The Rule or the Exception: A Framework for Addressing Co-Occurring Mental Health and Substance Use Disorders in an Effort to Effectively Respond to What Families Say They Want in Treatment

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This paper will...

- Provide an overarching framework for the importance of assessing and treating co-occurring disorders;
- Review co-occurrence rates in North Carolina;
- Report qualitative, data driven responses to what families say they want in treatment; and
- Discuss how to address co-occurring disorders within a system of care framework.

Background

- Data highlight that co-occurring disorders are the rule rather than the exception (Armstrong & Costello, 2007)
- Most of the work in applying system of care in mental health has not fully integrated the risk for substance abuse.

Co-Occurring Disorders (COD)

- Multiple terms (e.g., co-morbid)
- Multiple references (e.g., MH and physical health; MH and SA, co-occurring mental health diagnoses, etc.)
  - For this presentation, we are referring to MH co-occurring with SA.
- ***WORKING DEFINITION***: A person having one or more substance-related disorders as well as one or more mental disorders where each disorder can be established independent of the other.

(Center for Substance Abuse Treatment, 2007)

Rates of Co-Occurrence

- 20% of the general population with a substance use disorder also had one or more mood disorders, and 18% had an anxiety disorder (Flynn & Brown, 2008).
- Young adults (18-25) were found to be most vulnerable to co-occurring problems (Chan, Dennis, & Funk, 2008).
- More likely to receive treatment for their mental health alone (34.3%) than for their substance abuse alone (4.1%) or for both disorders (8.5%) (Clark, Power, Le Fauve, & Lopez, 2008).

Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders

Addiction Potential
LOW----------HIGH

Low Addiction/Low Mental Illness Severity	**High Addiction/Low Mental Illness Severity**
Low Addiction/High Mental Illness Severity	**High Addiction/High Mental Illness Severity**

Mental Health Severity
LOW----------HIGH

(NASADAD-NASMPHPD, 2005)

Assumptions of Conceptual Framework

- All children fall along this spectrum of substance use and mental health-related symptoms.
- Supports service coordination by severity rather than by diagnostic category.

States Implementing the Framework with Success

-Missouri
-Georgia
-Rhode Island
-Minnesota
-New York
-Virginia
-Connecticut
-Massachusetts
-California
-Delaware

(http://www.nasadad.org/index.php?wv_edit=1&wv_int=1&base_id=100)

North Carolina's Substance Abuse Treatment Grant

- Funded by SAMHSA/CSAT
- Awarded to the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse (NC Division of MH/DD/SA)
- Subcontracted with the Center for Youth, Family and Community Partnerships at the University of North Carolina at Greensboro

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- Multiple Components
  1. Awareness through Newsletters and Publications that are Family-Friendly
  2. Training Across the State
  3. Research Across the State
  4. Professional Development

North Carolina's Substance Abuse Treatment Grant

Website for downloadable information:

http://www.uncg.edu/csr/asatp/whatdowed.htm

Quantitative Data: Co-Occurrence in North Carolina

Child Gender	Co-Occurring SU Disorder			Total
	No Co-Occurring	Co-Occurring without SU	Co-Occurring with SU	
Boys	181 (33.4%)	318 (58.7%)	43 (7.9%)	542
Girls	92 (34.5%)	150 (56.2%)	25 (9.4%)	267
Total	273 (33.7%)	468 (57.8%)	68 (8.4%)	809

**All youth enrolled in descriptive study as part of the System of Care grants between the years 1997-2002.

Quantitative Data: Co-Occurrence in North Carolina

Child Gender	Alcohol/Substance Use Therapy in Past 12 Months		Total
	No	Yes	
Boys	350	26	26/376 = 6.9%
Girls	166	22	22/188 = 11.7%
Total	516	48	564

Girls more likely to have received alcohol/substance use therapy in the past 12 months than boys, $\chi 2\ (1) = 3.69$, $p < .05$.

**Includes youth enrolled in longitudinal study as part of the System of Care grants between the years 1997-2002.

Quantitative Data: Co-Occurrence in North Carolina

Most Common Co-Occurring MH Diagnoses Among Youth with a Diagnosed SUD:

- Oppositional Defiant Disorder – 36.1%
- Mood Disorder – 26.4%
- Conduct Disorder – 25%
- Adjustment Disorder – 13.9%
- AD/HD – 12.5%
- PTSD – 4.2%
- Anxiety Disorder (not PTSD) – 1.4%

Qualitative Data: Voices and Experiences

- Focus group sessions were convened to explore participants' personal experiences with Child and Family team curriculum and provide their insights into ways they could be more involved in their Child and Family team centered around substance use.
  - Sessions involved both caregivers of substance-involved youth and youth using substances.
  - Seven sessions in five different North Carolina counties: Alamance, Halifax, Mecklenburg, Gaston, & Person.
  - Between 7 and 21 family members in attendance at each group session.
  - Total of 76 youth and family members participated.

Qualitative Data: Voices and Experiences

- Focus group sessions were audio-recorded and subsequently transcribed.
- Major themes were identified.
- Final report is made up of 10 important themes with supporting focus group comments.

Keys to a Successful Child and Family Team Approach

1. Youth want to take the lead in their team meeting.

➢Rather than provider leading conversation, family and youth are active participants, discussing issues that are relevant to their specific situation.

➢Youth claimed that if they could speak more, they would feel that they could take more of a lead in their treatment process.

Keys to a Successful Child and Family Team Approach

2. ***Increase youth and family communication.***

- ➢ Successful teams must include an increased voice at the table in developing goals to address substance abuse issues and other needs.
- ➢ Providers should not use jargon in order to make the family feel more comfortable with speaking up.
- ➢ Speaking up was reported to be encouraged by the use of a discussion format at meetings and the presence of encouraging team members.

Keys to a Successful Child and Family Team Approach

3. Convenience of meetings and good use of time makes meetings more beneficial.

➢Having conveniently scheduled and well organized meetings made for better attendance and discussion.

➢Having meetings at a time that was best for most team members ensured that they were able to attend.

➢Organization of the meeting to fit into the time allotted was also reported to benefit everyone's busy schedule.

Keys to a Successful Child and Family Team Approach

4. Communication and cooperation between team members is essential.

- Shared goals among all team members is important to a clear understanding of what is to be accomplished.
- All team members should have a thorough and detailed understanding of the child and family situation past and present in order to participate in setting significant goals.

Keys to a Successful Child and Family Team Approach

5. Constant review and evaluation of progress and team members is important to youth and family improvement.

- Constant review and evaluation of what is working and why, and discussion of how to fix what isn't working is necessary to maintain progress.
- Team members should be reviewed and evaluated to ensure that everyone was contributing in a helpful way.

Keys to a Successful Child and Family Team Approach

6. Understanding that people from many different positions all bring something positive to a Child and Family team meeting.

- Youth and family reported that such actors as advocates, case managers, therapists, community partners, school teachers and personnel, and workers from agencies such as the DJJDP and NAACP all contribute to child and family team meetings in helpful ways.

Addressing Co-Occurring Disorders within a System of Care Framework: Six Guiding Principles

- Principle 1: Co-occurring disorders (COD) are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.
- Local Recommendations/Next Steps:
  - -Need to define requirements to address co-occurring needs.
  - -Regulations should detail necessary program and professional licensing and certification to address COD.
  - -Financing must be developed to support multiple service needs of those with COD.

(Center for Substance Abuse Treatment, 2007)

Addressing Co-Occurring Disorders within a System of Care Framework: Six Guiding Principles

- Principle 2: An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.
- Local Recommendations/Next Steps:
  - -Establish an awareness among providers and consumers of all services available.
  - -Provide mechanisms for movement between service levels.
  - -Continual monitoring of programs and services and providing feedback system-wide regarding the quality of the framework.

(Center for Substance Abuse Treatment, 2007)

Addressing Co-Occurring Disorders within a System of Care Framework: Six Guiding Principles

- Principle 3: The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door*) and be perceived as caring and accepting by the consumer.
- Local Recommendations/Next Steps:
  - -All providers within the system of care should be knowledgeable of services available to and needs of those with substance abuse and/or mental disorders.
  - -Financial barriers preventing access to multiple types of treatment must be broken down and reassessed.

(Center for Substance Abuse Treatment, 2007)

Addressing Co-Occurring Disorders within a System of Care Framework: Six Guiding Principles

- Principle 4: The system of care for COD should not be limited to a single "correct" model or approach.
- Local Recommendations/Next Steps:

  -Providers and programs should be trained and certified in various approaches to COD in order to be flexible and responsive to needs at any level of care.

  -Continual quality improvement efforts should take place.

(Center for Substance Abuse Treatment, 2007)

Addressing Co-Occurring Disorders within a System of Care Framework: Six Guiding Principles

- Principle 5: The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence*- and consensus*-based practices for persons with COD and evaluation of the efforts of existing programs and services.
- Local Recommendations/Next Steps:

  -Providers should be supported and encouraged to participate in research and evaluation efforts of services in order to develop and refine approaches.

(Center for Substance Abuse Treatment, 2007)

Addressing Co-Occurring Disorders within a System of Care Framework: Six Guiding Principles

- Principle 6: Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.
- Local Recommendations/Next Steps:

  -Partnerships must be built to support the integration of those with COD into various communities.

  -Strategies such as shared case management models, creation of local service coalitions, and interagency task forces should be explored and employed.

(Center for Substance Abuse Treatment, 2007)

Questions?

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Appendix

*__No wrong door__: An approach to service organization that provides individuals with or links them to appropriate service interventions regardless of where they enter the system of care. This principle commits all service agencies to respond to the individual's stated and assessed needs through either direct service or a linkage to appropriate programs, as opposed to sending the person from one agency to another.

*__Evidence:__ Information that suggests a clearly identified outcome will result from a clearly identified practice or intervention. The most reliable evidence comes from multiple published, peer-reviewed studies done by different investigators using (1) rigorous design, measurement, and analysis techniques; (2) random assignment to control and experimental conditions; (3) large number of subjects; and (4) multiple settings.

*__Consensus:__ General agreement among a group of experts in the field about the implications of available evidence concerning practices or interventions.

(Center for Substance Abuse Treatment, 2007)