National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders

June 16-17, 1998
Washington, DC

Sponsored by:

National Association of State Mental Health Program Directors (NASMHPD)

National Association of State Alcohol and Drug Abuse Directors (NASADAD)

Supported by:

Center for Substance Abuse Treatment (CSAT)
Substance Abuse and Mental Health Services Administration

Center for Mental Health Services (CMHS)
Substance Abuse and Mental Health Services Administration

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March, 1999
Washington, D.C.

EXECUTIVE SUMMARY

The human and economic toll of co-occurring mental health and substance abuse disorders in this country demands immediate attention. Though the problems associated with co-occurring disorders have long been acknowledged and discussed, there has been little consensus about how to accomplish needed system change.

The *National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders*, held June 16-17, 1998, in Washington, DC, offered participants an unprecedented opportunity to address this critical issue. Supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and two of its centers – the Center for Mental Health Services and the Center for Substance Abuse Treatment – the meeting was co-sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Invited participants included State mental health commissioners and alcohol and drug abuse directors, expert panelists, and Federal officials.

State alcohol and drug abuse directors and State mental health commissioners, whose dialogue forms the basis of this White Paper, exemplified a broad spectrum of treatment, administrative, and funding arrangements. Their extensive, collective experience framed the group's discussions and shaped an agenda for change.

A Consumer Group with Multiple and Complex Needs

Estimates suggest that up to 10 million people in this country have a combination of at least one co-occurring mental health and substance-related disorder in any given year (SAMHSA NAC, 1997). But numbers only begin to tell the story. Individuals with co-occurring disorders tend to have multiple health and social problems and to require costly care. Many are at increased risk for incarceration and for homelessness.

Historically, there have been a number of barriers to the provision of appropriate treatment for dually-diagnosed individuals. Most notably, there is no single locus of responsibility for people with co-occurring disorders. The mental health and substance abuse treatment systems operate independently of one another, as separate cultures, each with its own treatment philosophies, administrative structures, and funding mechanisms. This lack of coordination means that neither consumers nor providers move easily among service settings.

A New Paradigm

To reach any type of consensus on treatment and services for people with co-occurring disorders, the substance abuse and mental health communities need to develop a shared perspective and to speak the same language. Toward this end, participants in the *National Dialogue* developed a *conceptual framework* that represents a new paradigm for considering both the needs of

individuals with co-occurring disorders and the system requirements designed to address these needs.

Among its unique characteristics, the framework conceptualizes co-occurring disorders in terms of symptom multiplicity and severity rather than specific diagnoses, thereby encompassing the full range of people who have co-occurring mental health and substance abuse disorders. In addition, it specifies the level of service coordination – defined as consultation, collaboration, or integration – needed to improve consumer outcomes. This makes it flexible enough to address the needs of all individuals with co-occurring disorders and to be adopted or adapted for use in any service setting.

Finally, the framework points to the need for special attention to two groups: 1) individuals, especially children and adolescents, who are at risk for developing more serious disease; and 2) people with severe substance abuse and mental health disorders who may be found in jails, in forensic hospitals, in emergency rooms, or living on the streets. Individuals in these two groups are among those most poorly served by the current uncoordinated system of care.

A Comprehensive System of Care

A comprehensive service system designed to address the needs of people with co-occurring disorders must have support at the highest levels, meeting participants agreed. Further, it must be consumer-centered, culturally competent and feature a "no-wrong door" approach, i.e., services must be available and accessible no matter where and how an individual enters the system. The use of common data and assessment tools, staff who are trained in each other's disciplines, and flexible funding mechanisms are also critical components for success. Regardless of the specific organizational structure of the system, it must comprehensively address consumer needs in a coordinated manner.

The conceptual framework points to three specific levels of service coordination among the mental health, substance abuse, and primary health care systems required to address the needs of people with co-occurring disorders. These levels of coordination correspond to the level of severity of the disorder. The greater the severity, the more intense the level of coordination required to guarantee effective service delivery. The continuum of intensity begins with informal **consultation**, which ensures that both mental illness and substance abuse problems are addressed; moves to more formal **collaboration**, which ensures that both substance abuse and mental illness problems are included in the treatment regimen; and ends with services **integration**, which merges mental health and substance abuse efforts into a single treatment setting and treatment regimen. Each of the three types of coordination efforts requires a joint vision and ongoing commitment. In addition, shared treatment planning and interdisciplinary service teams help make all three types of coordination efforts more effective.

A Coordinated Effort

Each of the key players who participated in the meeting – the Federal agencies that supported the event, the national association sponsors, the State commissioners and directors and substance abuse and mental health experts – has an important role to play in system change. Meeting participants encouraged SAMHSA, through its Centers, to collect and disseminate best practice models; recommended that the States develop specific mechanisms to encourage, allow, and fund the collaborative efforts required to address the needs of this population; and urged NASMHPD and NASADAD to make co-occurring disorders a priority for each group separately and for both organizations together. Participants agreed to use the framework to continue the dialogue on co-occurring disorders.

Participants in the *National Dialogue* pledged to continue the work they began together and to involve all relevant stakeholders, including mental health and substance abuse providers and consumers and their families, in ongoing efforts to improve health outcomes for people with co-occurring disorders. Continued cooperation at the Federal, State, and local level will ensure that this effort proceeds with both deliberate speed and appropriate care.

INTRODUCTION

The co-occurrence of mental health and substance abuse disorders has a significant impact on individuals' lives, on their families, on health care delivery and costs, and on society as a whole. Though the problems associated with co-occurring disorders have long been acknowledged and discussed, there has been little consensus about how to accomplish needed system change.

The *National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders*, held June 16-17, 1998, in Washington, DC, offered participants an unprecedented opportunity to address this critical issue. Supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and two of its centers – the Center for Substance Abuse Treatment and the Center for Mental Health Services – the meeting was co-sponsored and facilitated by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD). Invited participants included State mental health commissioners and alcohol and drug abuse directors, expert panelists, and Federal officials.

State mental health commissioners and State alcohol and drug abuse directors, whose dialogue forms the basis of this White Paper, exemplified a broad spectrum of treatment, administrative, and funding arrangements. These individuals represented State mental health and alcohol and drug abuse systems that are separate; those in which mental health and substance abuse agencies are combined; States where both the mental health and alcohol and drug abuse director were present at the meeting; large and small systems; and urban, rural, and mixed geographic areas. Their extensive, collective experience framed the group's discussions and shaped an agenda for change.

A New Paradigm

Participants gathered with a set of ambitious goals. Specifically, they set out to:

- Define the population of individuals who have co-occurring mental health and substance abuse disorders;
- Identify specific groups within this population;
- Describe the characteristics of an effective service system designed to address the needs of these groups; and
- Make recommendations for future strategies to move this agenda forward.

In the process of defining the population and identifying specific groups within it, meeting participants created a conceptual framework that represents a new paradigm for addressing co-occurring disorders. The framework permits a comprehensive discussion of symptom severity, locus of care, and level of service coordination required to address the needs of all individuals who

have co-occurring mental health and substance abuse disorders. It also allows for future discussion of funding opportunities.

Further, the framework is flexible enough to be applicable to any service setting, even those in which service integration is not feasible. Finally, it points to the need for special attention to two groups: 1) people with severe substance abuse and mental health disorders who may be found in jails, in forensic hospitals, in emergency rooms, or living on the streets and who clearly need fully integrated services in order to achieve beneficial outcomes; 2) individuals, especially children and adolescents, who have less severe problems at present but who are at risk for developing more serious disease.

A Collective Effort

The meeting itself represented the type of collective effort that participants agreed is vital to addressing the needs of people with co-occurring disorders. Each of the participating groups had clearly defined roles that contributed to the outcome. Specifically, the Federal agencies that supported the meeting provided the catalyst for bringing the group together. The national associations co-sponsored and facilitated the process, and the State commissioners and directors determined the meeting's content and outcome. Expert panelists helped lay the groundwork for a shared understanding of the key issues that must be addressed.

Participants' contributions paralleled the recommendation that each group has a specific role to play in accomplishing system change. SAMHSA can provide needed support, and NASMHPD and NASADAD can keep this issue at the forefront of their agendas. Researchers and experts can continue to advance the field's knowledge of co-occurring disorders. The bulk of the work of creating a more effective service system for people with co-occurring mental health and substance abuse disorders, however, must take place at the State and local levels through the efforts of policy makers, providers, consumers, and advocates. The conceptual framework provides an important tool to develop solutions tailored to a community's needs.

Using This Report

This report represents a summary of the group's discussions and the products it developed. Section I describes in brief the characteristics of the population and some historic barriers to providing care for people with co-occurring disorders. Section II outlines and describes the conceptual framework, which is based on a model originally developed by the State of New York.

Desirable characteristics of a comprehensive system of care for people with co-occurring disorders are outlined in Section III, with specific attention to the three forms of service coordination the group defined – consultation, collaboration, and integration. Finally, Section IV

presents recommendations for future strategies designed to translate the theoretical underpinnings of the conceptual framework into practice.

Appendices include a record of participants and expert panelists, resources and a list of relevant World Wide Web sites. Individuals who would like more information about the problem of co-occurring disorders are encouraged to visit these sites, and to direct their questions and concerns to their State commissioners and directors and to NASMHPD and NASADAD representatives.

SECTION I
Background

In an era of declining resources and increasing health care needs, the problems of people with co-occurring mental health and substance abuse disorders assume special importance. This section examines the scope of the problem, some historic barriers to providing comprehensive care for these individuals, and signs that progress is being made.

The Scope of the Problem

Co-occurring mental health and substance abuse disorders are a significant problem in the United States today. Estimates suggest that up to 10 million people in this country have a combination of at least one co-occurring mental health and substance-related disorder in any given year. Three million individuals with co-occurring mental health and substance abuse disorders have at least three disorders, and one million people have four or more disorders (SAMHSA NAC, 1997).

But numbers only begin to tell the story. Individuals with co-occurring disorders tend to be more symptomatic; to have multiple health and social problems, and to require more costly care. Many are in jails and prisons, where they may receive treatment that is inappropriate, if they receive any treatment at all. Others end up homeless. Of the estimated 7.2 million adults between the ages of 18 and 54 with co-occurring disorders who are living in households, a majority receive no treatment at all, not even in the primary health care sector (SAMHSA NAC, 1997).

The Importance of the Population

Given the immense human and economic toll that co-occurring disorders exact, meeting participants agreed that individuals with co-occurring mental health and substance abuse disorders are a high priority population. Their needs should be addressed not only by the mental health and substance abuse systems, but by the primary health care system, as well.

However, the term "co-occurring disorders" does not connote a single problem with a simple solution. People with co-occurring disorders are a heterogeneous group with multiple medical and social problems. As noted above, they are at risk for incarceration and homelessness, and significant numbers are HIV-positive. Post-traumatic stress disorder (PTSD), often from childhood physical and/or sexual abuse, also tends to be a problem for this group, participants noted.

For a number of reasons that are outlined below, treatment for people with co-occurring disorders is problematic, at best. As a result, many of these individuals cycle in and out of costly and often inappropriate treatment settings, such as hospital emergency rooms. Some are being inappropriately treated in other settings, such as jails or prisons. Still others end up homeless and may be receiving no treatment at all.

In general, outcomes for physical health, substance abuse and mental health disorders are worse for individuals with co-morbid conditions. Meeting participants agreed that this is a population with whom no system is completely successful at this time.

Barriers to Providing Care

Historically, there have been a number of barriers to providing effective treatment for people with co-occurring substance abuse and mental health disorders. To begin with, there is no single locus of responsibility for people with co-occurring disorders. The mental health and substance abuse systems operate independently from one another and from the primary health care system.

The separation between the substance abuse and mental health systems is driven in large part by the fact that each system has its own treatment philosophies, administrative structures, and funding mechanisms. For example, substance abuse providers may treat mental health symptoms as part of addictive disease, rather than as an independent disorder. Typically, each system collects its own unique data; funding streams are usually separate. In addition, licensure and certification mechanisms reflect different training and experience requirements.

This level of separation between systems means that neither consumers nor providers move easily among service settings. Substance abuse and mental health providers, in particular, are not customarily trained in each other's disciplines, nor is the issue of cross-training adequately addressed in medical schools. There is a general lack of knowledge about what the other system does, and often there is a lack of trust born in part of the fear that one system will either subsume the other in any collaborative efforts or fail to fulfill its treatment commitments.

Further, there is still a great deal of stigma that surrounds both disorders, including among the people who have them. As one meeting participant noted, individuals with a mental health disorder are reluctant to be labeled with a substance abuse disorder, and vice versa.

Even when the two systems agree to work together, there are often no shared assessment tools to help determine the exact nature and extent of mental health and substance abuse disorders. This makes diagnosis and treatment planning especially challenging, as providers face the complex task of discerning the meaning of multiple symptoms independent of one another, often arriving at divergent diagnoses of similar presenting symptoms.

Setting the Stage for Dialogue

Despite their differences, the mental health and substance abuse communities have taken a number of important steps in recent years to find common ground. Recognizing the need to work together on behalf of individuals with co-occurring disorders, they have forged some innovative initiatives at the Federal, State, and local levels.

Key Federal/State Meetings

In 1995, SAMHSA convened a national conference on co-occurring disorders with more than 140 experts and Federal staff. The report resulting from the conference recommended a national strategy in the areas of data and research, best prevention and treatment practices, education and training, and financing and managed care (SAMHSA NAC, 1997). That meeting was a catalyst for a number of subsequent actions on the part of Federal, State, and local agencies; public and private providers; payers; program administrators; and policy makers.

As part of its goal to empower change at the State and local level, SAMHSA and two of its centers – the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) – supported the June 1998 meeting of State mental health commissioners and alcohol and drug abuse directors on which this report is based. Their effort was co-sponsored and facilitated by the directors' two national associations, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

A Rich Literature

In addition to Federal and State-level meetings addressing the issue of co-occurring disorders, an extensive body of literature has been developed in recent years. Prior to their meeting in June, the State mental health commissioners and alcohol and drug abuse directors reviewed a comprehensive set of resource materials that included technical assistance documents, epidemiological studies, service delivery design reports, and treatment efficacy studies (see the "References" section at the end of this report for a complete list of available materials). In reviewing this literature, which represents the state-of-the-art in knowledge about co-occurring disorders, participants came to the meeting with a thorough understanding of the issues and a common context for their discussions.

Expert Presentations

Finally, to set the stage for dialogue at the June 1998 meeting, the State alcohol and drug abuse directors and mental health commissioners heard from a panel of experts who addressed the extent and nature of the problem of co-occurring disorders and highlighted some emerging treatment options. Their presentations are summarized in brief below.

The Interactive Nature of Co-occurring Disorders. Mental illness and substance abuse can co-occur by chance or by the interactive nature of the conditions, noted Mark Schuckit, M.D., Professor of Psychiatry at the University of California, San Diego, and Director of the Alcohol and Drug Treatment Program at the San Diego Veterans Affairs Hospital. He outlined three ways in which mental health and substance abuse disorders may relate to one another: 1) psychiatric disorders may occur independently of substance abuse disorders; 2) psychiatric disorders, such as schizophrenia and anti-social personality disorder, may place individuals at greater risk for substance abuse; and 3) temporary psychiatric syndromes may be induced by drug abuse intoxication or withdrawal.

Individuals with psychiatric disorders may use alcohol or drugs to self- medicate their mental health symptoms, Dr. Schuckit noted, but the reason why the disorders co- occur may be less important than the need to screen for their overlap. Individuals with psychiatric disorders should be screened for substance abuse disorders, and vice versa, he urged the group. Treatment will be guided by the specific conditions the individual has; i.e., the clinician may need to treat psychotic symptoms before a substance abuse problem can be addressed.

The Need for Comprehensive and Individualized Services. Co-occurring disorders are chronic and complex, reflecting multiple medical and social problems and involving numerous service delivery systems, according to Bert Pepper, M.D., Executive Director of The Information Exchange in New York City. Successful and cost-effective treatment for these complicated conditions must be comprehensive, integrated, and individually tailored to reflect the consumer's changing needs and motivation.

Because people with multiple diagnoses tend to fall through the cracks of uncoordinated systems of care, Dr. Pepper stressed the need to integrate services and coordinate funding at the local service delivery level. He noted, however, that integration is a matter of degree–because of their multiple and complex needs, individuals with co-occurring disorders may require different levels of help to coordinate specialty care, such as treatment for HIV.

The Emergence of Innovative Service Delivery Techniques. Innovative treatment approaches for co-occurring disorders are being developed in both substance abuse programs and in mental health programs, according to the final two presenters at the meeting. Jerome Carroll, Ph.D., Vice President for Clinical Operations at Project Return, a modified therapeutic community (TC) for people with substance abuse disorders in New York City, described how his program used a small state grant to add mental health staff. This allowed staff to enhance services to residents with co- occurring mental health disorders.

Individuals with psychiatric disorders were fully integrated into the TC program, which sets positive expectations for residents and promotes their independence, Dr. Carroll said. Though such a program would not be appropriate for individuals in acute psychiatric crisis, the consumers with co- occurring disorders involved in Project Return have shown positive outcomes. These include decreased alcohol and drug use and homelessness and increased employment, Dr. Carroll reported.

Robin Clarke, Ph.D., Associate Professor of Family and Community Medicine at Dartmouth Medical School, reported on the results of a New Hampshire study that featured the addition of a substance abuse specialist to an assertive community treatment (ACT) team for people with serious mental illnesses. Individuals received their care at community mental health centers, and treatment included the stages of substance abuse recovery — engagement, persuasion, active treatment, and relapse prevention.

Results from a three-year follow-up reveal a decline in arrests, incarceration, and costs associated with family caregiving for the study group. Recovery for people with severe impairments is slow and potentially expensive at the outset, Dr. Clarke, said, but the positive impact on personal and societal costs is significant.

The Need for a Common Language

To reach any type of consensus on treatment and services for people with co-occurring disorders, the substance abuse and mental health communities must speak the same language. As has been recently pointed out by a number of observers in both mental health and substance abuse fields, there are significant opportunities for language confusion both within and between the two treatment communities. The phrases "severe mental illness", "serious mental illness" and "chronic mental illness" are often used interchangeably within the mental health field, although they convey different meanings and connotations. "Substance use disorder" and "substance abuse" present similar confusion with the alcohol and drug field. Phrases such as "dual diagnosis", "co-occurring disorders", "mental illness and chemical abuse (MICA)", "dual disorders" and "co-morbidity"— all apparently intended to describe the same clinical phenomenon — offer myriad opportunities for confusion between the two fields. Of particular importance to mental health and alcohol and drug service providers is defining specific co-occurring population groups to be served.

Modifying a model originally developed in the State of New York, the group formulated a conceptual framework for discussing symptom multiplicity and severity, locus of care, and level of service coordination needed among the mental health, substance abuse, and primary health care systems which effectively responds to this basic definitional question. This framework is outlined in the next section.

SECTION II
The Conceptual Framework

Just as individuals with co-occurring disorders are unique, so too are the service systems through which they receive their care. The conceptual framework that meeting participants proposed, which is outlined in this section, provides a common set of reference points and allows policy makers, providers, and funders to plan services for individuals regardless of their specific diagnoses or the current structure of the health care delivery system in their State or community.

The New York Model

James Stone, M.S.W., Commissioner of the New York State Office of Mental Health, presented a model his State uses to locate individuals with co-occurring mental health and substance abuse disorders on a continuum of care (see Figure 1). The underlying assumption of the New York model is the fact that people with co-occurring disorders vary in the severity of their mental health and substance abuse disorders, from less severe mental health and substance abuse disorders to more severe mental health and substance abuse disorders. Individuals for whom one or the other disorder is predominant fall between these two groups.

Further, the model is based on the fact that these differences in severity determine the service system location in which individuals receive their care, including the primary health care, mental health care, and alcohol and other drug treatment systems, as well as the criminal justice system, the homeless service system, and so on.

Participants chose to elaborate on the framework by expanding on these specific areas of concern. Most importantly, it was agreed that the framework could accommodate service coordination needs and (at some future point) funding sources quite well. Each of three areas — severity, primary locus of care, and service coordination — is discussed below.

The Revised Framework

The conceptual framework that meeting participants developed expands on the New York model and represents a new paradigm for considering both the needs of individuals with co-occurring substance abuse and mental health disorders and the system characteristics required to address these needs. Unique features of this approach include the following:

- The revised framework is based on symptom multiplicity and severity, not on specific diagnoses, and uses language familiar to both mental health and substance abuse providers. As such, it encompasses the full range of people who have co-occurring substance abuse and mental health disorders. In addition, it points to windows of opportunity within which providers can act to prevent exacerbation of symptom severity.

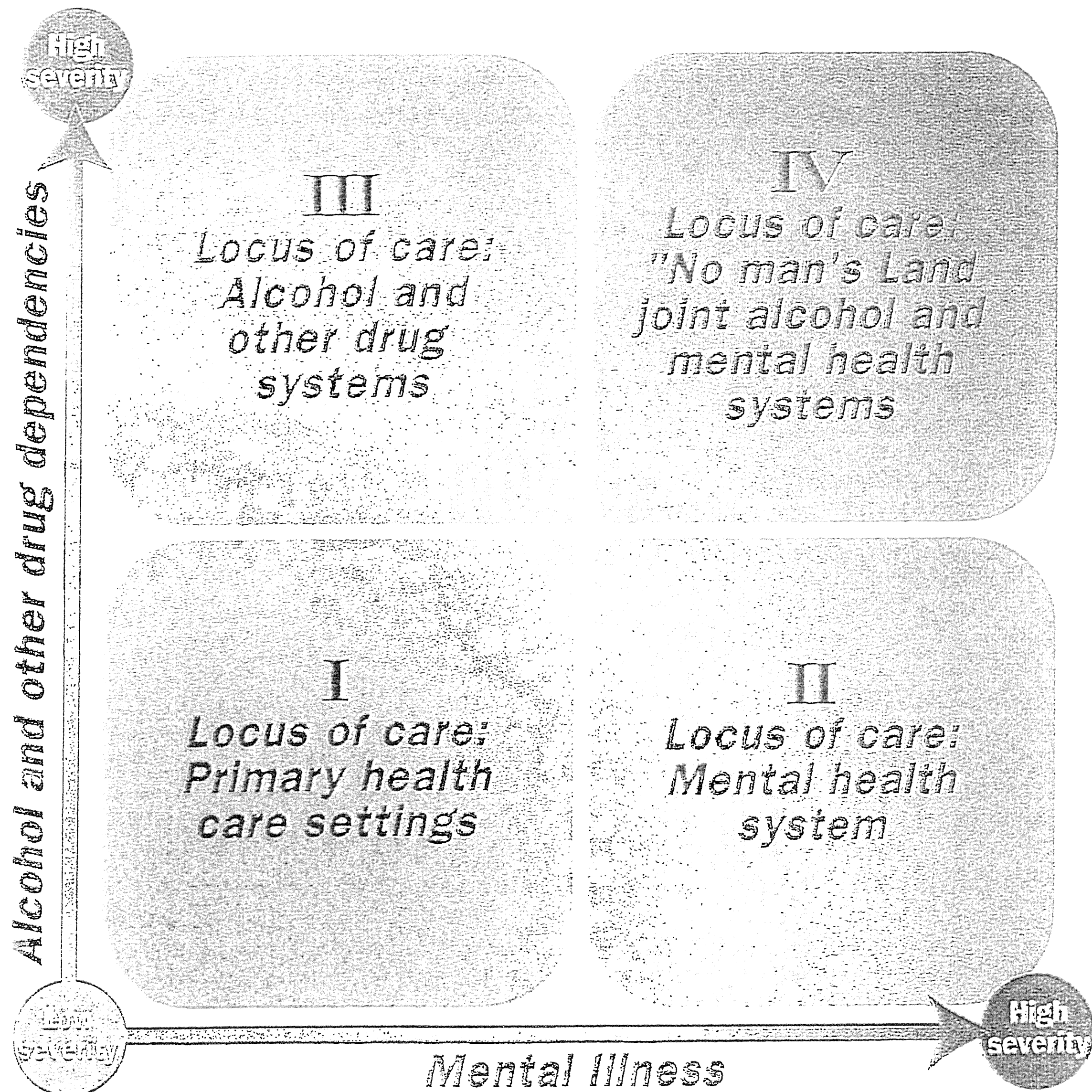
- The framework permits discussion of co-occurring disorders along several dimensions, including symptom multiplicity and severity, locus of care, and degree of service coordination. It permits a number of key decisions to flow from it, including the level of service coordination required and the best use of available resources.

- The framework accommodates different levels of service coordination rather than specifying discrete service interventions. It represents a flexible approach that can be adopted or adapted for use in any service setting.

- The framework identifies two levels of service coordination — consultation and collaboration — that do not require fully integrated services. It points to the fact that individuals can be appropriately served with interventions that do not require full service integration. This is important for those service settings in which integration is not feasible or desirable, and for those individuals whose needs can be addressed with a minimum amount of system change.

Figure 1

New York State generic model of locus of care based on severity of mental illness and alcohol and drug dependencies



Co-occurring Disorders by Severity

Regardless of specific diagnoses, meeting participants agreed that individuals with co-occurring disorders fall into one of four major categories based on the severity of their mental health and substance abuse disorders (see Figure 2):

- Category I. Less severe mental disorder/less severe substance disorder.
- Category II. More severe mental disorder/less severe substance disorder.
- Category III. Less severe mental disorder/more severe substance disorder.
- Category IV. More severe mental disorder/more severe substance disorder.

This is a simplified categorization that permits further discussion. Individuals at various stages of recovery from mental health and substance abuse disorders may move back and forth among these categories during the course of their disease.

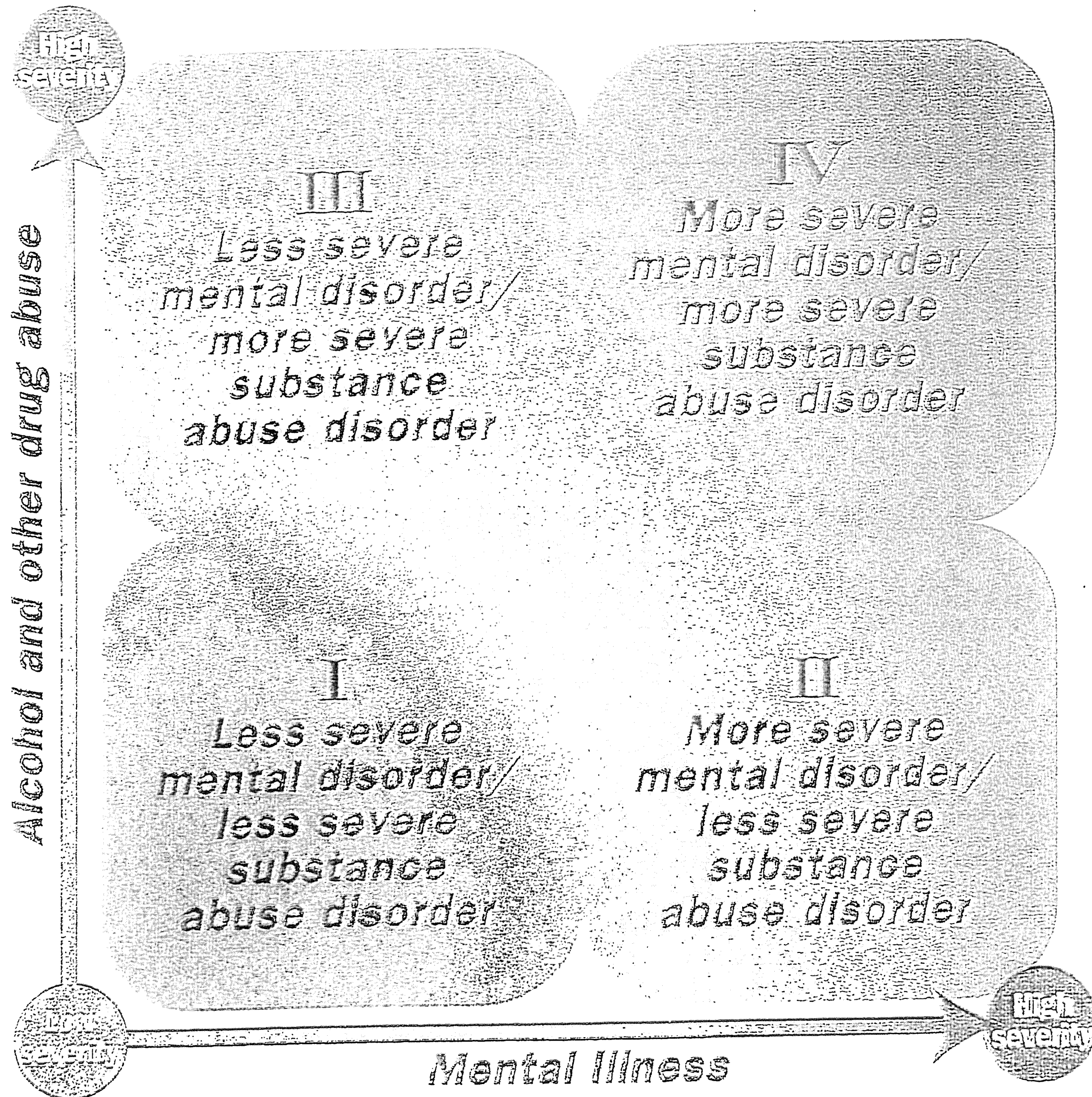
States need to be most concerned with individuals in categories I and IV, meeting participants agreed. While individuals in categories II and III may be receiving some level of care in the substance abuse and mental health systems, respectively, category I — those individuals whose disorders are not severe enough to bring them to the attention of the mental health or substance abuse treatment systems at this time — is largely ignored. This group is of particular concern because it includes many children and adolescents at risk for developing more serious disease. Meeting participants agreed that providers may have the greatest impact in minimizing future disease by providing appropriate prevention and early intervention strategies for people in category I.

Members of category IV — those with more severe mental health and substance abuse disorders — are more likely to be found in inappropriate settings (e.g., jails, homeless), to use the most resources, and to have the worst outcomes. This group includes those with severe, chronic disease who may be the most difficult to serve. Because those in category IV consume the bulk of a system's resources, attention to people in this group may help reduce treatment costs and produce better consumer outcomes.

Using the revised framework, States can decide how best to direct their mental health and substance abuse efforts. For example, the framework encourages States to respond to the needs of those individuals who fall into category I by expanding their prevention and early intervention efforts. By the same token, States may choose to reduce expenses and improve outcomes associated with serving persons in category IV by diverting them from inappropriate and more costly treatment settings. In general, the framework supports State-directed efforts to work toward meaningful integration of services for these persons with the most severe mental health and substance abuse disorders.

Figure 2

Co-occurring disorders by severity



Primary Locus of Care by Severity

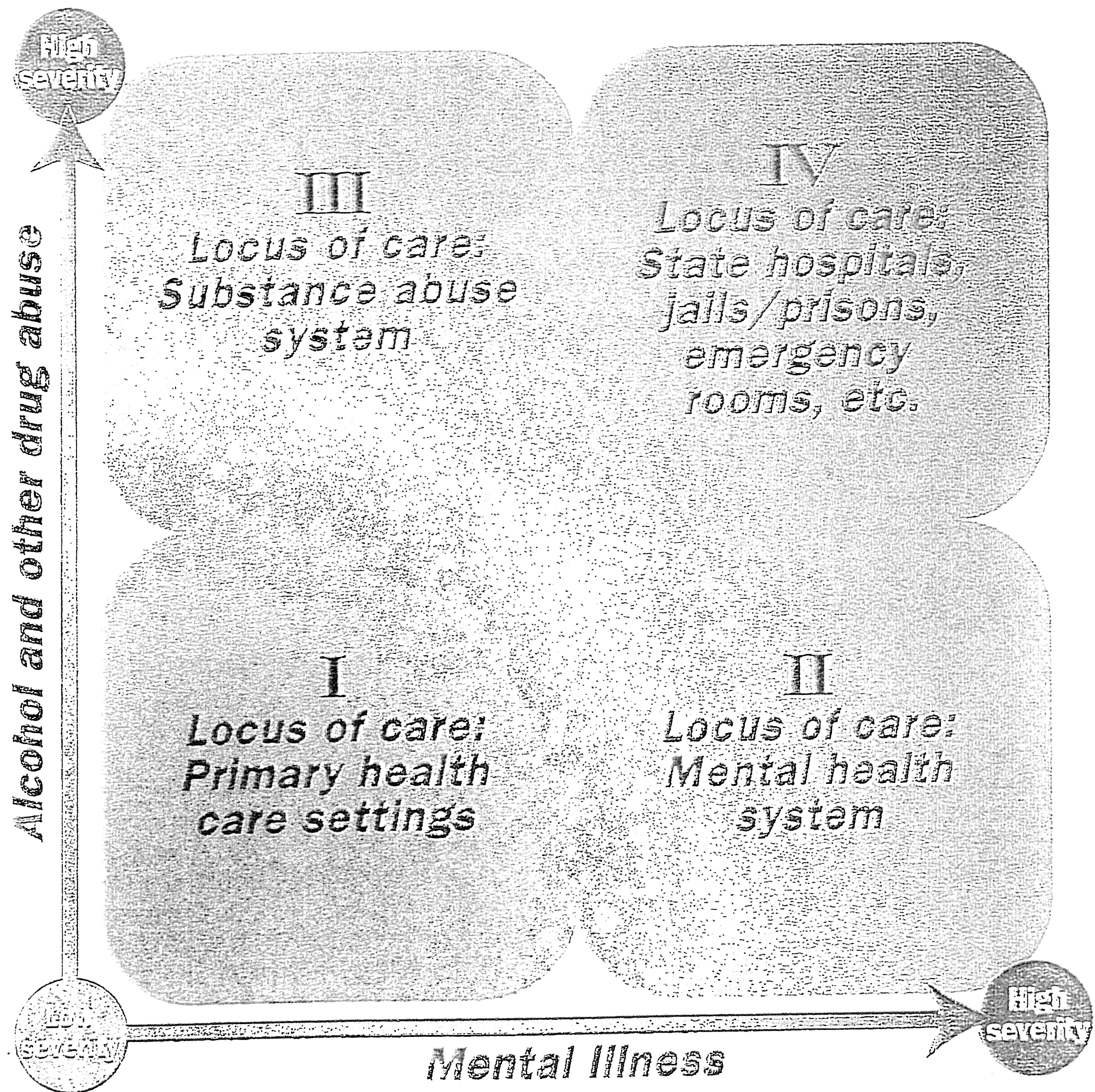
Based on the severity of their disorders, people with co-occurring mental health and substance abuse disorders currently tend to receive their care in the following settings (see Figure 3):

- Setting I. Primary health care settings, school- based clinics, community programs; no care.
- Setting II. Mental health system.
- Setting III. Substance abuse system.
- Setting IV. State hospitals, jails, prisons, forensic units, emergency rooms, homeless service programs, mental health and/or substance abuse system; no care.

As with categories of illness, the use of such clearly delineated settings is for ease of discussion. In reality, there is a great deal of overlap between and among these settings; individuals with different combinations of severity are served in all of the systems highlighted above. In addition, individuals may move back and forth throughout the system of care based on their level of recovery at any given time.

Figure 3

Primary locus of care by Severity



Service Coordination by Severity

Based on the severity of their disorders and the location of their care, the following levels of coordination among the substance abuse, mental health and primary health care systems is recommended to address the needs of individuals with co-occurring mental health and substance abuse disorders (see Figure 4):

- Level I. **Consultation.** Those informal relationships among providers that ensure both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention, and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.

- Levels II/III. **Collaboration.** Those more formal relationships among providers that ensure both mental illness and substance abuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co-occurring disorders and contribute to service delivery.

- Level IV. **Integrated Services.** Those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen.

Figure 4

Service coordination by Severity

High severity

Alcohol and other drug abuse

III
Locus of care:
Substance abuse system

IV
Locus of care:
State hospitals, jails/prisons, emergency rooms, etc.

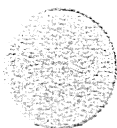
I
Locus of care:
Primary health care settings

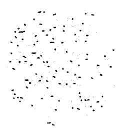
II
Locus of care:
Mental health system

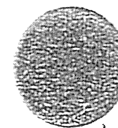
Low severity

Mental Illness

High severity


Consultation


Collaboration


Integrated Services

Putting the Pieces Together

The revised framework has implications for funding strategies. For example, Dr. Pepper strongly recommended making better use of existing resources through coordinated or shared funding at the local service delivery level. This may be of particularly value for those individuals who fall in categories II and III. Reducing the use of inappropriate service settings (e.g. jails and prisons) for people in category IV would help save costs. Recognizing that a topic of such significance could not adequately be addressed within the scope of the current meeting, participants stressed that future attention be paid to the topic of funding opportunities.

Finally, the framework is a necessary, but not sufficient, piece of the puzzle. To accomplish system change for people with co-occurring mental health and substance abuse disorders, policy makers, funders, and providers must define an effective system of care and delineate what successful consultation, collaboration, and integration look like. These concepts are discussed in the next section.

SECTION III

Desirable System Characteristics

An effective system of care for people with co-occurring disorders—one that encourages and allows for consultation, collaboration, and integration—will have several overarching characteristics in such key areas as philosophy, services, staffing, and funding. These qualities are described in this section, along with specific strategies for improving consultation, collaboration, and integration.

Overarching System Characteristics

Philosophy

An Ongoing Commitment. Any service system that can effectively care for people with co-occurring disorders must be built on a strong foundation of shared principles and values. There must be agreement among all key stakeholders—including Federal, State, and community officials; policy makers; mental health, substance abuse treatment and primary health providers; consumers; and advocates—about the need for, and the value of, treatment systems working together to improve consumer outcomes. Whether such agreement is spelled out in a formal memorandum of understanding or is simply acknowledged to be the case, there should be ongoing and shared commitments to address the needs of this group. It should be clear to all parties that consultation, collaboration, and integration are not only allowed, but are encouraged and programmatically supported, depending on consumer needs. States will play a key role in defining and implementing these policy changes, in part because of their role to ensure appropriate treatment for the individual while also operating in the public interest.

Consumer-Centered. Because the underlying goal of working together is to improve consumer outcomes, any successful service system must be consumer-centered as well as culturally-competent. A consumer-centered system is one in which mental health and substance abuse consumers and their families are actively involved not only in treatment decisions, but also in program design, administration, and evaluation. The role of mental health consumers in advancing care for people with serious mental illnesses may be instructive in this regard, several meeting participants noted.

Services

"No-Wrong Door." Meeting participants were unanimous in their belief that services for people with co-occurring disorders must be available and accessible wherever, and whenever, the person enters a service system. Often called a "no-wrong door" approach, this ensures that an individual can be treated, or referred for treatment, whether he or she seeks help for a mental health problem, a substance abuse problem, or a general medical condition. This eliminates unnecessary

duplication of services and reduces the likelihood that an individual will fall through the cracks of an uncoordinated system of care.

Comprehensive, Long-Term Care. In addition, because of the chronic and severe nature of many co-occurring conditions, treatment for such individuals must be comprehensive, longitudinal, and increased or decreased according to changing needs and consumer motivation.

Engagement. Because many individuals with co-occurring disorders are not currently receiving any treatment at all, a strong recommendation was made that providers focus on engaging those who are not currently in the mental health or substance abuse treatment systems. Special efforts should be made to reach out to children and adolescents at risk for developing mental health and substance abuse disorders, many of whom present in primary care settings or school- based clinics. In addition, individuals with co-occurring disorders are found in jails and prisons, in hospital emergency rooms, and living in shelters or on the streets. These sites constitute primary sources for case finding and service delivery.

Integrated Service Delivery. While service *delivery* for some individuals with co-occurring disorders should be integrated (i.e., those with the most severe disorders), service *agencies* or *programs* need not be. Because both the mental health and substance abuse systems have unique characteristics that will be important in an overall system of care, their efforts should be combined, but it may be neither practical nor desirable to merge the systems themselves. Regardless of the specific organizational structure of the mental health and substance abuse treatment systems in a particular community, however, the system must be experienced as *seamless* by the consumer. The use of common intake forms, used to facilitate a "no- wrong door" approach, is one example of an integrated service delivery technique.

Staffing

Respect and Trust. A comprehensive service delivery system for people with co-occurring disorders will be as successful as the individuals who staff it allow. Their ability to work together begins with an appreciation for the skills and strengths of providers in both systems. Further, front-line staff must be able to trust one another and know that they are working together for the good of the consumer.

Cross-Training. Substance abuse and mental health staff must be oriented toward, and have a basic understanding of, each other's disciplines in order to be effective with consumers who have co-occurring disorders. However, participants offered the caveat that cross-training alone does not make an individual an expert in the other field. Further, credentials in a specific area do not necessarily equal competence. In order to be effective, mental health and substance abuse staff must have enough knowledge to know what they don't know and to seek appropriate advice from one another (see "specific strategies for consultation," below). In addition, primary health care providers would also benefit from further training in mental health and substance abuse disorders.

Administration

Common Data, Assessment Tools, and Performance Indicators. Because one of the biggest barriers to coordinated care for people with co-occurring mental health and substance abuse disorders is lack of common assessment tools, meeting participants strongly recommended that such instruments either be developed specifically for this purpose or selected from among existing tools. The use of common instruments will help providers in both systems determine the primacy of an individual's mental health and substance abuse disorders and plan effective treatment and follow-up care.

Movement of consumers between the mental health and substance abuse systems will be further enhanced by the collection of common data. Also, when both systems are using shared performance indicators to assess treatment of co-occurring disorders, consumers, family members, program planners, advocates and funders can better determine whether stated outcomes are being met.

Funding

Flexible Funding Streams. Flexible funding is a necessary tool if local mental health and substance abuse providers are to meet the needs of individuals whose disorders don't fall neatly into one or another categorical funding stream. Maintenance of separate funding streams at the Federal and/or State level may help to ensure that the mental health and substance abuse systems remain viable and able to complement one another, each retaining and refining their areas of expertise. In the final analysis, coordination of those funding streams at the local level by community providers may permit the most effective response to the unique needs of consumers with co-occurring disorders.

Specific Funding Mechanisms. To support a philosophy of consultation, collaboration, and integration, State and local planners may need to develop specific funding mechanisms that allow such partnership activities (e.g., special work groups or task forces) to be reimbursed.

Specific Strategies for Consultation

Knowledge of Each Other's Needs

For *consultation* to be effective, mental health, substance abuse and primary care providers will need to know what the other system expects of them. Meeting participants suggested the following general categories of knowledge exchange:

- From the mental health field, substance abuse providers need information about how to recognize the symptoms of mental illness and differentiate them from the symptoms of substance use/abuse; how to plan effective treatment interventions for mental illness that co-occurs with substance abuse disorders; how best to take advantage of consumer participation

in treatment planning; and how to directly and immediately access the mental health services available to their clients.

- From the substance abuse field, mental health providers need information about how to assess and recognize patterns of substance use/abuse, particularly as they relate to mental health disorders; how to help consumers through the phases of substance abuse treatment (engagement, persuasion, treatment, and relapse prevention); how to plan effective treatment interventions for substance abuse that co- occurs with mental illness; and how best to use the self- help approach to recovery from substance abuse.

- From the primary health care sector, both the mental health and substance abuse systems need to know more about the medical consequences of co-occurring disorders and how to manage diseases that may result from, or co- occur with, mental health and substance abuse disorders.

- From the mental health and substance abuse fields, primary care practitioners need more information, education and training about how to recognize the symptoms of mental illness and substance abuse, especially as they relate to one another; and how to make appropriate referrals for mental health and substance abuse treatment, particularly for those individuals with co-occurring disorders.

Knowledge of the Consultation Process

In addition to knowledge about each other's disciplines, substance abuse, mental health and primary care providers need to know how best to construct and use the consultation process. Providers should be trained to know whom they should ask for help, when they should seek it, and what types of assistance they can expect.

Specific Strategies for Collaboration

Develop a Joint Vision

Collaboration will be easier to achieve if the mental health and substance abuse systems have a joint vision that clarifies the importance of their efforts. A vision statement might refer to the need to improve consumer outcomes, to ensure the most appropriate services, and to use resources more effectively.

Solidify the Commitment

System planners can solidify their commitment to work together by signing a formal memorandum of understanding (MOU) that helps operationalize their joint vision. For example, parties to the agreement might spell out specific areas of collaboration, including the use of common data, assessment tools, and performance indicators.

Create Ongoing Mechanisms for Communication

An MOU or other formal agreement should specify how the key players will monitor their progress. Ongoing mechanisms for communication will be vital to this effort. These should include work groups of both administrative and front-line staff responsible for maintaining the spirit of collaboration and for ensuring that the needs of specific consumers are met. The absence of these players in the communication process severely diminishes the chances of implementing an effective program.

Consider Joint Budget Initiatives/Shared Resources

Participants were united in their belief that sharing resources at the local service delivery level is the best way to ensure that an individual consumer gets the specific services he or she needs. Joint fiscal support will help providers make the best use of limited resources and provide consumers with the most appropriate mix of services.

Specific Strategies for Service Integration

Create Integrated Crisis and Treatment Teams

One of the primary *integrated service* mechanisms through which providers can serve individuals with co-occurring disorders is the addition of substance abuse specialists to mental health crisis and treatment teams and the addition of mental health specialists to substance abuse crisis and treatment teams. Integrated treatment teams provide "one-stop shopping" for consumers, and they help providers in both systems to be more aware of, and more knowledgeable about, co-occurring disorders.

Develop Integrated Treatment Plans and Services

When mental health and substance abuse providers are part of the same treatment team, they can develop and monitor a joint treatment plan that serves the unique needs of each individual with co-occurring disorders. Joint treatment plans and services take into account the interactive nature of the individual's specific diseases and are designed to provide appropriate support for recovery from both mental health and substance abuse disorders.

Leverage Additional Resources

Additional funding specifically geared to people with co-occurring disorders may be identified at some future point. However, planners and providers may choose to use existing funds, including Federal and State monies, to leverage new resources. These might include, for example, housing funds tied to the provision of supportive services or foundation monies targeted to a specific population.

Reinforce Comprehensive and Integrated Service Models in Managed Care Contracts

Meeting participants noted that there is a trend for many states to contract with managed care organizations for the provision of mental health and/or substance abuse services. Concern was expressed about the ability of managed care organizations to serve individuals with co-occurring disorders effectively. Because their needs are complex and long-term, such individuals are likely to be ill-served by the short-term treatment approaches that tend to be favored within the managed care environment. Mental health and substance abuse policy makers and funders can have a significant impact on the care of this group by reinforcing comprehensive and integrated models of care in managed care contracts that will cover people with co- occurring disorders throughout their recovery process.

Next Steps

The group recognized that the type of system changes outlined in this dialogue will not happen overnight, and certainly cannot happen in a vacuum. They require a coordinated effort at all levels — local, State, and Federal — to have a significant impact. Recommendations for moving forward with these critical suggestions are highlighted in the final section.

SECTION IV
Recommendations

Much of the work involved in changing the health care system to meet the needs of people with co-occurring mental health and substance abuse disorders must take place at the State and local level. However, participants noted appropriate roles for relevant Federal agencies — including SAMHSA, CMHS, CSAT, and the Center for Substance Abuse Prevention (CSAP) — as well as for NASMHPD and NASADAD. Recommendations for each group are highlighted in this final section.

The Federal Role

Demonstrate Support

Federal agencies concerned with substance abuse and mental health disorders have an important role to play in demonstrating their support for consultation, collaboration, and integration at the State and local level. They can do so by:

- **Modeling cooperation at the federal agency level.** CMHS, CSAT, and CSAP should undertake further cooperative ventures in their knowledge development activities that concern people with co-occurring mental health and substance abuse disorders.

- **Funding and evaluating integrated services for the most severely ill persons.** Research demonstrates that providing integrated services for persons with the most serious co-occurring disorders results in more effective treatment outcomes. SAMHSA and its Centers should support services that can demonstrate the most effective response to the needs of this population.

- **Supporting and funding models of consultation and collaboration.** Additional research is needed which helps to define both administrative approaches and clinical protocols involved in establishing the most effective models for implementing consultation and collaboration activities between substance abuse and mental health systems.

- **Collecting and disseminating best practice models.** To eliminate the need for local providers to reinvent the wheel, SAMHSA can collect from the field, and disseminate broadly, successful approaches to consultation, collaboration, and integration for people with co-occurring disorders.

- **Identifying national resources/experts.** To help meet the need for training and technical assistance, SAMHSA can create a resource list of national experts in the field of co-occurring disorders, as well as information on training opportunities and technical assistance providers.
- **Continuing to support State and Association efforts.** SAMHSA and its Centers should continue to support such efforts as the meeting on which this report is based. When Federal

agencies act as a catalyst for these events, they make clear the importance of the collective effort needed to address the problem of co- occurring disorders.

The National Association Role

Adopt Co-Occurring Disorders as a Priority

Co-occurring disorders *must be a priority issue* for both NASMHPD and NASADAD. An important first step will be adoption of the conceptual framework developed at this meeting. Some additional recommendations follow.

Create a Joint NASMHPD/NASADAD Standing Committee. A joint committee on co-occurring disorders that includes members of both associations can serve as a liaison between the groups and among mental health and substance abuse staff at the national and State level. This group would oversee the collective efforts of NASMHPD and NASADAD in the area of co-occurring disorders, including those highlighted here.

Hold Overlapping and/or Joint Meetings. The associations should explore the possibility of arranging their annual meetings to overlap for one day to focus on co-occurring disorders. A related recommendation is that NASMHPD and NASADAD should co-sponsor a national meeting, perhaps in conjunction with SAMHSA, to highlight Federal, State, and local efforts to address the needs of people with co-occurring substance abuse and mental health disorders.

Develop a Joint Marketing Plan. There is a strong need to focus more attention on the issue of co- occurring disorders, particularly at the State and local level. They recommended that NASMHPD and NASADAD work together to develop a joint marketing plan to make information about the conceptual framework, and the decisions that flow from it, available on a broad scale. Such efforts might include a joint press conference, written materials, and presentations by experts in the field of co-occurring disorders.

Engage Other Key Stakeholders. Any effort to improve services for people with co-occurring mental health and substance abuse disorders must include those who provide direct care, as well as those for whom the services are designed. NASMHPD and NASADAD should encourage participation by providers, consumers, and their families in follow-up meetings, as well as in the development of any informational materials the groups produce.

The State Role

Adopt the Conceptual Framework

The State mental health commissioners and alcohol and substance abuse directors who participated in the meeting agreed that one of their most important roles would be to encourage adoption in their States of the conceptual framework they established. Whether the directors oversee joint or separate mental health and substance abuse agencies, use of the framework will help

key stakeholders speak the same language about symptom severity, locus of care, and level of service coordination needed to address co-occurring disorders.

Develop Specific Mechanisms for Change

State-level mechanisms that encourage collective efforts on behalf of people with co-occurring mental health and substance abuse disorders will be critical to their success. For example, State mental health and alcohol and substance abuse agencies might enter into formal agreements that delineate the scope of consultation, collaboration, and integration the State will expect and support. Further, agency directors might work together to develop creative funding strategies that allow such collective efforts to be financially viable.

Create and Implement Cross-Training Programs

Properly trained staff are an integral component of any program aimed at improving outcomes for people with co-occurring disorders. State directors are encouraged to create and implement cross-training programs for their substance abuse and mental health staff. Such training can be given to all new staff and can be an ongoing activity for existing staff in local agencies and in statewide offices.

Fund Pilot Projects

Some of the most innovative efforts to address the needs of people with co-occurring mental health and substance abuse disorders have been developed in communities around the country. States can encourage such efforts by funding pilot projects that focus on such critical issues as the best way to integrate services for people with co-occurring disorders and the types of outcomes that can and should be measured. Details about successful projects can be included in information about best practices collected and disseminated by the Federal agencies and national associations.

Moving Forward

Federal and national officials and State directors who participated in this meeting produced a new paradigm for considering the needs of people with co-occurring mental health and substance abuse disorders, and they set forth an ambitious set of recommendations to move the agenda forward. Continued cooperation at the Federal, State, and local level will ensure that this effort proceeds with both deliberate speed and appropriate care. Highlights of the group's work are recapped in the conclusion of this report.

CONCLUSION

The human and economic toll of co-occurring mental health and substance abuse disorders in this country demands immediate attention. The mental health and substance abuse systems must work together to address the barriers to care this population currently faces.

The conceptual framework identified in this report is an important first step. Among its unique characteristics, the framework encompasses the full range of people who have co-occurring mental health and substance abuse disorders, and it can be adopted or adapted for use in any service setting.

In addition, the framework suggests the level of service coordination —defined as consultation, collaboration, or integration—needed to improve consumer outcomes. These levels of coordination are specifically related to the severity of the disorders. Finally, it points to the need for special attention to two groups: 1) individuals, especially children and adolescents, who are at risk for developing more serious disease; and 2) people with severe mental health and substance abuse disorders who may be found in jails, in forensic hospitals, in emergency rooms, or living on the streets.

A comprehensive service system designed to address the needs of people with co-occurring disorders must have support at the highest levels. Further, it must be consumer-centered and feature a "no-wrong door" approach, i.e., services must be available and accessible no matter where and how an individual enters the system. The use of common data and assessment tools, staff who are trained in each other's disciplines, and flexible funding mechanisms are also critical for success.

Each of the key players who participated in the meeting—the Federal agencies, national associations, and State directors—has an important role to play in system change. Meeting participants encouraged SAMHSA to collect and disseminate best practice models; recommended that the States develop specific mechanisms to encourage, allow, and fund the collective efforts required to address the needs of this population; and urged NASMHPD and NASADAD to make co-occurring disorders a priority for each group separately and for both organizations together.

The time to begin this process is now. Meeting participants pledged to continue the work they began together and to involve all relevant stakeholders, including mental health and substance abuse providers and consumers and their families, in ongoing efforts to improve health outcomes for people with co-occurring disorders. In particular, NASMHPD and NASADAD made a commitment to present the group's conceptual framework and recommendations to both their leadership and their members and to obtain support for future activities designed to move this cooperative effort forward.

REFERENCES

SAMHSA National Advisory Council. *Improving Services for Individuals at Risk of, or with, Co-Occurring Substance- Related and Mental Health Disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997.

APPENDIX A

Agenda and Meeting Participants

National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders

June 16-17, 1998
Washington, DC

Sponsored by:
National Association of State Mental Health Program Directors (NASMHPD)
National Association of State and Drug Abuse Directors (NASADAD)

Supported by:
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Center for Substance Abuse Treatment (CSAT)

AGENDA

Tuesday, June 16

8:00 AM - 8:30 AM	Registration and Continental Breakfast
8:30 AM - 9:45 AM	Welcome and Overview of Meeting *Camille T. Barry, Ph.D., R.N., Acting Director, CSAT* *Bernie Arons M.D., Director, CMHS* *Robert W. Glover, Ph.D., Executive Director, NASMHPD* *Robert Anderson, Dir. of Research & Program Applications, NASADAD*
8:45 AM - 9:00 AM	Participant Introduction and Agenda Review *Noel A. Mazade, Ph.D., Facilitator* *Manny Brandt, Facilitator*
9:00 AM - 9:45 AM	Expert Presentations *Marc Schuckit, M.D.* *Jerome (Jerry) F.X. Carroll, Ph.D.* *Robin E. Clark, Ph.D.* *Burt Pepper, M.D.*
9:45 AM - 10:30 AM	Panel/Participant Dialogue *Moderator: Thomas M. Fritz*
10:30 AM - 10:45 AM	Break

National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders - Agenda
Page two

10:45 AM - 12:30 AM	Discussion of Definitions and Populations
12:30 PM - 1:30 PM	Working Lunch: Continued Discussion of Definitions and Targeted Sub-Populations
1:30 PM - 3:15 PM	Identification of Promising Service & System Characteristics for Targeted Sub-Populations (1)
3:15 PM - 3:30 PM	Break
3:30 PM - 5:00 PM	Identification of Promising Service & System Characteristics for Targeted Sub-Populations (2)

Wednesday, June 17

8:30 AM - 10:30 AM	Identification of Promising Service & System Characteristics for Targeted Sub-Populations (3)
10:30 AM - 10:45 AM	Break
10:45 AM - 12:30 PM	Recommendations for Future Strategies
12:30 PM - 1:30 PM	Working Lunch: Continued Discussion of Recommendations for Future Strategies
1:30 PM - 2:00 PM	Summary, Evaluation and Adjourn

National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders

June 16-17, 1998
Washington, D.C.

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APPENDIX B

Resource Materials

NATIONAL DIALOGUE ON CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS MEETING
JUNE 16-17, 1998
WASHINGTON, DC

RESOURCE MATERIALS

I. Annotated Bibliography:

Center for Mental Health Services (1997). Annotated bibliography: Co-Occurring mental and Substance Disorders (Dual Diagnosis) Panel. (Table of Contents and Introduction only. Full copy available on site).

II. Center for Mental Health Services Technical Assistance documents:

Center for Mental Health Services (1998). Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care. Practice Guidelines. Workforce Competencies. and Training Curricula. Report of the Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project. (CMHS Publication). Rockville, MD. Parts 1-4 (Part 5 "Training Curricula" not included in materials provided in briefing packet. Full copy available onsite).

Center for Mental Health Services (1997). Addressing the Needs of Homeless Persons with Co-Occurring Mental Illnesses and Substance Use Disorders. (SAMHSA Publication) Rockville, MD.

Center for Mental Health Services (1996). Implementing Interventions for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders. (SAMHSA Publication) Rockville, MD.

Center for Mental Health Services (1996). Preventing Homelessness Among People with Serious Mental Illnesses. (Draft SAMHSA Publication). Rockville, MD.

III. Epidemiological/descriptive studies of co-occurring disorders:

Drake, R.E., Alterman, A.I., & Rosenberg, S.R. (1993). Detection of Substance Use Disorders in Severely Mentally Ill Patients. Community Mental Health Journal. 29, 175-192.

This paper reviews issues related to detecting alcohol and other drug problems in severely mentally ill patients. Reviews current knowledge in the field, suggests clinical guidelines, and indicates areas of future research. Proposes separate detection strategies for alcohol and illicit drug use.

Kessler, R. C., Nelson, C.B., McGonagle, K. A., Edlund, M. J., Frank, R.G., & Leaf, P. J. (1996). The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization. American Journal of Orthopsychiatry. 66, 1, 17-31.

Presents results from the National Comorbidity Survey (NCS). Results indicated that 51 percent of those with a lifetime addictive disorder also had a lifetime mental disorder, which is a higher prevalence rate than that found in the NIMH Epidemiological Catchment Area study. Additionally, the NCS found that the majority of those with co-occurrence had at least one mental disorder occur at an earlier age than their first addictive disorder. In general, co-occurrence is highly prevalent in the general population and is associated with a significantly increased probability of treatment.

National GAINS Center. (1997). The Prevalence of Co-Occurring Mental and Substance Abuse Disorders in the Criminal Justice System. Delmar, NY.

This fact sheet presents details on the explosive growth in co-occurring mental and substance abuse disorders in the criminal justice system over the past decade. It explains 3 percent of the total U.S. adult population is currently under some form of correctional supervision, discusses how the growing correction population includes an increasing number of individuals with special treatment needs, and reports on estimates that indicate that more than half of the people in the criminal justice system have diagnosable, serious mental illness or substance abuse disorders. This fact sheet addresses the percentage of jail detainees and persons in jail with a mental illness or substance abuse disorder, or both; comments on the prevalence estimates of serious mental illness among the growing number of people under community supervision; and expresses concern for the co-morbidity of serious mental illness and substance abuse or dependence among the general population.

Schuckit, M.A., & Hesselbrock, V. (1994). Alcohol Dependence and Anxiety Disorders: What is the relationship? American Journal of Psychiatry. 151, 1723-1734.

This paper critically reviews literature regarding the relationship between lifelong DSM-III-R anxiety disorders and alcohol dependence. The paper notes that the interaction between alcohol use and anxiety disorders is complex. Findings based on available data do not prove a close relationship between lifelong anxiety disorders and alcohol dependence. Prospective studies of children of alcoholics and individuals from the general population do not indicate a high rate of anxiety disorders preceding alcohol dependence. Concludes that high rates of comorbidity in some studies reflect a mixture of true anxiety disorders among alcoholics at a rate equal to or slightly higher than the general population, along with temporary substance-induced anixety syndromes.

Service Delivery Design issues:

Minkoff, K. (1997). Integration of Addiction and Psychiatric Services. Managed Mental Health Care in the Public Sector. Harwood Academic Publishers, Amsterdam, 233-245.

This chapter discusses the importance of integrated programming of psychiatric and addiction services in order to respond competitively to the demands of managed care. Advantages and disadvantages of integrated services are discussed, followed by an argument in favor of integrated service delivery. A step-by-step process for implementation is presented, focusing on organizational philosophy and mission, agency structure, clinical programs, and staff development.

Minkoff, K. (1991). Program Components of a Comprehensive Integrated Care System for Serious Mentally Ill Patients with Substance Disorders. New Directions for Mental Health Services. 30, 13-27.

This chapter describes an integrated theoretical framework for understanding dual diagnosis and uses this framework to develop a model system of care.

NASADAD (1997). Preliminary Information on Services to Individuals with Co-Existing Substance Abuse and Mental Health Disorders. (NASADAD report submitted to CSAT).

Summarizes results of a NASADAD survey of State Alcohol and other Drug Agencies and State Mental Health Authorities. Provides State-level analysis of the organization, design, delivery, and financing of services for co-exisiting disorders. Includes State-level definitions of co-occurring disorders.

NASADAD and NASMHPD (1998). Substance Abuse and Mental Health Services Linkages with Primary Care: Analysis of State Surveys and Case Studies. (Joint NASADAD and NASMHPD draft report to HRSA).

Examines policies and procedures States have developed and implemented to promote linkage among mental health, substance abuse, and primary health care services. Identifies the structural barriers which interfere with linkage efforts, as well as the methods States have used to overcome such barriers. Additionally, through case studies, the report examines innovative practices three states have used to promote linkages.

National Health Policy Forum. (1997). Dual Diagnosis: The Challenge of Serving People with Concurrent Mental Illness and Substance Abuse Problems. Issue Brief, 718.

This report summarizes a roundtable discussion held on April 14, 1998 in Washington, DC on the prevalence of co-occurring mental illness and substance abuse problems or "dual diagnosis. It explains how this population seems to have emerged as a consequence of deinstitutionalization, points out that this population is prone to homelessness and/or incarceration, and addresses considerable barriers to effective intervention. It presents data from major surveys; comments on trends in comorbidity, causality, and relapse; illustrates the proximate risk factors of dual diagnosis,

homelessness, and crime; notes several factors contributing to increased comorbidity; and addresses issues in the improvement of treatment. This report also includes strategies suggested by the SAMHSA National Advisory Council to improve prevention, treatment, and rehabilitation services for the several million individuals with, or at risk of developing, co-occurring substance-related and mental health disorders.

Osher, F. (1996). A Vision for the Future: Toward A Service System Responsive to those With Co-Occurring Addictive and Mental Disorders. American Journal of Orthopsychiatry. 66, 1, 71-76.

Identified by providers, family members, administrators, and consumers as an issue creating frustration, high costs, and a profoundly negative impact on quality of life, co-occurring addictive and mental disorders cry out for creative and alternative clinical responses. With empirical research and clinical experience supporting the effectiveness of integrated addictive and mental health services. A change toward integrated systems of care is likely to benefit the mental health and addiction treatment needs of all people, not just those with co-occurring disorders.(author)

SAMHSA National Advisory Council. (1997). Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders. Rockville, MD.

Conference report and proposed National Strategy based on the National Conference, "Improving Services: Co-occurring Substance Abuse and Mental Health Disorders" held in November, 1995. Presents background information, as well as National Strategy organized around 4 main goals relating to data and research; best prevention and treatment practices; training and education; and financing and managed care.

Ridgely, M.. Susan, Goldman, H., Willenbring, M. (1998). Barriers to the Care of Persons with Dual Diagnosis: Organization and Financing Issues. Readings in Dual Diagnosis. IAPSRS, Columbia, MD, 399-414.

Among the frustrations of managing the dual disordrs of chronic mental illness and alcohol and drug abuse is the fact that knowing what to do (by way of special programming) is insufficient to address the problem. The systems problems are at least as intractable as the chronic illnesses themselves. Organizing and financing care of patients with comorbities is complicated. At issue are the ways in which we administer mental health and alcohol and drug treatment as well as finance that care. Separate administrative divisions and funding pools, while appropriate for political expediency, visibility, and administrative efficiency, have compounded the problems inherent in serving persons with multiple disabilities. Arbitrary service divisions and categorical boundaries at the State level prevent local governments and programs from organizing joint projects or creatively managing patients across service boundaries. When patients cannot adapt to the way services are organized, we risk reinforcing their overutilization of inpatient and emergency services, which are ineffective mechanisms for delivering the care these patients need. This article reviews the barriers in organization and financing of

care (categoric and third party financing, including the special problem of diagnosis-related groups limitations) and proposes strategies to enhance the delivery of appropriate treatment.(author)

Sciacca, K., & Thompson, C. M. (1996). Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness, Drug Addiction, and Alcoholism (MIDAA). Journal of Mental Health Administration. 23, 3.

The authors discuss a model of program development that has integrated mental health and substance abuse systems in the Jackson-Hillsdale counties of Michigan in 1993. To offer a comprehensive plan, the program incorporated and integrated elements of both systems throughout the continuum of services. The collaboration involved a formulated and integrated philosophical perspective, redefined roles, and an integrated, treatment approach. The article discusses planning for integration, staff selection and training, program implementation, working definitions of those with dual/multiple disorders, and program philosophy and approach to treatment.

Treatment -related and Treatment Efficacy studies:

Clark, R. (1996). Family Support for Persons with Dual Disorders. Dual Diagnosis of Major Mental Illness and Substance Abuse, Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services. 70, 65-78.

This journal article discusses how families play a critical role in the lives of most persons with dual disorders. It explains that although community mental health and psychosocial rehabilitation programs place a high premium on helping persons with severe mental illness to live independently, independence cannot be achieved at the expense of informal social support from family and friends. This journal article explains that optimal functioning is not something that a person achieves independently but rather in the context of a supportive system, and stresses the importance of effective interdependence. It discusses various benefits and burdens of family support, factors that influence family support, treatment and family relationships, and clinical implications of family support. The authors note research findings involving this system of treatment and encourage clinicians and policy makers to incorporate services that strengthen family relationships.

Drake, R. E., Mueser, K. T., Clark, R. E., & Wallach, M. A. (1996). The Course, Treatment, and Outcome of Substance Disorder in Persons with Severe Mental Illness. American Journal of Orthopsychiatry. 66, 42 - 51.

Reviews findings on the longitudinal course of dual disorders; describes the movement towards programs that integrate both types of treatment; and reviews evidence on the efficacy of integrated treatment (noting that there are over 30 studies of integrated treatment, most of which suffer from methodological weaknesses). Also includes discussion of policy implications.

Drake, R. and Mueser, K. (1996). Alcohol-Use Disorder and Severe Mental Illness. Alcohol Health and Research World. 20, 2, 87-93.

Alcohol-use disorders (AUDs) commonly occur in people with other severe mental illnesses, such as schizophrenia or bipolar disorder; and can exacerbate their psychiatric, medical, and family problems. Therefore, to improve detection of alcohol-related problems, establish correct AUD diagnoses, and develop appropriate treatment plans, it is important to thoroughly assess patients with severe mental illness for alcohol and other drug abuse. Several recent studies have indicated that integrated treatment approaches that combine AUD and mental health interventions in comprehensive, long-term, and stagewise programs may be most effective for these clients.(author)

Drake, R.E., Bartels, S.J., Teague, G.B., Noordsy, D.L., & Clark, R.E. (1993). Treatment of Substance Abuse in Severely Mentally Ill Patients. Journal of Nervous and Mental Diseases. 181, 606-611.

This paper identifies and clarifies emerging treatment principles from current clinical research related to the treatment of substance abuse among severely mentally ill patients. Surveys published clinical research and reviews 13 demonstration projects on young adults with serious mental illness and substance abuse problems funded by NIMH.

Janssen Pharmaceutica. (1997). Providing Coherent Treatment to Those with Co-Occurring Addictive and Mental Disorders Requires New Vision. Mental Health Issues Today. 2.

This newsletter article discusses the current need to provide coherent treatment to those with co-occurring addictive and mental disorders and new approaches to this type of delivery system. It describes the characteristics of the co-occurring illness population, opinions of federal and state behavioral health experts related to existing barriers to care, highlights of innovative public sector treatment models, and complications associated with administering the pharmacy component of care. This newsletter article also includes recommendations drafted in 1995-1996 by a national council of co-occurring disorders experts to the federal body responsible for funding and overseeing substance abuse and mental health services.(author)

Jerrell, J. M. & Ridgely, M. S. (1995). Comparative Effectiveness of Three Approaches to Serving People with Severe Mental Illness and Substance Abuse Disorders. Journal of Nervous and Mental Disease. 183, 566-576.

This study examined the relative effectiveness of three intervention models (behavioral skills training, intensive case management, and Twelve Step recovery) for treating individuals with severe mental illness and substance abuse disorders. Changes in psychosocial outcomes, and psychiatric and substance abuse symptomatology were assessed over 24-months in 132 dually diagnosed clients. Results indicated that clients in the behavioral skills group demonstrated the most positive and significant differences in psychosocial functioning and symptomatology compared to the Twelve Step approach.

However, the case management intervention also yielded several positive and important differences compared to the Twelve Step intervention.

Webb, J. (1996). Dual Disorders: The Co-Morbidity of Chemical Dependency and Psychiatric Illness or, Why Psychiatric Hospitals are Still in the Chemical Dependency Business. Report: 33 pages.

This report offers comprehensive information on the prevalence, nature, and treatment of dual disorders. It includes selected comparisons of twelve step and mental health models; presents a definition of alcoholism by the National Council on Alcoholism and Drug Dependence, Inc.; notes prevalence data on morbidity, comorbidity, anxiety disorders, personality disorders, psychotic disorders, chemical dependency; and lists symptoms of a number of transient and persistent syndromes. Characteristic signs of intoxication states, chemically-induced toxic syndromes, and hazards in dual diagnosis recovery are also noted.

APPENDIX C

World Wide Web Sites

Web Sites Relevant to Dual Diagnosis Disorders

American Academy of Addiction Psychiatry – Provides information on a wide range of addiction issues, including co-morbidity, research findings and technologies. Detailed information on education, research, treatment, public policy and educational materials is also provided. http://members.aol.com/addicpsych/private/homepage.htm

American Council for Drug Education (ACDE), Affiliate of Phoenix House – Offers details on ACDE prevention and education efforts designed to help diminish substance abuse based on the most current scientific research, programs and materials. Provides access to publications and related web sites. http://www.acde.org

American Managed Behavioral Healthcare Association (AMBHA) – Describes AMBHA efforts to promote coverage of mental illness and addictive disorders in health benefits. Provides ordering information for reports, studies and a media kit. http://www.ambha.org

American Society of Addiction Medicine (ASAM) – Discusses ASAM's efforts to educate physicians and improve the treatment of individuals suffering from alcoholism and other addictions. The web site also offers information on accessing training activities, a discussion forum, practice guidelines, publications, public policy and links to state chapters. Includes a search engine. http://www.asam.org

Association for Medical Education and Research in Substance Abuse (AMERSA) – Provides background information on the association; discusses the role of technology transfer, medical education and research in supporting faculty development and other educational programs in the substance abuse arena; and offers information on publications, discussions on various topics and links to other internet resources. http://center.butler.brown.edu/AMERSA

Bowes Center for Alcohol Studies (University of North Carolina) – Describes the center's efforts to improve intervention and treatment for alcohol abuse and alcoholism. Includes a calendar of events, newsletter and links to other web sites. http://www.med.unc.edu/alcohol/welcome.htm

Brown University Center for Alcohol and Addiction Studies (CAAS) – Demonstrates how the Center promotes the identification, prevention and effective treatment of alcohol and other substance abuse problems in our society through research, publications, education and training. Provides detailed information on the CAAS Post-Doctoral Training Program in Alcohol Treatment and Early Intervention Research. http://center.butler.brown.edu

California Department of Mental Health Dual Diagnosis Page – Presents information on Dual Diagnosis Demonstration Projects (DDDP) as they assist the California Department of Mental Health and Department of Alcohol and Drug Programs in replicating demonstration programs in other counties at the end of the three year demonstration period. Also provides information on program evaluations, the Dual Diagnosis Project Forum, recent press releases and publications. http://www.dmh.cahwnet.gov/dualdiag.htm

Center On Addiction and Substance Abuse (CASA) at Columbia University – Describes the economic and social costs of substance abuse and its impact on the lives of Americans. Summarizes recent publications, news releases and various information on CASA research programs. A list of related resources and links to other web sites is provided. http://www.casacolumbia.org

The College on Problems of Drug Dependence (CPDD) – Discusses the role that the college plays as an independent body affiliated with scientific and professional societies representing various disciplines concerned with problems of drug dependence and abuse since 1976. Provides a history of drug dependence research, policy statements, information on research, fact sheets; a calendar of events and a list of related web sites. http://views.vcu.edu/cpdd

The Dual Diagnosis Pages - Offers a dual diagnosis bibliography and a short list of continuing education providers in substance abuse, counseling, dual
diagnosis and related topics. Provides a newsletter, site map, search engine and links to related web sites. http://www.monumental.com/arcturus/dd/ddhome.htm

The Dual Diagnosis Web Site – Provides information and resources for service providers, consumers and family members who are seeking assistance and/or education in the area of substance abuse. Also provides information on educational and training opportunities, a dual diagnosis bibliography, bulletin board, chat room and a list of related web sites. http://www.erols.com/ksciacca/

Dual Recovery Anonymous (DRA) – Describes how DRA helps individuals who are chemically dependent and also affected by an emotional or mental illness. Provides meeting information, access to the Dual Diagnosis Recovery Network Bookstore and other recovery links. http://dualrecovery.org/index.html

Indiana Prevention Resource Center (IPRC) - Presents information on IPRC activities in the areas of prevention technical assistance and information about alcohol, tobacco and other drugs. This web site also provides a virtual library, prevention statistics, local and national prevention news and a calendar of upcoming events. http://www.drugs.indiana.edu

The Inter-University Consortium for Political and Social Research (ICPSR) – Describes ICPSR's work within the Institute for Social Research at the University of Michigan to provide access to the world's largest archive of computerized social science data; training facilities for the study of quantitative social analysis techniques; resources for social scientists using advanced computer technologies; and data on education, aging, criminal justice, substance abuse and mental health. Several discussion forums are provided. http://www.icpsr.umich.edu

The Midas Dual Diagnosis Web Site - Offers detailed information on consultation services, educational resources, residential programs, project development and research for those helping persons with mental illness and/or substance abuse disorders. An online newsletter includes conference reports, special events and a link to the Carers' Network.
http://ourworld.compuserve.com/homepages/Rich_as_Midas/

National Association of Addiction Treatment Providers (NAATP) – Presents information on NAATP efforts to raise public awareness of addiction as a treatable disease, promote the highest standards of addiction treatment and secure adequate reimbursement for treatment programs. Provides discussions on national policy issues and legislative information, links to related web sites and a newsletter. http://www.naatp.org

National Association of Alcoholism and Drug Abuse Counselors (NAADAC) – Provides tools for addiction-focused professionals who enhance the health and recovery of individuals, families and communities through education, advocacy, knowledge, standards of practice, ethics, professional development and research. Information on parity for alcohol and drug abuse treatment, discussions on legislative issues, a list of publications and links to other web sites are also provided. http://www.naadac.org

National Association of Psychiatric Health Systems (NAPHS) – Explains how the association works to coordinate clinically effective treatment and prevention programs for people with mental and substance abuse disorders. Offers a resource catalog, news releases and marketing opportunities for behavioral health care advocates. www.naphs.org

National Clearinghouse on Alcohol and Drug Information (NCADI) –
Presents a wide range of information on alcohol and drug abuse facts, resources and referrals, research and statistics; current drug and alcohol abuse prevention campaigns and initiatives and a discussion of workplace issues. A list of publications, upcoming events, related web sites and related services is provided. http://www.health.org

National Council on Alcoholism and Drug Dependence (NCADD) – Provides information for alcoholics and their families; children, teenagers and parents;
government policymakers; the media; the medical community, educators and other national health organizations. Provides information on the activities of the Committee on Treatment Benefits, an online communications center and a wide variety of publications.
http://www.ncadd.org

National Drug Prevention League – Provides a forum for national private-sector drug abuse prevention organizations; offers summaries of national surveys and studies; and discusses federal programs and budgets, federal legislative activities and other information and resources. Press releases, links to other web sites, and other resources are also provided.
http://www.ndpl.org/index.html

National Institute on Alcohol Abuse and Alcoholism (NIAAA) – Describes how the National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment and prevention of alcoholism and

alcohol-related problems. Offers publications, press releases, a database containing information on alcohol abuse and alcoholism, research programs, frequently asked questions, legislative activities and access to databases and other alcohol-related resources. http://www.niaaa.nih.gov

National Institute on Drug Abuse – Provides information on drug abuse, publications, international activities, training; scientific meetings and summaries, media advisories, funding information and links to related web sites. http://www.nida.nih.gov

Society for Prevention Research – Presents information on how the society works with scientists, practitioners, advocates, administrators, and policymakers toward the advancement of science-based drug, alcohol and tobacco use and abuse prevention programs and policies through empirical research. Provides information on the International Classification of Preventive Trials, a newsletter and the Early Career Preventionists Network. http://www.oslc.org/spr/sprhome.html

Web of Addictions (WOA) – Offers a "rolodex" of organizations working in the substance abuse arena; links to addictions-related web sites; a collection of fact sheets on various drugs; upcoming meetings and detailed information on special topics. http://www.well.com/user/woa