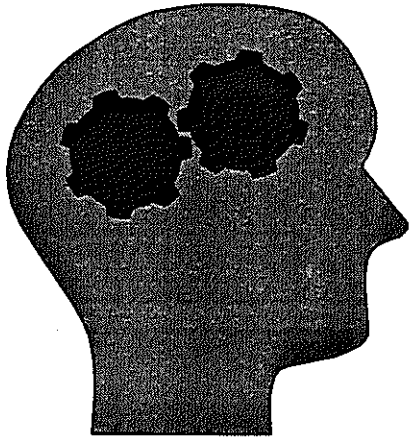
MHSA Policy Update: Co-occurring Psychiatric and Substance Use Disorders

David Pating, MD
Kaiser, San Francisco CDRP
Assistant Clinical Professor, UCSF
Past President California Society of Addiction Medicine

Overview

- National Consensus
- Scope of Problem
- Review California Policy



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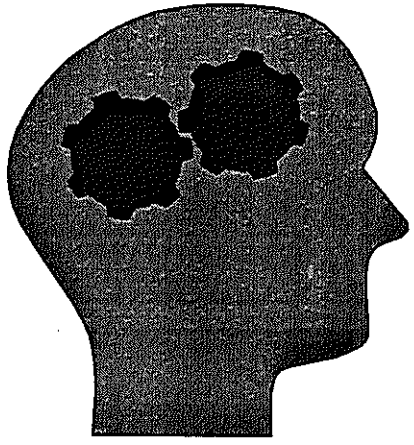
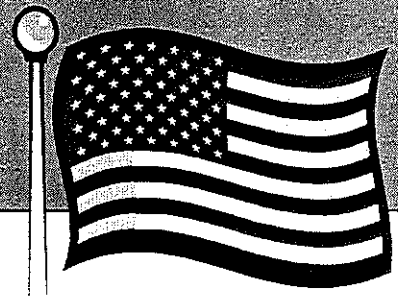


National Consensus Principles

Co-Occurring National Policy

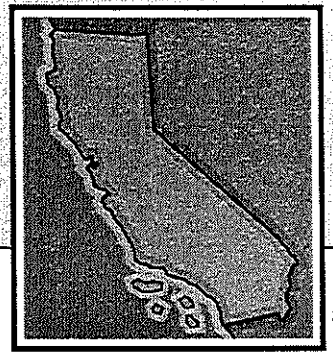
- US (Federal), 2002: Congress Mandates SAMHSA to develop National Dual Co-morbidity Policy.

- Charles Curie, SAMHSA director declares: Co-Occurring Disorders *Nation's Highest Priority*



California COD Initiatives

- California, 1996 & 2002: DMH &ADP convene Dual Diagnosis Task Force and Co-Occurring Disorders Workgroup
- Co-Occurring Joint Action Committee, 2005. DMH & ADP sign MOU to develop staff positions.



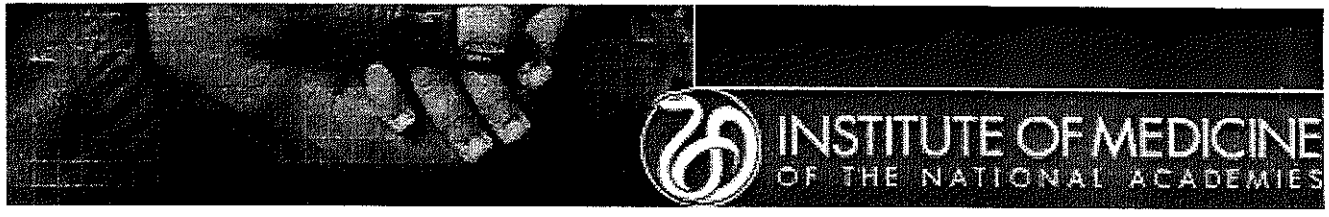
Institute of Medicine 2006

Crossing the Quality Chasm: Improving the Quality of Healthcare for Mental and Substance Use Disorders: (2006)

- *Overarching Principle:*

"Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.

Improving care delivery and outcomes for any one of the above depends upon improving care and outcomes for the other two."



SAMHSA – CSAT (2006)

- Treatment Improvement Protocol 42:

Substance Abuse Treatment for Persons With Co-Occurring Disorders

- Catalogues National Best Practices

SAMHSA

National Treatment Principles

Integrated:

Communication & Collaboration

Comprehensive:

Spectrum of Resources

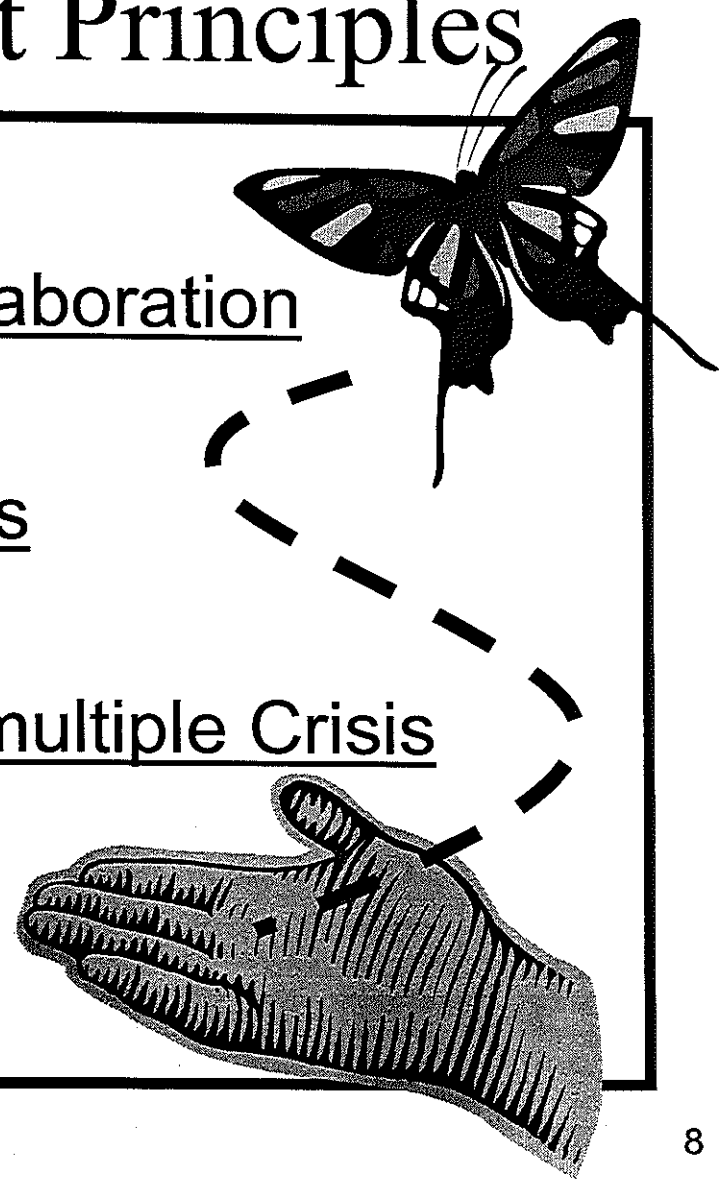
Continuous:

Commitment through multiple Crisis

Individualized:

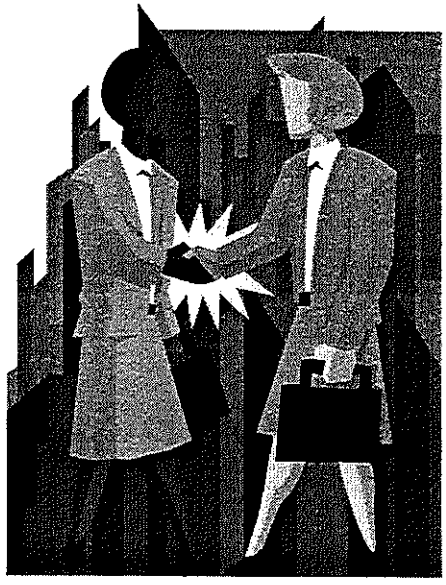
Client Centered

Systems



National Treatment Principles

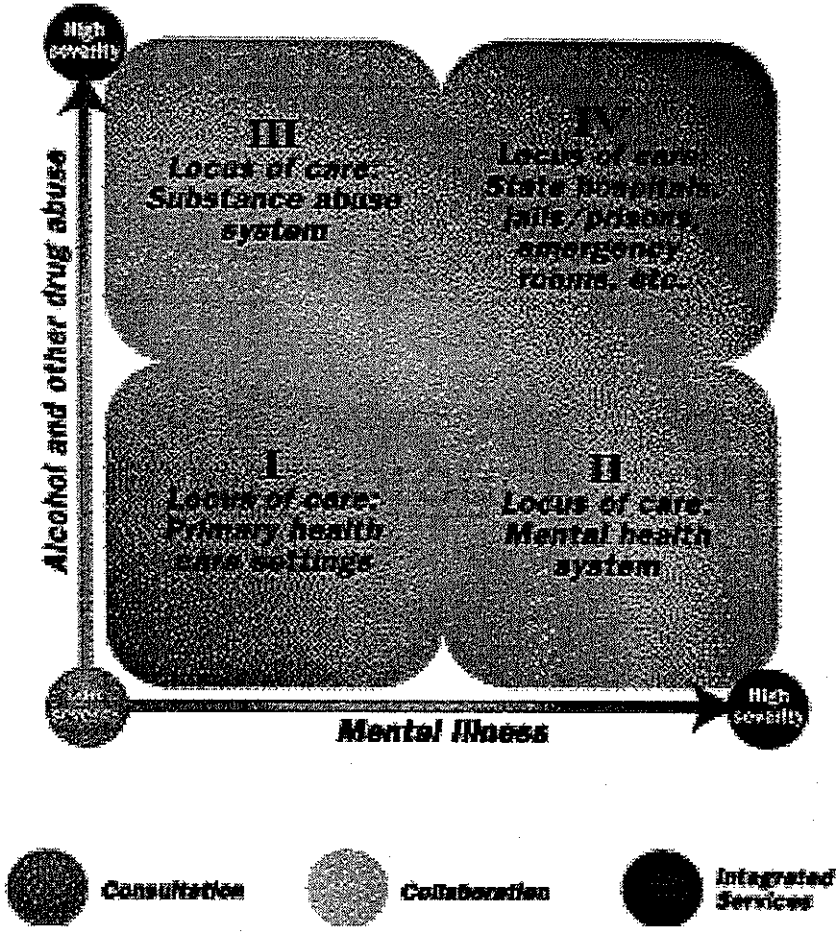
- Expectation (not Exception)
  - Dual Patients Welcomed
  - Co-morbidities Assessed



"No Wrong Door!"

National Treatment Continuum

Service coordination by Severity



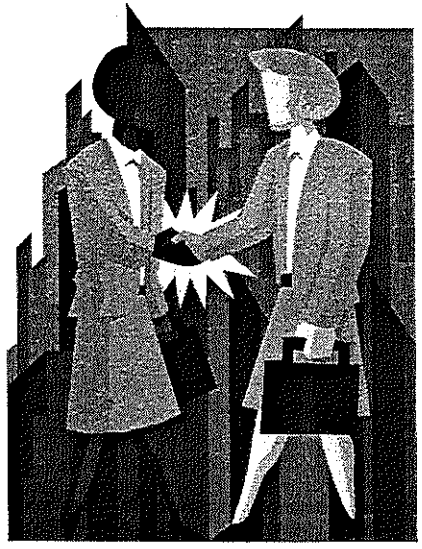
(NASMPHD/NASADAD, 1999)

Harm Reduction

- *"For Patients Unwilling or Unable to Stop using drugs…any steps to decrease risk are steps in the right direction"*

  (Marlatt, JPsyADrugs, 2001)

- Services must emphasize:
  - **Open Access**
  - **Engagement**
  - **Motivation**
  - **Hope**

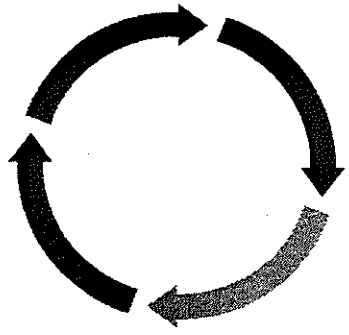


Evidence Based Treatment of COD

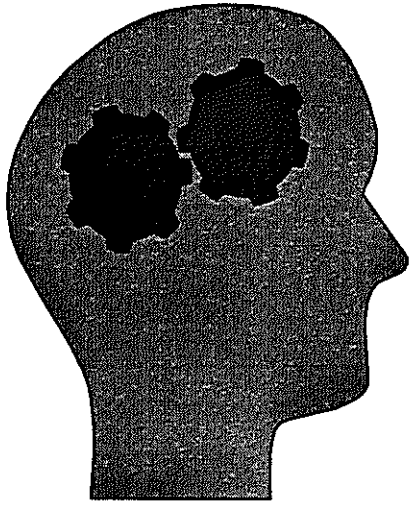
Transformation

And

Recovery



Why Co-Occurring Disorders?

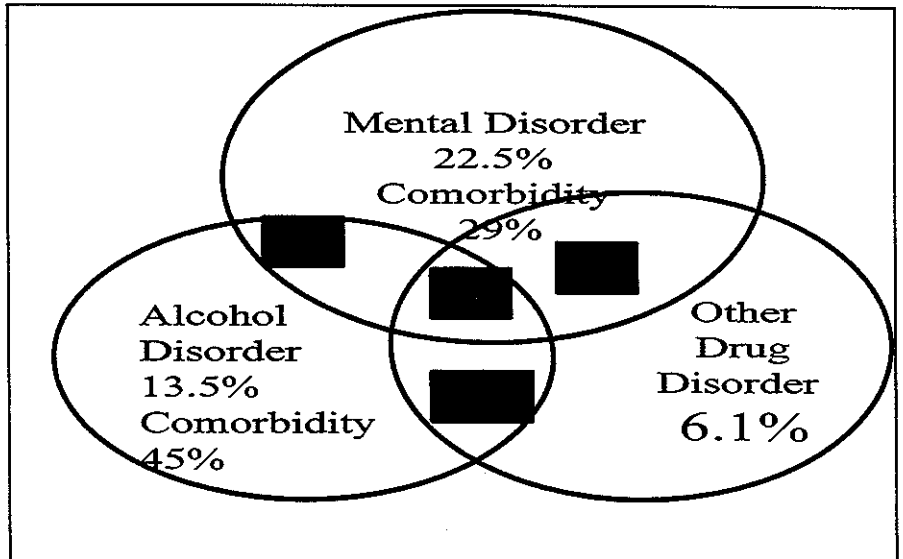


Many Dual Comorbidities

A	B
Mental Health	***Substance Use***
Schizophrenia	Alcohol
Bipolar Disorder	Cocaine/Meth
Depression	Opiates
Anxiety	Marijuana
Personality disorders	Prescription drugs
PTSD	Nicotine

Why Co-Occurring Disorders?

Epidemiology



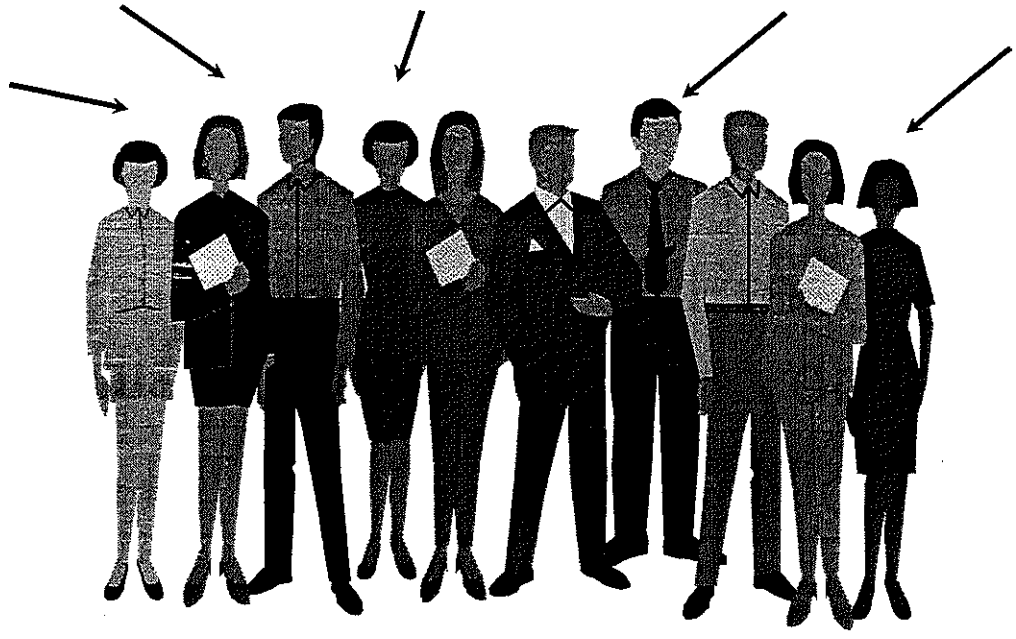
Lifetime prevalence of comorbid mental and addictive disorders in the United States, combined

(Regier, Arch. Gen Psy, 1991)

Why Co-Occurring Disorders?

- **51%** indiv w/ Mental Health disorder
- **41-65%** individuals w/ Sub Use disorder

…will have lifetime Co-morbid Disorder



Why Co-Occurring Disorders?

Alcoholic or Substance Dependent
with Psychiatric Impairment

2-4 times more likely to seek treatment than any single disorder.

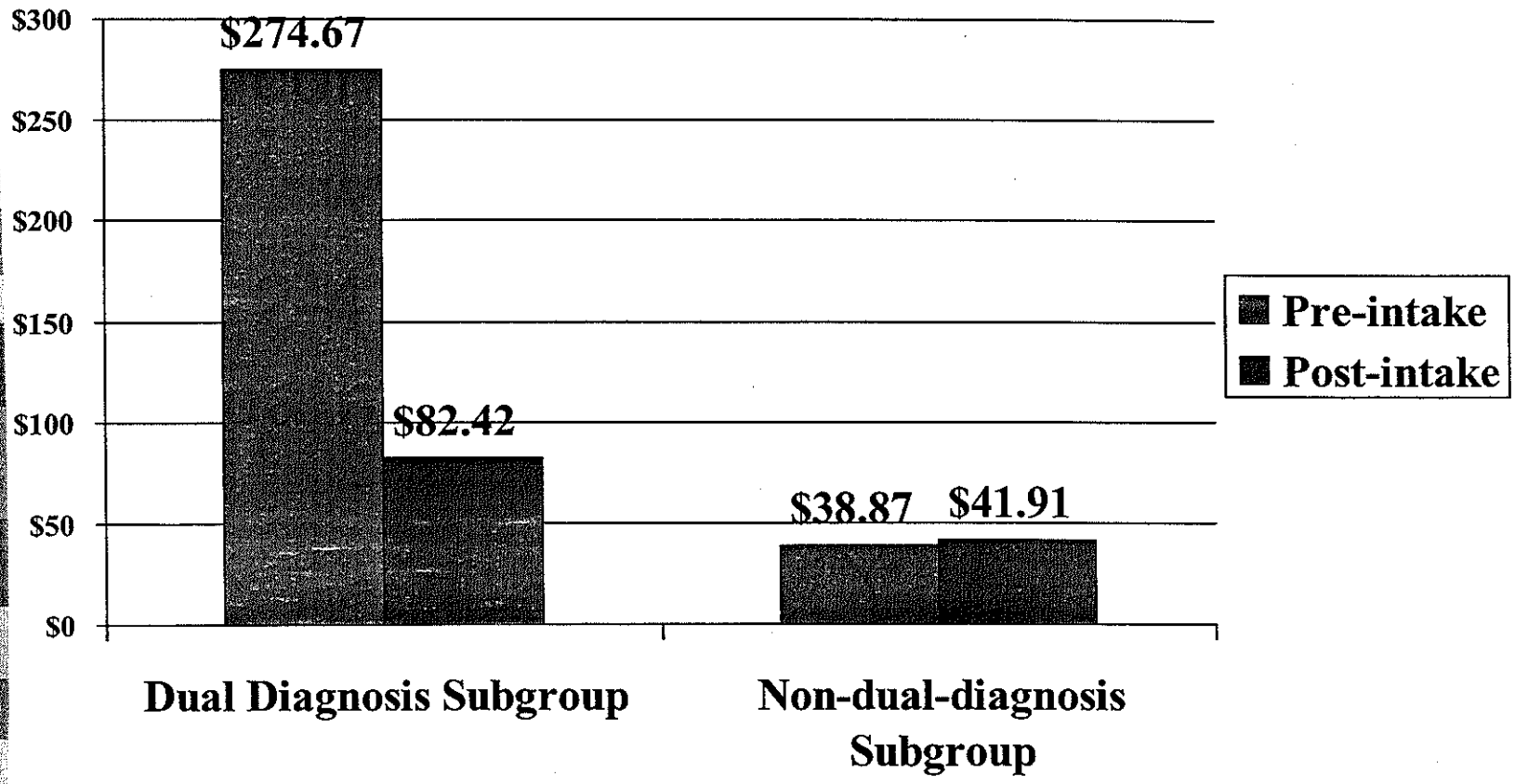
(Grant, NIDA Monographs, 1997)

Negative Outcomes in COD

- More relapses, re-hospitalization
- Depression and suicidality, violence
- Housing instability and homelessness, HIV
  Family burden, service utilization
- Treatment Non-compliance

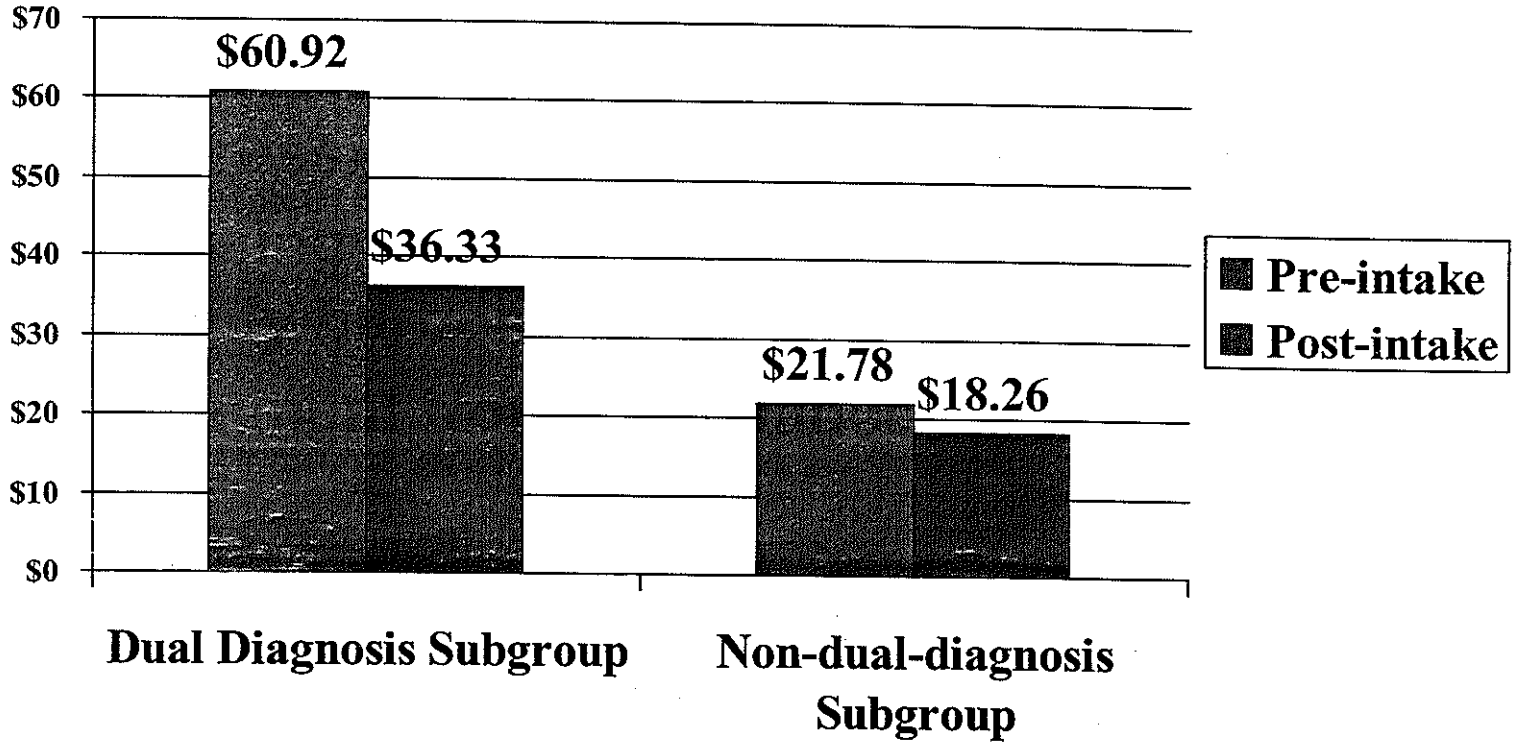
(Mueser, Drake, et.al. NIDA, 1997)

Change in Inpatient Cost by Dual-diagnosis Status with Integrated Treatment Services (CD/Med/Psy) (average per member month)



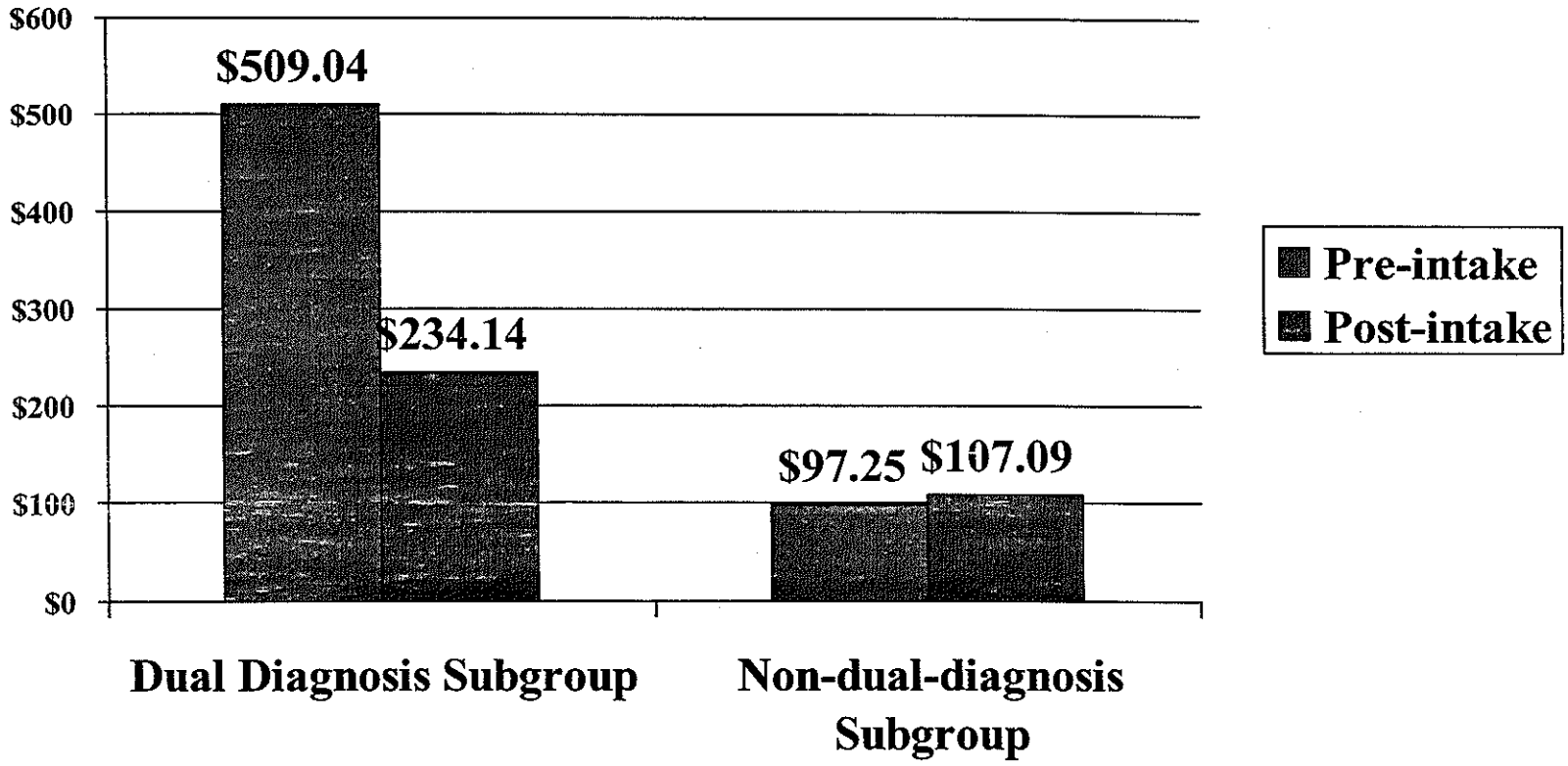
(Kaiser, NCAL, Parthasarathy et al., unpublished, 2001)

Change in ER Cost by Dual-diagnosis Status with integrated treatment (average per member month)



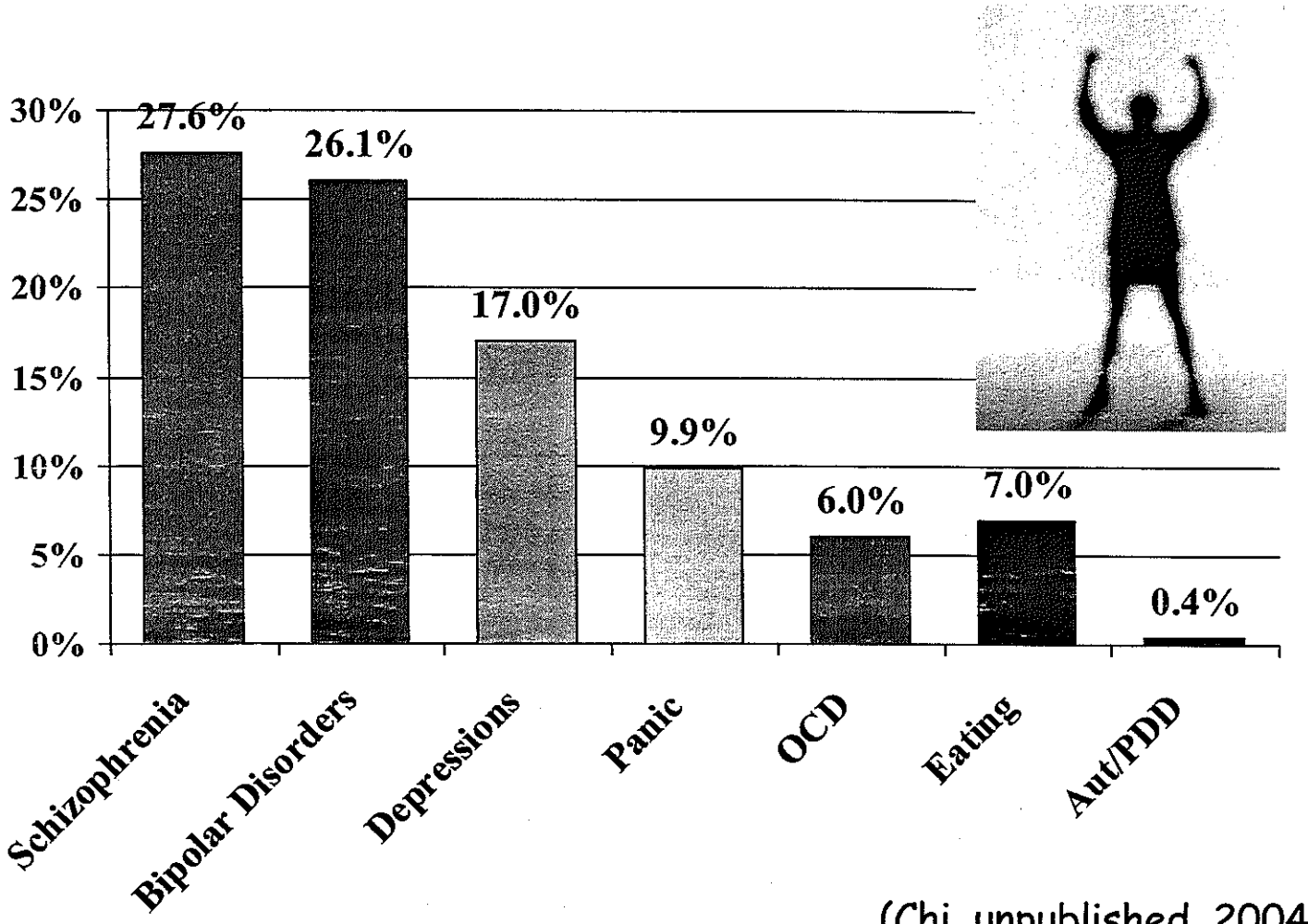
(Kaiser, NCAL, Parthasarathy et al., unpublished, 2001)

SAC CDRP Integrated Treatment Study: Change in Medical Cost Pre- and Post- Substance Abuse Treatment (average per member month)



(Parthasarathy et al., unpublished, 2001)

Percentage Substance Abuse Diagnosis among Kaiser Mental Health **(Adolescent)** Patients - 1999



(Chi, unpublished, 2004)

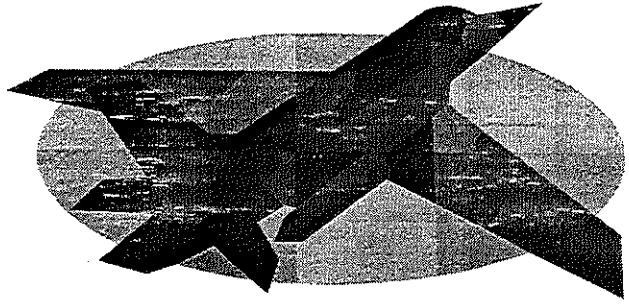
California's Burden

- Proposition 36

- *"Treatment, not Incarceration for Non-violent Drug Possession"*

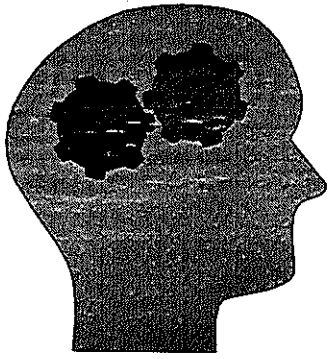
Iraq War

- Unknown Toll: Impact of Trauma on Mental Health and Substance Abuse



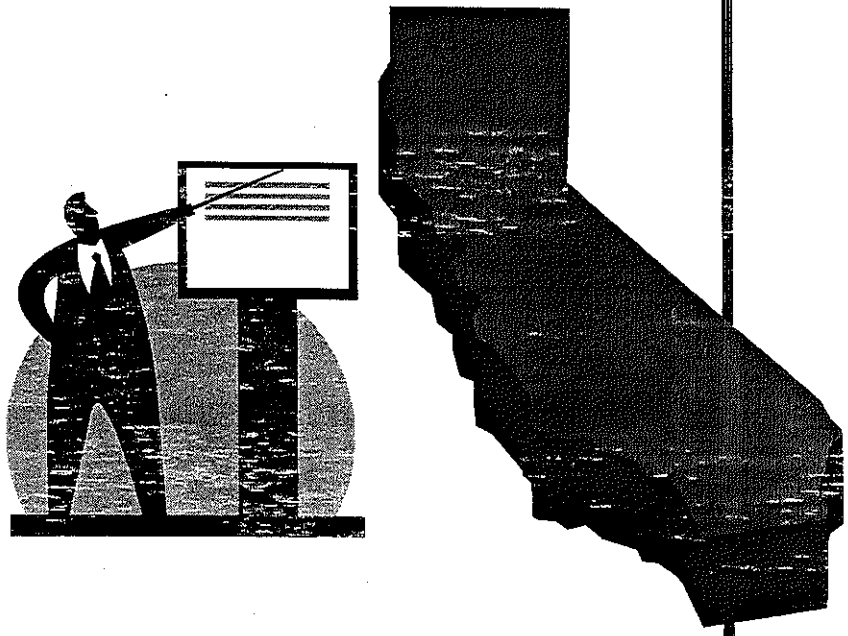
Need for Trauma Informed Services

What to Do?
The State of California's COD Policy



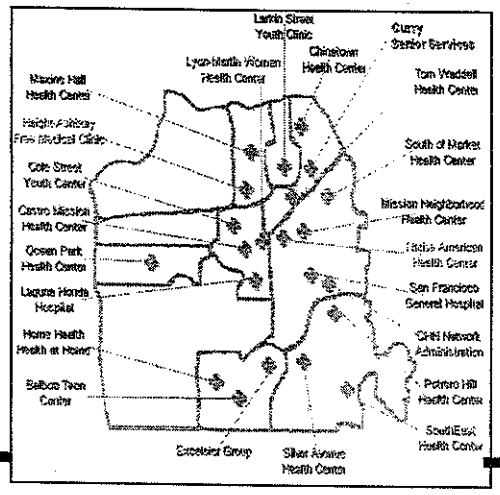
County "Ken Minkoff" Trainings

- San Diego
- Santa Clara
- San Francisco
- San Mateo*
- Placer
- Kern*



*Used MHSA funding

San Francisco CMHS



Treat Modal Patients:

- **Homeless *Bipolar Disorder *Alcoholism**
- **Hospitalized*Cocaine Dep* Schizophrenia**

California: Current COD Policy

1. MHSA COD Draft (2007)
2. COJAC Workplan (2007)
3. Alcohol & Drug Policy Institute (2007)
4. ADP PEI Recommendations (2007)
5. California MH Planning Council (2007)
6. Suicide Prevention Advisory Group (draft)
7. Little Hoover Commission (draft)
8. Assembly Select Committee on Sub Abuse

OAC COD Draft 3.07

1. Integrate COD tx
2. Staffing standards & competency
3. Train Physicians
4. "No Wrong Door" Policy
5. MH/SUD Parity
6. Coordinate wP36
7. COD Housing
8. Explicit Medical Necessity criteria
9. COD in CDRC: "whatever it takes"
10. Train Prison staff.

MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

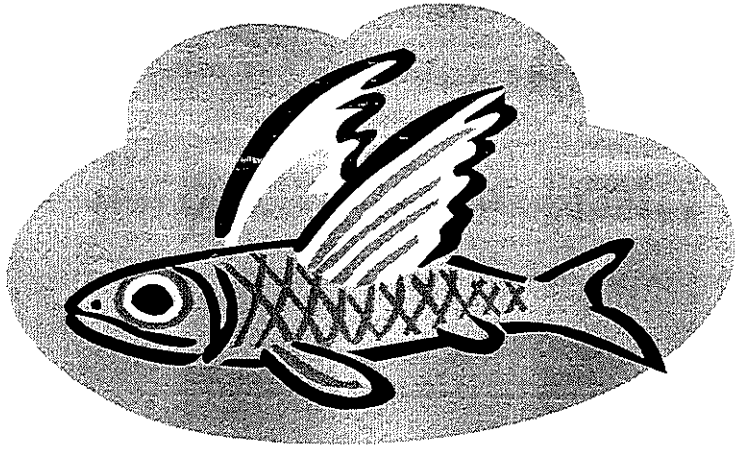
…More Recommendations

- More Youth Treatment!
- Unified Screening Tool
- Integrate COD into PEI & Suicide Prevention
- Promote Peer-run alternatives
- Develop "Trauma-aware" services
- Develop integrated Full-Service Partnerships
- Address Hospital-Bed Shortage
- Promote formal linkages to Child Welfare, Foster Care, DDS, DHS & CJS.

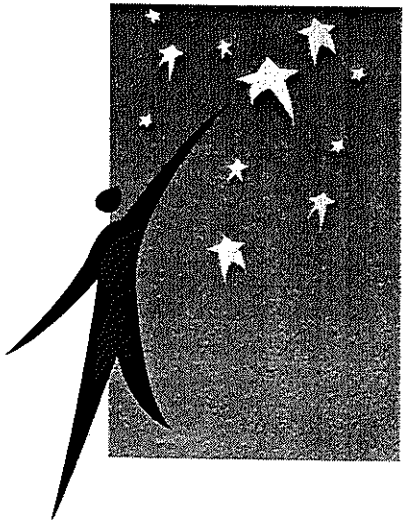
Co-Occurring Disorders

A Pause to Refresh…

Avoid drowning in details.



MHSA Co-Occurring Disorders Workgroup

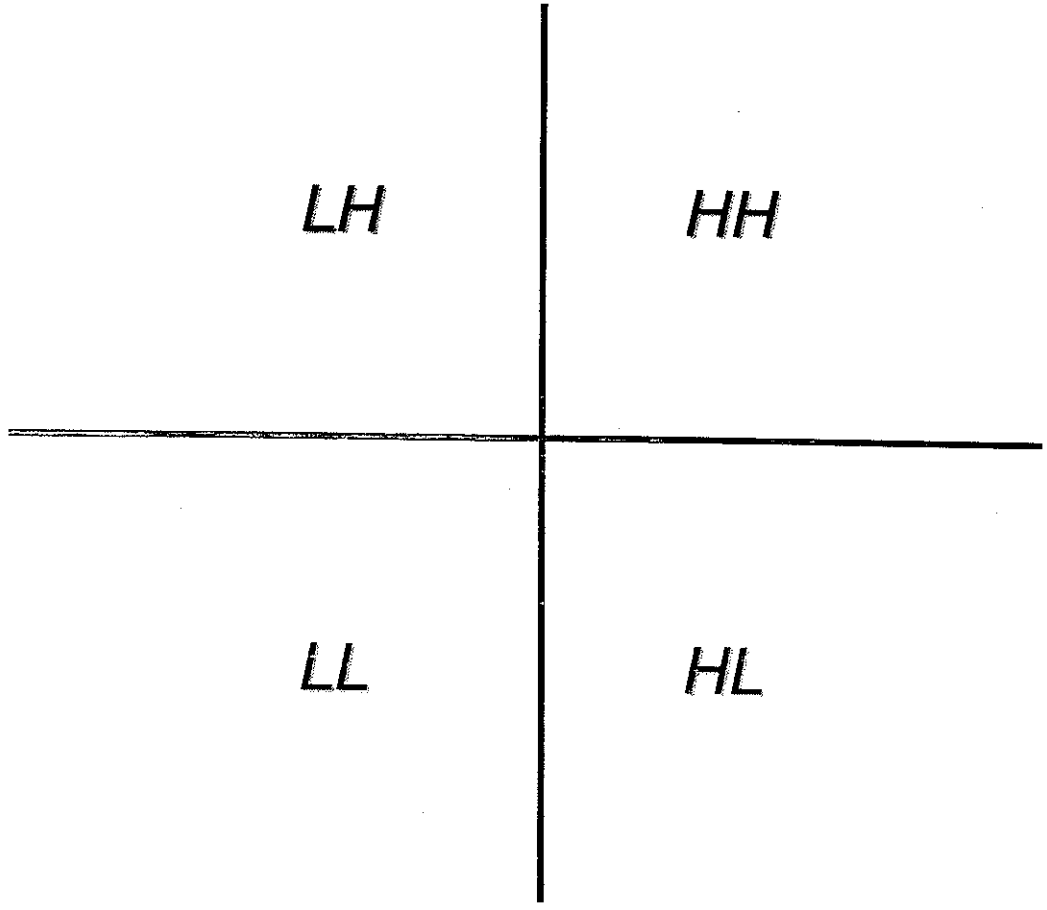


- **Coordination**
- **Interagency Collaboration**
- **Establish MHSA Priorities**

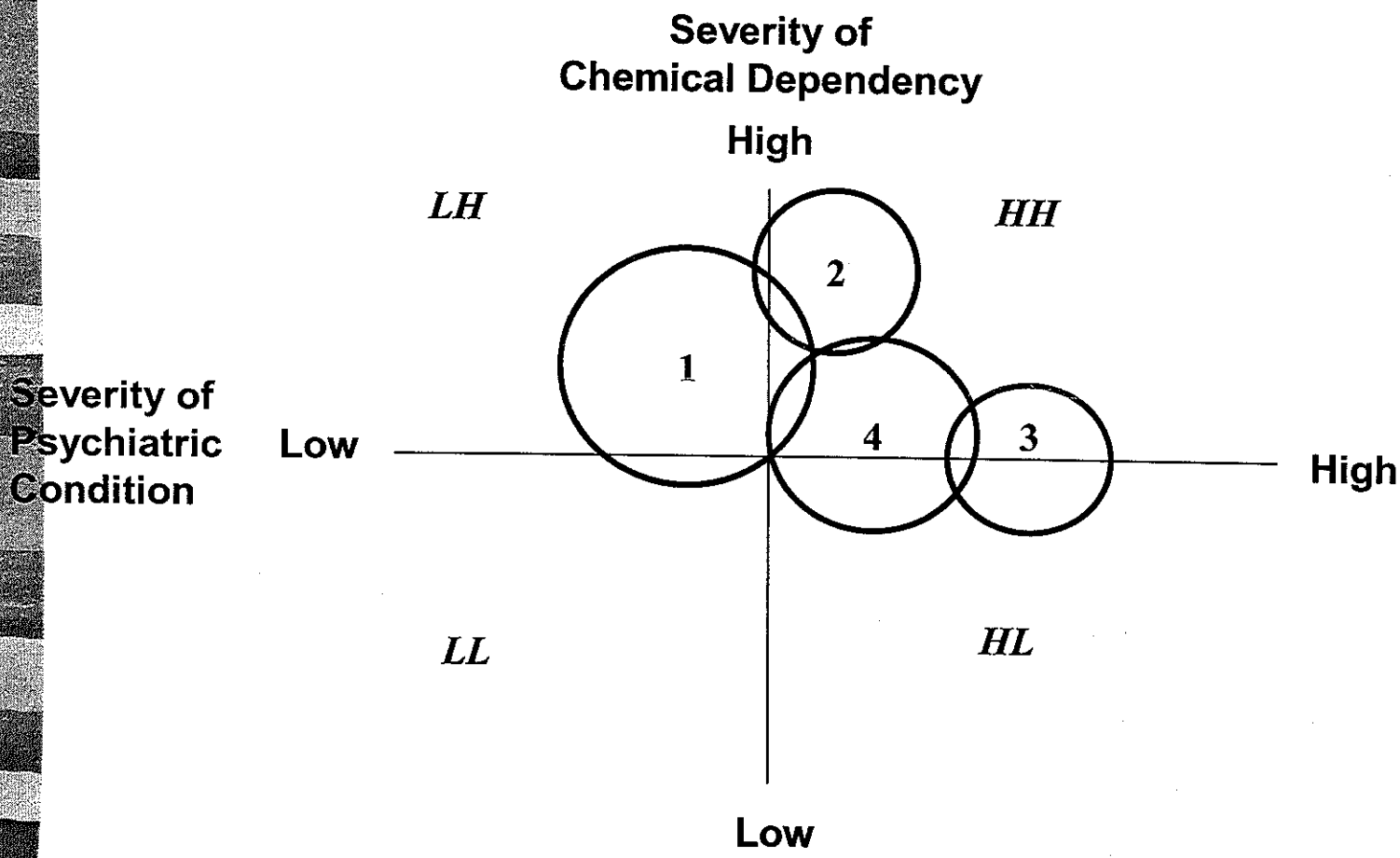
Transformation & Recovery

MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Future Directions

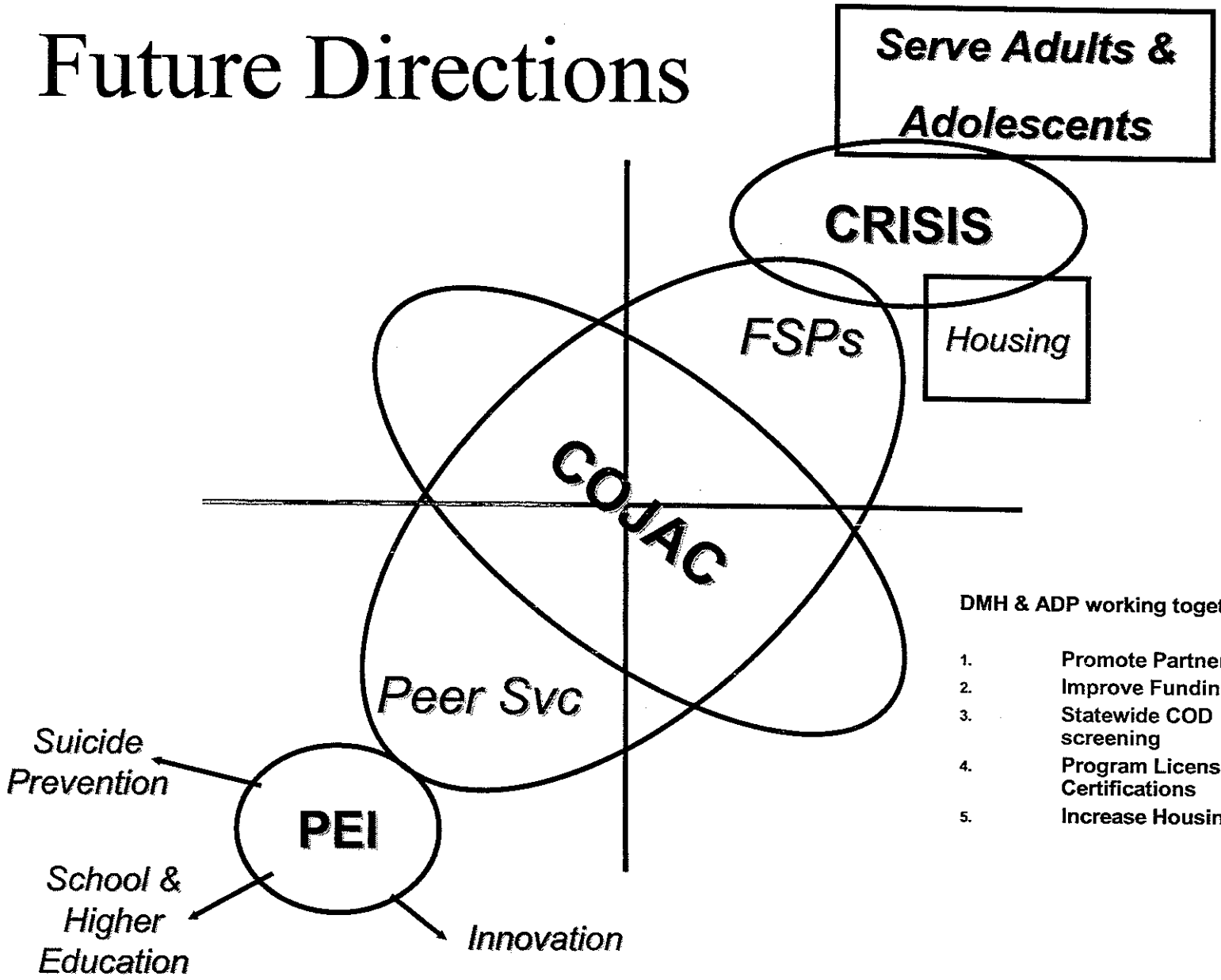


CHARACTERISTICS OF THE DUAL DIAGNOSIS CLIENT IN KING COUNTY



(Courtesy of Richard Ries, 2004)

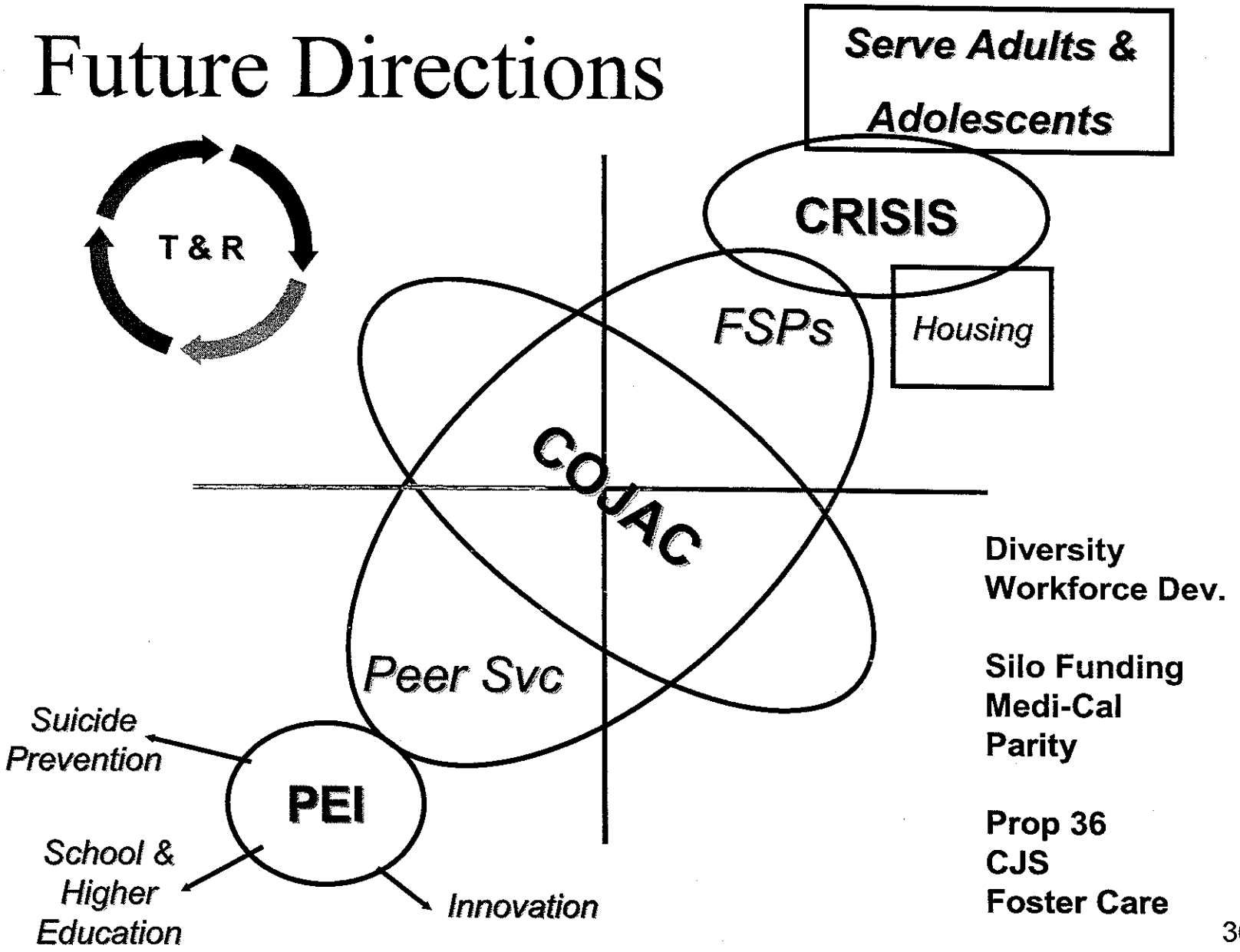
Future Directions



DMH & ADP working together to:

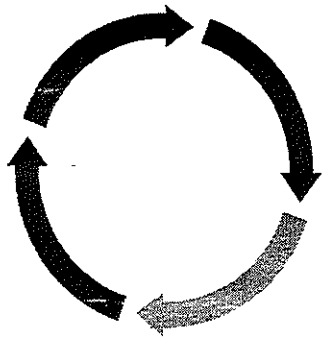
1. Promote Partnerships
2. Improve Funding
3. Statewide COD screening
4. Program Licensing & Certifications
5. Increase Housing

Future Directions



Next Steps

- Establish MHSA Workgroup
- Additional Stakeholder Input
- Revise Recommendations
- Coordinate & Collaborate



Transformation & Recovery

Public Discussion

Transformation & Recovery

Improving the Quality of Health Care for Mental and Substance-Use Conditions

1. Supporting patient decision making and preferences
2. Strengthening the evidence base and QI infrastructure
3. Coordinating care
6. Ensuring the NHII benefits persons with M/SU needs
7. Increasing workforce capacity
8. Using marketplace incentives for QI

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES