

# *Designing the Future*

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## ***Building Co-Occurring Capability in Addiction Treatment Settings***

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# Building Co-Occurring Capability in Addiction Treatment Settings

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“I am not here to be  
dually or diagnosed...”

# **Building Co-Occurring Capability**

## **in Addiction Treatment Settings**

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### **Learning Objectives**

- **Define co-occurring disorders (COD) and identify the prevalence of CODs in the US**
- **Explore several emerging trends and effective practices of integrated care for CODs**
- **Identify two methods to build COD capability in their agency**
- **Introduce TIP 42 Training Manual (SAMHSA, 2007)**

# **Building Co-Occurring Capability**

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### **Introductions**

**Name**

**Agency/Organization**

**Something about co-occurring disorders  
you would like to learn more about:  
resources, services, providers, training,  
credentialing**

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**What is your definition of  
co-occurring disorders?**

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### **Definitions**

**Co-occurring disorders (COD) refers to co-occurring substance use and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders.**

**CODs exist when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.**

**SAMSHA 2005 COCE: Overview Paper 1**

M. Rosier (2009)

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### Emerging Trends in the Field

- Increasing awareness of and observed incidence of CODs since the late 1970's
- Several studies found relationship between substance use and mental disorders

*Depression and Substance Abuse (Woody & Blaine, 1979)*

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### Emerging Trends in the Field

- In the 1980s, Studies in addiction programs found that 50 to 75 % of all people entering treatment had some type of concurrent mental disorder
- Studies found that 20 to 50 % of mental health clients had co-occurring substance use disorders

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### Emerging Trends in the Field

- In the 1980s, researchers found that as substance use disorders increased, so too did mental disorders
- Treatment, when integrated, was found to be helpful with both disorders
- New models and interventions began to emerge that adopted an integrated treatment approach

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## Evolution of Addictive Disorders in the DSM

DSM - I	<ul style="list-style-type: none"><li>• Alcoholism was placed under personality disorders.</li><li>• Addiction was a subcategory of sociopath personality disturbance.</li><li>• Addiction was considered a derangement of a person.</li></ul>
DSM - II	<ul style="list-style-type: none"><li>• Addiction was dropped to provide a more comprehensive diagnosis</li><li>• Drug dependence replaced addiction.</li><li>• Drug dependence was placed under certain other non-psychotic mental disorders.</li><li>• Drug dependence would not require the presence of physiological addiction but "evidence of habitual use or a clear sense of need for the drug".</li></ul>
DSM - III	<ul style="list-style-type: none"><li>• Abuse, which implied choice and value judgements was used to describe a pattern of pathological use.</li><li>• Adoption of the word "substance" was intent to clean the nomenclature of old attitudes.</li></ul>
DSM - IIR	<ul style="list-style-type: none"><li>• De-emphasized the importance of tolerance and dependence as criteria to diagnose addiction.</li><li>• Behavioral dependence more accurately defined loss of control over drinking.</li></ul>
DSM - IV	<ul style="list-style-type: none"><li>• Very little change from the previous edition concerning addictions.</li><li>• It does show a distinction for physiological withdrawal - with or without - physiological dependence.</li></ul>

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### Emerging Trends in the Field

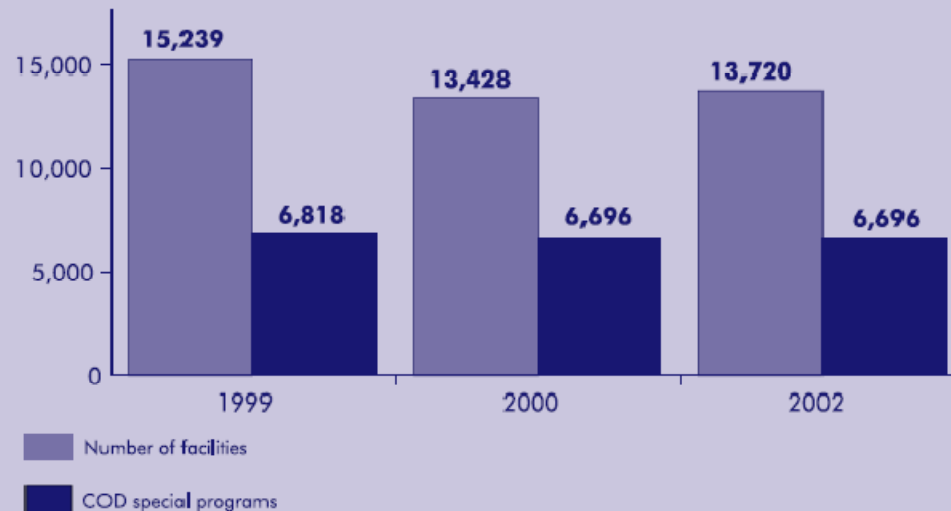
By 1999, CODs were determined not only to be common in the general population, but also largely untreated and diagnosed.

President's New Freedom Commission

2002 Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorder and Mental Disorders

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**Figure 1-3**  
**Substance Abuse Treatment Facilities Offering Special Programs for Clients With COD: 1999–2002<sup>1</sup>**



<sup>1</sup>Survey reference dates were October 1 for 1999 and 2000 and March 29, 2002. See appendix C of source for changes in the survey base, methods, and instruments that affect analysis of trends over time.

Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, UFDS Survey, 1996–1999; National Survey of Substance Abuse Treatment Services (N-SSATS), 2000 and 2002.  
[www.dasis.samhsa.gov/02nssats/nssats2002report.pdf](http://www.dasis.samhsa.gov/02nssats/nssats2002report.pdf)

# Building Co-Occurring Capability in Addiction Treatment Settings

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*“You people want the  
whole world to have  
co-occurring  
disorders”*

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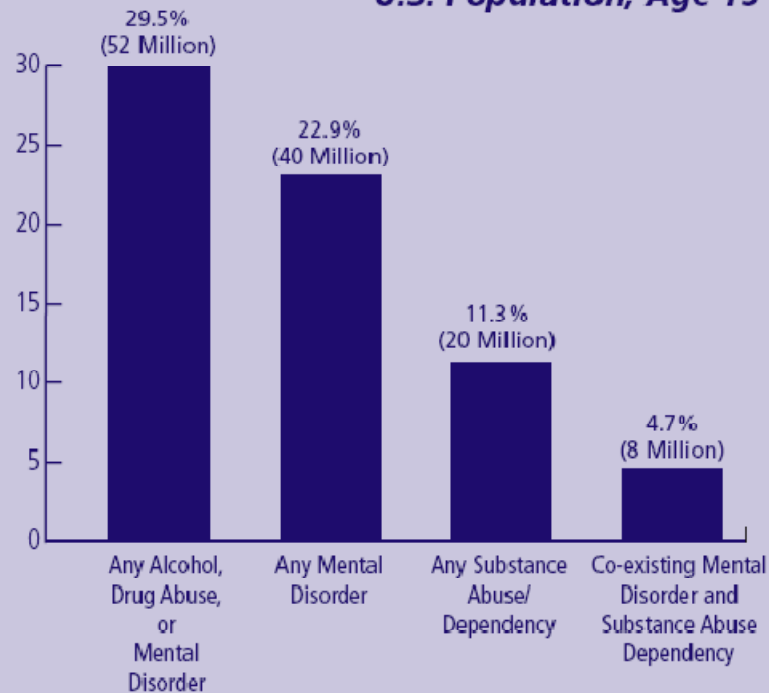
**Prevalence of co-occurring disorders**

**How common is it?**

**How many people have CODs?**

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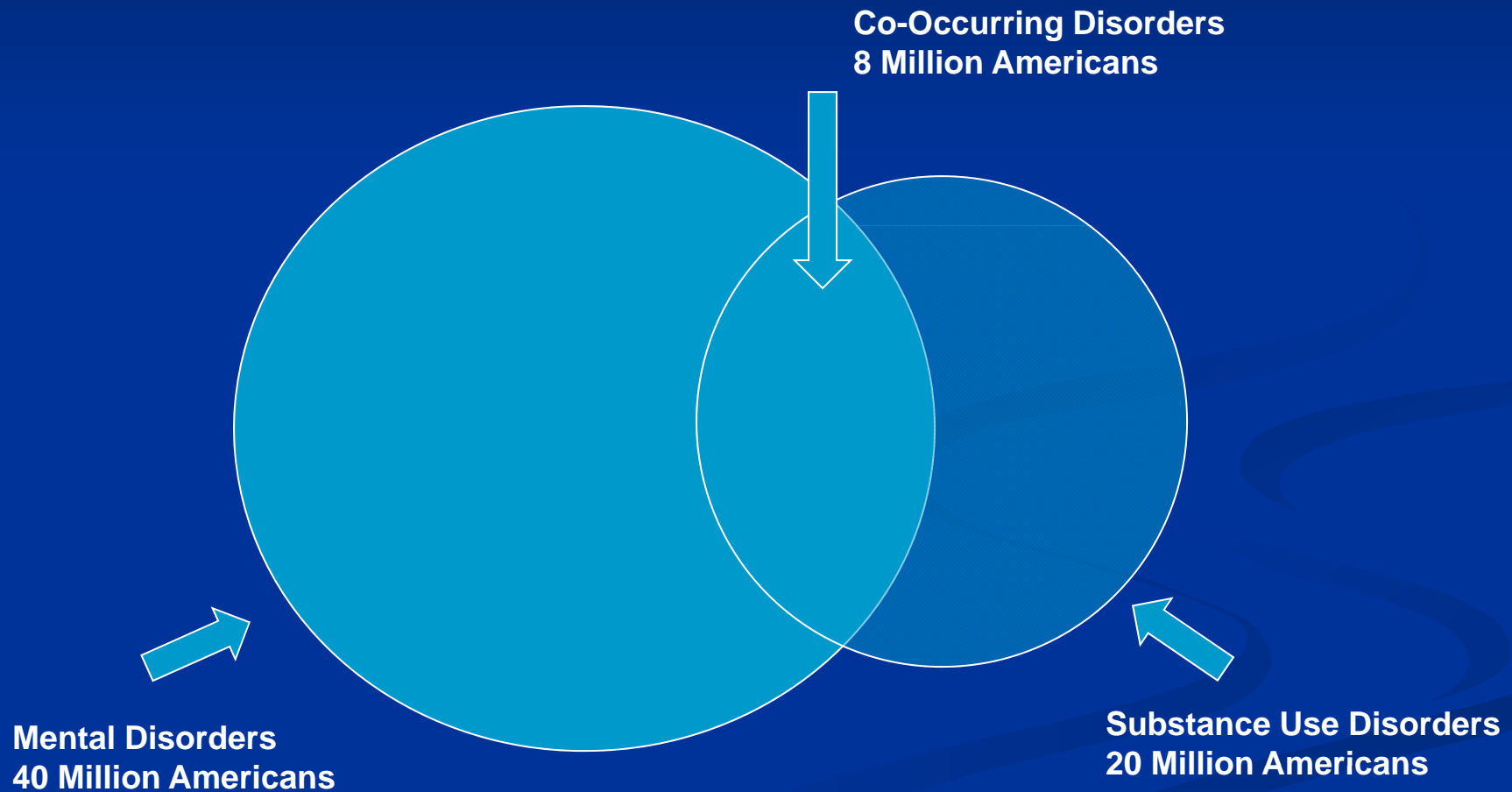
**Figure 1-1**  
**Persons With Alcohol, Drug Abuse, or Mental Disorder in the Past Year**  
**(See Endnote<sup>1</sup>)**  
**U.S. Population, Age 15 to 54, 1991**



Source: Kessler et al. 1994. Table 2 and unpublished data from the survey.

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### Prevalence of co-occurring disorders

- Each year 7 to 10 million individuals in the US have at least one mental disorder and one substance use disorder (SAMSHA National Advisory Council, 1998)

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**Over 50 % of people in the United States who have been diagnosed with a severe mental illness have also been diagnosed with a co-occurring substance use disorder.**

[www.ohiosamiccoe.com](http://www.ohiosamiccoe.com)

**Implementing IDDT: A step-by-step guide, p. 6**

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### Prevalence of co-occurring disorders

- 41 to 65 percent of people with a substance use disorder (lifetime incidence) have a lifetime history of at least one mental disorder
- 51 percent of people with a mental disorder (lifetime incidence) have a lifetime history of at least one substance use disorder

U.S. Surgeon General, 1999

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### Treatment Models

**Traditional services are frequently designed to respond to crises or to manage risk rather than to foster a full recovery process...**

[www.ohiosamiccoe.com](http://www.ohiosamiccoe.com)

Implementing IDDT: A step-by-step guide, p. 7

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## Treatment Models for CODs



**Sequential**



**Parallel**



**Integrated**

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# **Treatment Models for CODs**

## **Sequential**

- **First – and historically most common – model used**
- **Person is treated by one system at a time**
- **Controversy as to which disorder should be treated first**
- **Person receives conflicting information**
- **Emphasis is placed on system-specific issues/perspective**
  - **Addiction treatment provider sees all issues as related to addiction**

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### **Treatment Models for CODs**

#### **Parallel**

- **Simultaneous treatment provided by mental health and addiction treatment settings**
- **Utilizes existing treatment programs, settings and resources**
  - **Fits the “person” into the treatments being offered**
- **Coordination of services between settings varies widely and is uncommon**
- **Person frequently receives conflicting information and may experience pressure to choose preferred treatment approach**

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### **Treatment Models for CODs**

#### **Integrated**

- **Combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program**
- **Both types of disorders treated as primary**
- **Person receives simultaneous treatment of both disorders in a setting designed to accommodate both disorders**
- **Clinicians have typically received specialized training in integrated care**
- **Person is not responsible for coordination of care**

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### Integrated Treatment Models

#### Common Themes

- Shared focus on both disorders
- Present focused and strength-based
- Focused on acquiring skills and learning information useful in recovery planning
- Encourage self-acceptance, hope, healthy behaviors and optimism

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## Principles of Effective Integrated Care

- SAMSHA Center of Excellence
  - Overview Paper 3: Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders
    - 12 principles based in large part on Minkoff's Service Planning Guidelines

SAMSHA 2005 COCE: Overview Paper 3

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## Principles of Effective Integrated Care

### *Principle 1*

Co-occurring disorders 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.

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## Principles of Effective Integrated Care

### *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.

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## Principles of Effective Integrated Care

### *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 (see Table 1, Key Definitions, page 1).

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## Principles of Effective Integrated Care

### *Principle 4*

The system of care for COD should not be limited to a single “correct” model or approach.

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## Principles of Effective Integrated Care

### *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 (see Table 1, Key Definitions, page 1).

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## Principles of Effective Integrated Care

### *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.

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## Principles of Effective Integrated Care

### *Principle 7*

Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.

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## Principles of Effective Integrated Care

### *Principle 8*

Within the treatment context, both co-occurring disorders are considered primary.

SAMSHA 2005 COCE: Overview Paper 3

M. Rosier (2009)

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### Principles of Effective Integrated Care

#### *Principle 9*

Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.

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## Principles of Effective Integrated Care

### *Principle 10*

Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.

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## Principles of Effective Integrated Care

### *Principle 11*

The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.

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### Principles of Effective Integrated Care

#### *Principle 12*

The contribution *of the community* to the course of recovery for consumers with COD and the contribution of consumers with COD *to the community* must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

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## Key Principles of Effective Integrated Care

Treatment success involves formation of empathic, hopeful, integrated treatment relationships.

Minkoff (2001)

## Therapeutic Alliance

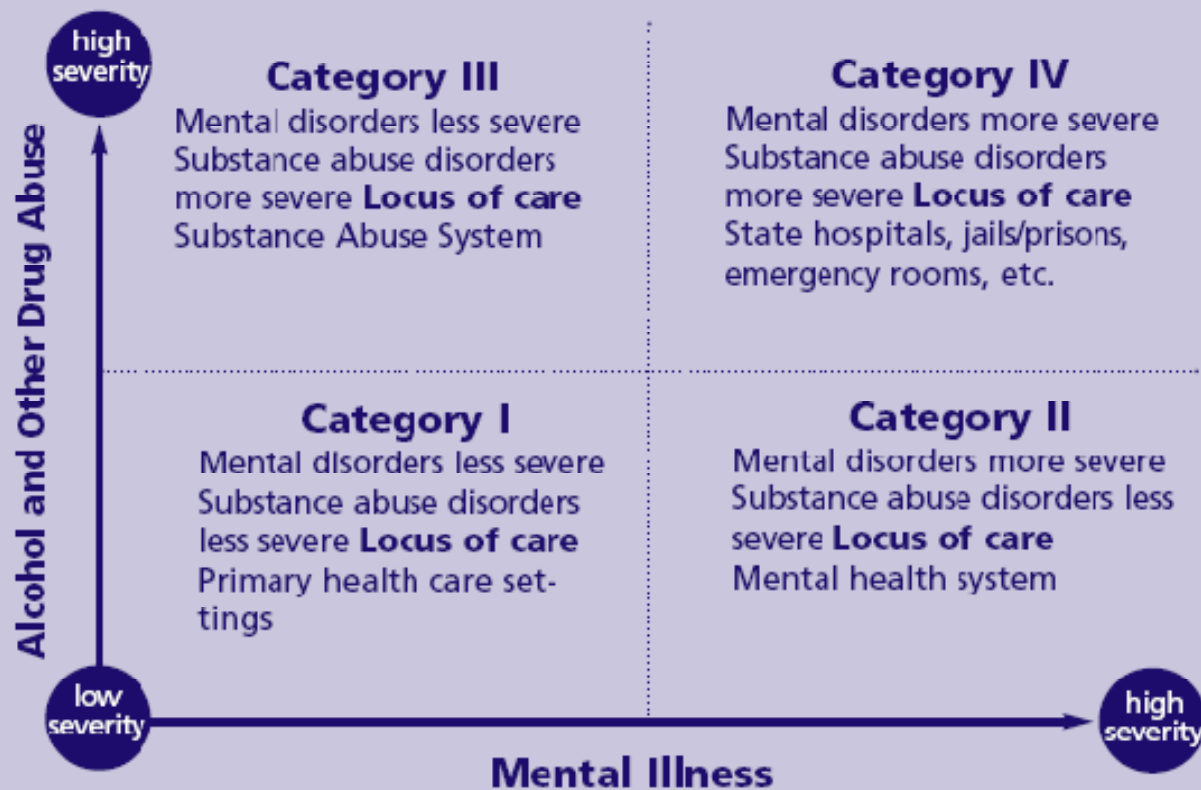
**The Heart and Soul of Change (2005)** Mark Hubble, Barry Duncan & Scott Miller

40 % Extra, 30 % TA, 15 % Placebo/Expectancy, 15 % EBPs

M. Rosier (2009)

# Building Co-Occurring Capability in Addiction Treatment Settings

*Figure 2-1  
Level of Care Quadrants*



# Building Co-Occurring Capability

## in Addiction Treatment Settings

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### Key Principles of Effective Integrated Care

People with CODs can be organized into four specific groups based on the severity of each type of their disorders

- Low or High severity
- Mental or Substance Use Disorders

**Minkoff (2001)**

M. Rosier (2009)

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### Levels of Care: Locus of Care

Category I: Mental Illness Low Severity/SUD Low Severity

Locus of Care: **Primary Health Care/No care**

Category II: Mental Illness High Severity/SUD Low Severity

Locus of Care: **Mental Health System**

Category III: Mental Illness Low Severity/SUD High Severity

Locus of Care: **Addiction Treatment System**

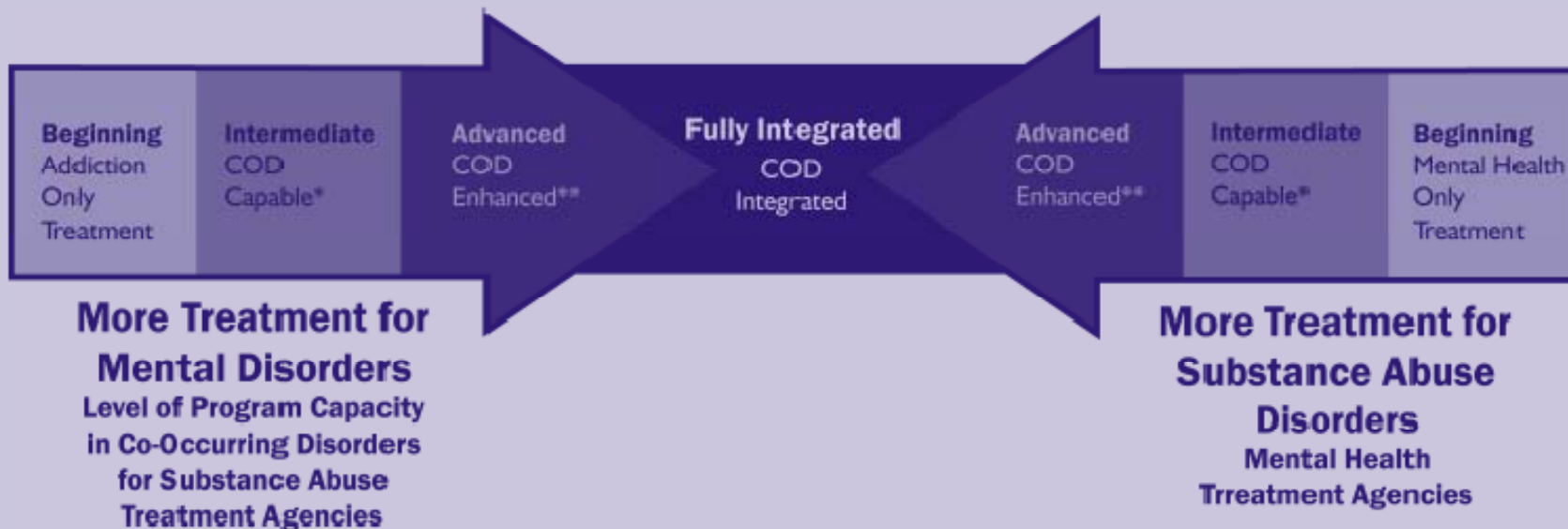
Category IV: Mental Illness High Severity/SUD High Severity

Locus of Care: **State Hospital/ER/Jail & Prison**

# Building Co-Occurring Capability in Addiction Treatment Settings

Figure 3-2

## Levels of Program Capacity in Co-Occurring Disorders



\*ASAM dual diagnosis capable  
\*\*ASAM dual diagnosis capable

# Building Co-Occurring Capability in Addiction Treatment Settings

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## Discussion

What is your definition of Integrated Care?

How close is your agency to this definition?

What are some of the challenges/barriers?

# Building Co-Occurring Capability in Addiction Treatment Settings

**Figure 3-3**

## ***A Vision of Fully Integrated Treatment for COD***

- The client participates in one program that provides treatment for both disorders.
- The client's mental and substance use disorders are treated by the same clinicians.
- The clinicians are trained in psychopathology, assessment, and treatment strategies for both mental and substance use disorders.
- The clinicians offer substance abuse treatments tailored for clients who have severe mental disorders.
- The focus is on preventing anxiety rather than breaking through denial.
- Emphasis is placed on trust, understanding, and learning.
- Treatment is characterized by a slow pace and a long-term perspective.
- Providers offer stagewise and motivational counseling.
- Supportive clinicians are readily available.
- 12-Step groups are available to those who choose to participate and can benefit from participation.
- Neuroleptics and other pharmacotherapies are indicated according to clients' psychiatric and other medical needs.

*Source:* Adapted from Drake et al. 1998b, p. 591.

# Building Co-Occurring Capability in Addiction Treatment Settings

## *Figure 3-7*

### *Essential Attitudes and Values for Clinicians Who Work With Clients Who Have COD*

- Desire and willingness to work with people who have COD
- Appreciation of the complexity of COD
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the limitations of one's own personal knowledge and expertise
- Recognition of the value of client input into treatment goals and receptivity to client feedback
- Patience, perseverance, and therapeutic optimism
- Ability to employ diverse theories, concepts, models, and methods
- Flexibility of approach
- Cultural competence
- Belief that all individuals have strengths and are capable of growth and development (added by consensus panel)
- Recognition of the rights of clients with COD, including the right and need to understand assessment results and the treatment plan

# Building Co-Occurring Capability

## in Addiction Treatment Settings

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### Building Integrated Care Capacity

#### Lesson One:

*“There are many replicable strategies and tools – often simple and inexpensive – that people in the mental health & substance abuse treatment fields can use to successfully provide treatment for people with co-occurring disorders.”*

From SAMHSA (2003 – No . 3782)

# Building Co-Occurring Capability

## in Addiction Treatment Settings

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### Building Integrated Care Capacity

#### Lesson Two:

*“Leadership is a key ingredient for ensuring progress at both the provider and systems levels.”*

From SAMHSA (2003 – No . 3782)

# Building Co-Occurring Capability

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### Building Integrated Care Capacity

#### Lesson Three:

*“When initiating and sustaining programs and systems, it is important to involve numerous stakeholders , including consumers and family members.”*

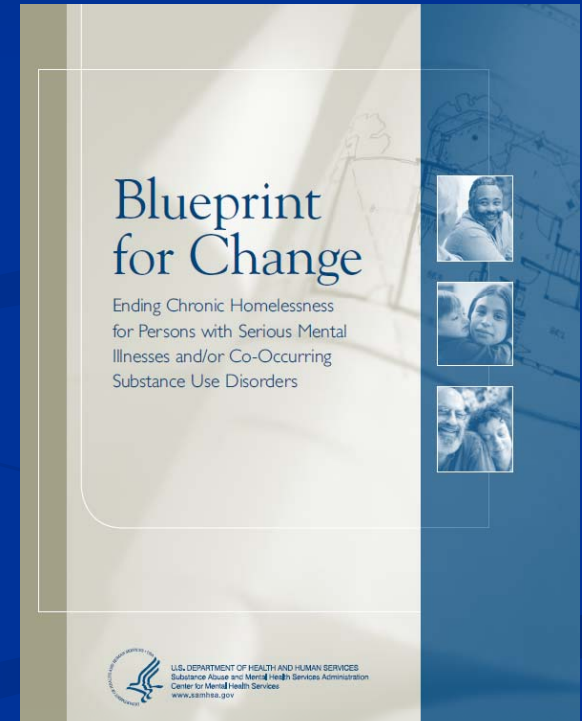
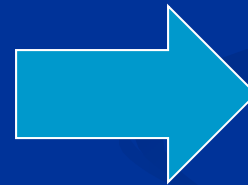
From SAMHSA (2003 – No . 3782)

# Building Co-Occurring Capability in Addiction Treatment Settings

## Building Integrated Care Capacity

### *Building COD Capacity*

- 1) *Identify the context and setting*
- 2) *Identify core values*
- 3) *Evaluate the agency*
- 4) *Identify the goals*
- 5) *Develop an action plan*
- 6) *Create Recovery Partnerships*
- 7) *Evaluate results*
- 8) *CQI & Celebrate*



**SAMHSA (2003)**

# Building Co-Occurring Capability in Addiction Treatment Settings

## Building Integrated Care Capacity

C H A P T E R	K E Y L E S S O N S
<b>Section I. BEFORE YOU BEGIN</b>	
<b>1. Understand the Changing Context of Care and the Nation's Response</b>	<ul style="list-style-type: none"><li>■ Understand how treatment for serious mental illnesses and substance use disorders has evolved</li><li>■ Study the Nation's response</li><li>■ Recognize individual risk factors</li><li>■ Explore service system challenges</li><li>■ Learn about societal risk factors</li><li>■ Understand the concept and practice of recovery</li><li>■ Support values that put people first</li><li>■ Create a system that supports recovery</li></ul>
<b>2. Learn About the Population</b>	
<b>3. Establish Core Values</b>	

**SAMHSA (2003)**

M. Rosier (2009)

# Building Co-Occurring Capability in Addiction Treatment Settings

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## Building Integrated Care Capacity

### Section II. PLAN FOR SERVICES

4. Establish a Comprehensive, Integrated System of Care

5. Finance a Comprehensive System of Care

- Develop the infrastructure for systems change
- Engage in strategic planning
- Participate in community-wide planning
- Streamline existing funding
- Secure additional resources
- Leverage new funds

SAMHSA (2003)

M. Rosier (2009)

# Building Co-Occurring Capability in Addiction Treatment Settings

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## Building Integrated Care Capacity

### Section III. ORGANIZE SERVICES

#### 6. Use Evidence-Based and Promising Practices

- Adopt or adapt evidence-based practices
- Offer a comprehensive set of essential services
- Make use of Federal resources, including toolkits, TIPS,<sup>1</sup> and CAG<sup>2</sup> and TCE<sup>3</sup> grants

SAMHSA (2003)

M. Rosier (2009)

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## Building Integrated Care Capacity

### Section IV. SUSTAIN SERVICES

#### 7. Measure Results

- Measure client-level outcomes
- Measure system-level outcomes
- Use management information systems

#### 8. Use Mainstream Resources to Serve People Who Are Homeless

- Use mainstream resources to prevent homelessness
- Improve access to mainstream programs
- Expand the capacity of mainstream programs
- Promote coordination and collaboration
- Build the infrastructure of housing and services
- Create public awareness

SAMHSA (2003)

M. Rosier (2009)

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## **Building Integrated Care Capacity**

### **How Can We Strengthening Collaboration?**

#### ***Recovery Partnerships.....***

**Families, Significant Others, Community Stakeholders/Leaders**

**Local Providers: Medical, Behavioral Health, etc.**

**Community Associations/Coalitions**

**Recovery Support Organizations**

**Federal/State/City/Town**

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### **Building Integrated Care Capability**

**Integrated care of CODs is all about relationships**

**Workforce development is one of the best and most cost effective methods of building COD capacity**

**Ongoing multidisciplinary training is essential to developing a competent and diverse workforce capable of meeting the needs of people in recovery**

# Building Co-Occurring Capability

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### Building Integrated Care Capability

- 1) Culture and Program Philosophy
- 2) Workforce Development
  - 1) Expertise & Qualifications of Clinical Team
  - 2) Training – USE THESE SLIDES!!!
  - 3) Credentialing
- 3) Collaborations
- 4) Services
  - 1) Screening & Referral
  - 2) Integrated Care Models – Seeking Safety

# **Building Co-Occurring Capability**

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## **Building Integrated Care Capacity**

### **Group Activity**

**Develop/Use an Addiction Recovery Provider**

**Choose ONE:**

**Quadrant III - High Severity SUDs and Low Severity MH**

**Quadrant IV - High Severity SUDs and High Severity MH**

- 1 – Define the strengths, assets and resources of “your” agency**
- 2 – Identify capacity objectives to enhance integrated care**
- 3 – Develop a strategy to build integrated care capacity to enhance program capacity**

# **Building Co-Occurring Capability**

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### **Building Integrated Care Capacity**

#### **COD Resource Disk**

- **Several tools and resources**
- **COCE Overview Papers**
- **TIP 35 Inservice Manual**
- **TIP 42 and TIP 42 Inservice Manual**
  - **Documents**
  - **Slides**
  - **Manual to offer agency based (inservice) training**

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