. These programs are located in Oklahoma City, Norman, Tulsa, Vinita, and Tahlequah.

C. Needs and Existing Barriers

Unmet Needs

The SAMHSA annual National Survey on Drug Use and Health (NSDUH), 2004, estimated that 9.6 percent of all adults in the United States had serious psychological distress (SPD) in the past year (Wright & Sathe, 2006).

Oklahoma ranked ninth among all states, with an estimated 10.9 percent of the population, age 18 years or older, having serious psychological distress in the past year. In the 2002 NSDUH, an estimated 28.9 percent of adults aged 18 or older with SPD used an illicit drug in the past year. (Epstein J., Barker, P., Vorbürger, M., & Murtha, C., 2004). Extrapolating these numbers to the estimated Oklahoma population with SPD results in an estimated 83,909 adults aged 18 or older with a co-occurring disorder in Oklahoma.

Among the 71,584 clients who received ODMHSAS-funded services in fiscal year 2005, an estimated 14,615 (27%) should have been served in an either integrated-capable programs (where providers can link people with the right treatment) or in enhanced programs (which provide integrated mental health and substance abuse services), based on diagnosis, presenting problem or assessment scores. While there is currently no ideal way to collect data on clients served in integrated programs, providers report the service focus for each client. During FY2005, 2,701 clients were served with ODMHSAS funds under one of three multi-service categories: mental health, substance

abuse and domestic violence; mental health and substance abuse (where a program provides both services separately); or co-occurring (where integrated mental health and substance abuse services are provided). This results in 11,914 (82%) dually diagnosed clients with an unmet need for integrated substance abuse and mental health services.

This is an underestimate of unmet need for two reasons. First, the analysis does not include an additional 18,032 persons for whom mental health or substance abuse services were reimbursed by OHCA, and who are therefore not included in the client information system. Extrapolating from the ODMHSAS data, there are an additional 4,868 persons estimated to need integrated services. Finally, this analysis is limited to persons who present for treatment. As described above, we estimate that almost 84,000 adults have co-occurring disorders. Based upon the services data, 77% of this group is not presenting for either mental health or substance abuse treatment.

Policies

Focus group participants said that there are several policy issues that need to be resolved if the Department's goal of providing integrated mental health and substance abuse treatment is to be implemented successfully statewide. It was noted that while plans call for coordination or integration of treatment at the provider level for people with dual diagnoses, the Mental Health and Substance Abuse Divisions within ODMHSAS maintain their separate "silos," and have policies that are not always compatible. For instance, the two divisions have different eligibility requirements, different staff licensures and certification requirements, and focus group participants said that the divisions have different approaches to monitoring and oversight. They even refer to the people they serve by different names: people using mental health services are called "consumers," and people receiving substance abuse services are called "clients." It was pointed out that while one of the Department's goals is that providers develop "Dual Diagnosis Capability," this concept has yet to be defined concretely.

Practices/Services

Staff and management in several programs pointed out that for clients with dual diagnoses, services are still fragmented: "About 85% of our clients have co-occurring disorders. We run a co-occurring outpatient group, but we're not allowed to do substance abuse treatment because we don't have a Certified Alcohol and Drug Counselor. Yet there's little in the way of outpatient substance abuse services locally." Consumers, family members and providers all described how difficult it is for dually-diagnosed individuals to find services that meet their needs. "We have no place to take mental health consumers who have acute drug and alcohol problems. There's no place to take them for detox," one CMHC manager said. A consumer said, "Mostly staff do not understand how to treat co-occurring mental health and substance abuse problems. If you're a mental health consumer, they don't want to hear about your drug issues." A CMHC staff member noted that "most drug and alcohol programs will not accept people with dual diagnoses - including our own! It's very frustrating to clinicians, even more so to clients."

In a residential substance abuse program that says it provides co-occurring mental health and substance abuse services, dually diagnosed clients indicated that the only mental health service they received was medication, and that in groups, they only dealt

with substance abuse issues. “That’s not co-occurring treatment to me,” a client said. Clients also stated that almost everyone in the program was put on psychiatric medications, sometimes on multiple medications, even though fewer than half of them were dually diagnosed. Most people in the focus group said they felt seriously over-medicated: “I am too out of it from the meds to really work my recovery program.”

It was noted that drug courts seem to be moving away from including persons with co-occurring mental health and substance abuse problems because they believe that they don’t have capacity to serve them. Staff said that there is a need to ensure that every drug court has a mental health provider on the team, and that every mental health court has a substance abuse provider involved.

Workforce Development and Training

Issues related to licensure, certification and program accreditation were raised by several providers. It was noted that the master’s degree curriculum for Licensed Professional Counselors (LPCs), a licensing category common among mental health staff, does not include any required substance abuse courses. Most substance abuse treatment facilities use unlicensed Certified Alcohol and Drug Counselors (CADCs). As services are currently organized, most substance abuse agencies said they do not have staff members qualified to do mental health screening or provide mental health services, and many such providers’ accreditation also limits the agency to providing substance abuse services only. Reciprocally, participants said that staff in most mental health programs are not trained to provide substance abuse services, so it is difficult for these agencies to envision how they will be able to provide integrated services. Staff and management suggested that there is a need for co-licensing of individual staff so that they can provide and bill for both types of services to an individual client.

Organization/Collaboration

Respondents pointed out that differences in the cultures of mental health and substance abuse services providers remains a barrier to systems integration and services integration for co-occurring disorders. The ISI Advisory Committee noted that “There is still a lot of work to do in the effort to make sure the substance abuse agencies are full partners in the integrated system of services.”

Data

The ISI Outcomes/Evaluation Subcommittee found that there was a need for training for data entry personnel and providers related to the ability to enter more than one diagnosis into the information system. The subcommittee also called for assurances that the data system has the capacity to use the Integrative Treatment Screening instrument once it is ready for implementation.

Financing

The lack of a blended funding stream to serve people with co-occurring disorders was the most frequently mentioned barrier by focus group participants. “We should be able to co-mingle mental health and substance abuse funds,” one mental health program manager said. “It’s hard to do co-occurring treatment when the funding streams are segregated.” Another provider asked “What about integrated funding? They say it is not

an option. Providers are asked to integrate their thinking about serving this population, but at the state level, the separate funding silos exist.” Yet another provider stated that “We have high rates of identifying consumers with co-occurring disorders, but there’s no path to getting paid – neither mental health nor substance abuse wants to pay for it.” In fact, mental health funding can be used to provide substance abuse services, but apparently, this fact is not clearly understood at the direct service level. Another participant warned that “there’s a danger of creating a third silo, because both systems want to avoid treating people with co-occurring disorders. And for financial reasons, they each fear they will lose clients to the other system.”

Some providers noted that reimbursement rates were lower for substance abuse services than for mental health: “The Department pays \$48 for a substance-abuse session but \$74 for a mental health session. There's no reason for this disparity, and sometimes it drives agencies to game the system,” staff at one agency said. It was noted that, while many mental health consumers are Medicaid-eligible, many substance abuse clients are not, and that this issue needs to be addressed if integrated services are to be provided and funded. The ISI Financial Subcommittee recommended that an enhanced Medicaid rate specifically for co-occurring treatment services should be developed, reflecting the additional cost involved in assessment and treatment for both mental health and substance abuse.

Many substance abuse treatment facilities use unlicensed Certified Alcohol and Drug Counselors (CADC) to provide substance abuse treatment to dually diagnosed individuals, but the Oklahoma Health Care Authority does not reimburse for services provided by CADCs.

Leadership at agencies serving as model sites for the ISI noted that “under the grant, responsibilities are being cost-shifted to the providers.” A program manager said, “These initiatives are expensive for providers to participate in. We have to train 25% of our staff in co-occurring disorders –for us, that’s 100 people at \$65 per hour –the investment is huge.” It was also noted that agencies lose additional money by sending staff to training because that time is not billable.

Consumer & Family Involvement

While consumers and families were involved with planning at the project’s outset, it was pointed out that many consumers have dropped out since the project started. An advocate said, “The process must be made more welcoming to people with dual diagnoses.” It was also noted that a number of consumers who have been hired as Recovery Support Specialists would like to participate but are unable to get leave time from their jobs to attend meetings.

References:

Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04–3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D., & Sathe, N. (2006). *State Estimates of Substance Use from the 2003–2004 National Surveys on Drug Use and Health* (DHHS Publication No.

SMA 06-4142, NSDUH Series H-29). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.