

**Services for People in  
Montgomery County who have  
Co-Occurring Mental Health and  
Substance Abuse Disorders**

**Office of Legislative Oversight  
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# Office of Legislative Oversight Report 2003-6

## Services for People in Montgomery County who have Co-Occurring Mental Health and Substance Abuse Disorders

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## EXECUTIVE SUMMARY

People with co-occurring disorders have both a mental illness and a substance abuse disorder. Co-occurring disorders affect an estimated seven to ten million adults in the U.S. each year, including a large number of individuals who are homeless and/or criminal offenders. In Montgomery County, at least 1,900 people suffer from co-occurring disorders.

People diagnosed with co-occurring disorders typically receive disjointed treatment from separate mental health and substance abuse service systems. Research indicates that integrating treatment, or addressing both mental health and substance abuse disorders together, provides a more effective means of treatment.

In Montgomery County, individuals with co-occurring disorders receive treatment from programs within the substance abuse, mental health, crisis, and criminal justice service systems. Treatment typically focuses on one disorder, and does not integrate substance abuse and mental health care. In an effort to begin to integrate services, several providers have implemented discussion or therapy groups specifically for people with co-occurring disorders.

Three County programs currently integrate substance abuse and mental health services for people with co-occurring disorders. The Assertive Community Treatment (ACT) Team and the Avery Road Combined Care (ARCC) use multi-disciplinary staff to provide comprehensive integrated services. Case managers from the Substance Abuse Services for Women (SASW) program link clients with community-based mental health, substance abuse, and other services, and provide on-going support. A State grant fully funds the ARCC for FY04 and FY05. Federal funds support the SASW program through FY04. The County has not identified full ongoing funding for those two programs.

This year, the Department of Health and Human Services partnered with community-based providers to establish the Co-occurring Disorders Steering Committee. The Committee is charged with improving the integration of mental health and substance abuse services for individuals with co-occurring disorders.

To ensure continued progress on this important issue, OLO recommends that the Council:

- Closely track the Co-Occurring Disorders Steering Committee's efforts to improve services for individuals with co-occurring disorders. The Council should request quarterly written updates on the Committee's work, and schedule a Health and Human Services (HHS) Committee worksession on the effort in early 2004.
- Request that the County Government submit a report on the activities of the new Avery Road Combined Care facility by March 1, 2004. The Council should also discuss potential future funding for the facility.
- Review DHHS' evaluation of the Substance Abuse Services for Women program and consider potential future funding for the program.

## **I. Introduction**

### **A. Authority**

Council Resolution 14-1395, *FY 2003 Work Program of the Office of Legislative Oversight*, adopted July 30, 2002. The original project scope was amended and approved by the Council in February 2003.

### **B. Scope and Organization**

This Office of Legislative Oversight (OLO) report describes services in Montgomery County for people who have co-occurring substance abuse and mental health disorders. It begins with background information about co-occurring disorders and summarizes research on effective treatment for co-occurring disorders. The majority of the report describes how Montgomery County identifies, assesses, and treats individuals who have co-occurring disorders. The report also includes examples of programs in other jurisdictions for people who have co-occurring disorders. The report concludes with findings and recommendations.

The report is organized as follows:

- II. Background** - Defines co-occurring disorders and describes traditional treatment for the disorders. It also summarizes research on more effective, integrated treatment for co-occurring disorders.
- III. Services for People in Montgomery County who have Co-Occurring Disorders** – Provides estimates of the number of people in Montgomery County who have co-occurring disorders. The majority of the chapter describes the programs in Montgomery County to assess needs and provide treatment.
- IV. Examples of Integrated Treatment Services in Other Jurisdictions** – Provides examples from other jurisdictions of integrated assessment and treatment services for individuals who have co-occurring disorders.
- V. Findings** – Summarizes OLO’s findings on effective services for individuals who have co-occurring disorders, the services provided in Montgomery County, and programs implemented in other jurisdictions. The findings also present issues that impact service delivery in Montgomery County.
- VI. Recommendations** – Presents OLO’s recommendations for Council consideration.
- VII. County Government Comments** – Includes the Chief Administrative Officer’s comments on the draft report in their entirety.

### **C. Methodology**

Jennifer Kimball, Legislative Analyst and Elizabeth Freund, Research Assistant from the Office of Legislative Oversight conducted this study. OLO gathered information from document reviews and individual and group interviews. Background and research information came from the Federal Substance Abuse and Mental Health Services Administration and other sources listed in Attachment A at ©1.

OLO conducted interviews with staff in the County's Department of Health and Human Services and Department of Correction and Rehabilitation. OLO also interviewed representatives of the State Department of Health and Mental Hygiene, Montgomery County Coalition for the Homeless, Montgomery County Mental Health Association, Washington Adventist Hospital, Montgomery General Hospital, and public mental health system providers.

OLO contacted staff in Fairfax County, VA; Arlington County, VA; San Diego County, CA; Worcester County, MD; San Francisco, CA; Santa Cruz County, CA; Philadelphia, PA; and Baltimore, MD for examples of integrated mental health and substance abuse services for individuals who have co-occurring disorders.

### **D. Acknowledgements**

OLO thanks staff in the Department of Health and Human Services for their cooperation and contribution to this study, including Carolyn Colvin, Daryl Plevy, Richard Kunkel, Dudley Warner, Alease Black, Carolyn McAlpine, Steve Stahley, Agnes Leshner, Peggy Bradley, Athena Morrow, Terry Flynn, Robert Wright, Nancy Doran, Larry Wilson, and Laura Hefner. OLO also thanks Art Wallenstein, Claire Gunster-Kirby and Patricia Sollack in the Department of Correction and Rehabilitation for their assistance.

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## II. Background

### Highlights:

1. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines people who have co-occurring disorders as individuals who have at least one mental disorder, as well as an alcohol or drug use disorder.
2. SAMHSA estimates that co-occurring disorders affect seven to ten million adults in the U.S. each year. Co-occurring disorders are particularly common among individuals that are homeless and/or involved in the criminal justice system.
3. People who have co-occurring disorders have traditionally received disjointed treatment services from separate mental health and substance abuse service systems which often do not have the resources, training, and treatment that people who have co-occurring disorders need. Research supports a shift to integrated treatment interventions that address both mental health and substance abuse disorders simultaneously.
4. SAMHSA describes three levels of treatment integration. The first level involves relatively informal relationships and interaction between separate mental health and substance abuse providers. The second level involves more formal coordination of separate mental health and substance abuse treatment services. The third level involves combining mental health and treatment services in one service setting.

## **A. Defining Co-Occurring Disorders**

The Federal Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) defines people who have co-occurring disorders as:

Individuals who have at least one mental disorder, as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other. (SAMHSA, 2002)

Co-occurring disorders emerged as a public health concern in the early 1980s, as it became more evident that many people with a serious mental illness also had substance abuse problems. SAMHSA estimates that co-occurring disorders affect seven to ten million adults in the U.S. each year. According to the 1999 Surgeon General's Report on Mental Health, as many as half of all people with a serious mental illness develop alcohol or other drug abuse problems at some point in their life. Federal studies currently underway will provide new data on the number of people who have co-occurring disorders.

Co-occurring disorders are both common and highly complex. They may include any combination of two or more substance abuse disorders and mental disorders. They vary by severity and degree of impairment in functioning. Both disorders may be severe or mild, or one may be more severe than the other. In addition, the disorders in one individual may change over time.

People who have co-occurring disorders tend to have more difficulty than people with a single disorder in dealing with their mental health and substance abuse issues. There is a strong positive association between co-occurring disorders and:

- Worsened mental health and substance abuse symptoms,
- Treatment noncompliance,
- Frequent hospitalizations,
- Likelihood of suicide,
- Incarceration,
- Family friction, and
- High services use and cost.

People who have co-occurring disorders also tend to experience a variety of other health and social problems which require multiple services such as housing, employment, legal, and health care services.

Co-occurring disorders are particularly common among individuals that are homeless or involved in the criminal justice system. Studies show that individuals who use drugs or alcohol and have an untreated serious mental illness, have a higher potential for violent behavior. This increases the likelihood that individuals who have co-occurring disorders will be involved in the criminal justice system. According to the Department of Justice, 6 percent of men and 12 percent of women entering jail has a severe mental disorder. An estimated 72 percent of incarcerated adults with a serious mental illness has a co-occurring substance abuse disorder.

An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Studies show that people who are homeless and have co-occurring disorders tend to be older, male, and unemployed. They also tend to be homeless longer, more mistrustful and resistant to help, and live in harsher, more isolated conditions, than people who are homeless without co-occurring disorders. They often have other serious health problems, less ability to adjust to daily life (e.g., keep a job, pay bills), and fewer improvements in their condition over time compared to homeless individuals with a serious mental illness alone. Attachment B, beginning at ©3, includes an article on co-occurring disorders and homelessness.

## **B. Traditional Treatment for Co-Occurring Disorders**

Federal Substance Abuse and Mental Health Services Administration (SAMHSA) studies indicate that individuals who have co-occurring disorders have difficulty seeking and receiving services. One SAMHSA study found that only 19 percent of those studied received treatment for both their mental health and substance abuse disorders, and 29 percent did not receive treatment for either disorder. The study also reported that if treatment was received at all, it most often was for the mental disorder alone.

People who have co-occurring disorders have traditionally received disjointed treatment services from separate mental health and substance abuse service systems. These systems separately often do not have the resources, training, and treatment services that people who have co-occurring disorders need. For example, public mental health service systems are not typically equipped to address substance abuse disorders. Similarly, substance abuse treatment programs do not provide mental health therapy, and are only able to manage clients with mild or moderate mental illnesses. In addition, the systems do not coordinate services and share resources to best serve the clients' needs.

Consequently, individuals who have co-occurring disorders may be excluded from mental health programs due to their substance abuse disorder, and similarly excluded from substance abuse treatment programs because of their mental disorder. They often bounce back and forth between the two systems of care, resulting in incomplete, disjointed, and/or sequential treatment.

Traditional funding practices also contribute to difficulties serving people who have co-occurring disorders. According to SAMHSA, mental health and substance abuse services are funded through a patchwork of Federal, State, local, and private sources that can



create gaps in the availability of services. For example, existing funding streams may not cover “wraparound” supports, such as transportation, vocational training, and child care. Insufficient treatment resources can mean that a substance abuse outpatient treatment program cannot afford a psychiatric specialist to evaluate and manage psychotropic medications.

SAMHSA reports that one of the most significant barriers to effectively serving people who have co-occurring disorders is insufficient professional training. SAMHSA reports in 2003 that “Despite an increasing body of evidence affirming the importance of integrating mental health and substance abuse treatment, few educational institutions teach this approach.” In addition, few incentives exist in the current system to motivate clinicians to become cross-trained. Opportunities for joint credentialing or licensing are not currently available.

Other factors which hinder the effective treatment of persons who have co-occurring disorders include:

- The lack of a single locus of responsibility or coordination of treatment,
- Different treatment philosophies and approaches,
- Limited insurance coverage for services for people with substance abuse or mental disorders that require long-term treatment, and
- Separate mental health and substance abuse data collection and performance measurement systems.

### **C. Research Findings on Integrated Treatment of Co-Occurring Disorders**

SAMHSA reports that if co-occurring disorders are untreated or ineffectively treated, both disorders usually get worse and additional complications arise. This often leads to individuals needing additional higher cost services, such as inpatient and emergency room care. These potential consequences have led researchers to seek new treatment strategies that result in better outcomes.

Research completed to date on co-occurring disorders primarily took place in clinical settings using small sample groups with a specific mental illness, such as schizophrenia. There have been some evaluations of small pilot programs at the state level. The primary compilation of research on co-occurring disorders is the 2002 SAMHSA Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse and Mental Disorders.

According to the Surgeon General, research supports a shift to integrated treatment interventions that address both mental health and substance abuse disorders simultaneously. Integrated treatment is broadly defined as “any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting”.

SAMHSA reports that,

Studies within substance abuse and mental health settings have demonstrated that integrated treatment is successful in retaining individuals who have co-occurring disorders in substance abuse treatment, reducing substance abuse disorders, and reducing symptoms of mental disorders. (SAMHSA, 2002)

Research also indicates that integrated treatment maintains continuity and consistency of care and reduces hospitalization.

In general, integrated systems of care include:

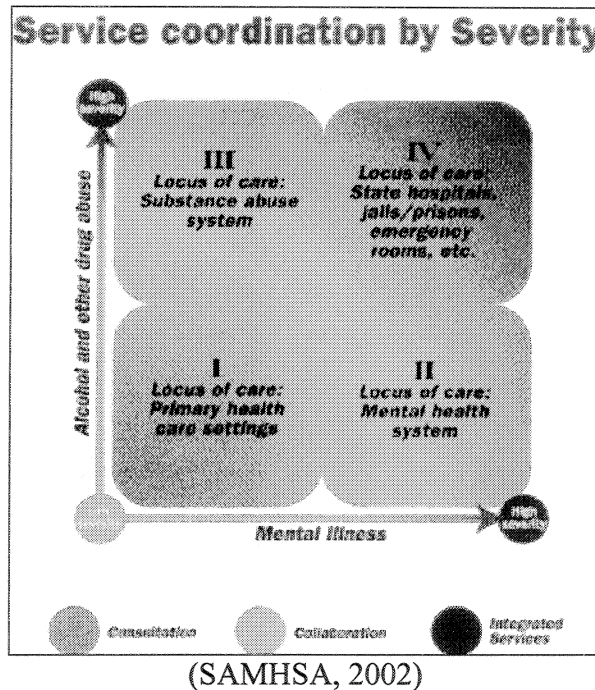
- A broad range of services unique to each individual's needs;
- Assertive outreach,
- Time sensitive, comprehensive screening and assessment,
- Case management,
- Interventions that help to motivate patients and modify risky behaviors, and
- Involvement of other service systems, such as housing and employment.

One of the most important components of providing integrated services is the cross training of mental health and substance abuse professionals so they are able to identify symptoms, develop treatment plans, and refer to additional services. Cross-training allows staff to focus on their field of expertise, while working as part of a multi-disciplinary team which addresses multiple client needs.

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors developed a model that identifies the typical treatment setting for an individual with co-occurring disorders. The figure on page 8 illustrates the model's four quadrants, which represent different severities of mental health and substance abuse disorders. It also indicates the locus of care or primary service setting for individuals that fall in each quadrant. In sum:

- Individuals in quadrant I have low severity mental health and substance abuse disorders, and tend to receive their care from a primary health care setting, school based clinic, or community program.
- For individuals in quadrants II and III, one disorder is more severe than the other. Individuals typically receive care from the mental health service system if the mental illness is more severe and the substance abuse system if the substance abuse disorder is more severe.
- Individuals in quadrant IV have high severity of both disorders and typically receive care from state hospitals, jails, emergency rooms, homeless service programs, or the mental health or substance abuse system.

Figure 1.



SAMHSA describes three levels of treatment integration that relate to the model described above. The levels of integration range from informal consultation among providers to formal combining of services.

1. The first level involves relatively informal relationships and interaction between separate mental health and substance abuse providers, as necessary. This level of integration is usually appropriate for individuals in quadrant I. The low severity of their disorders allows for care in a primary health care setting with informal coordination among mental health and substance abuse providers.
2. The second level involves more formal coordination among separate mental health and substance abuse treatment services. This formal coordination ensures that treatment addresses both mental health and substance abuse problems and provides linkages to other needed services. This level of integration is usually appropriate for individuals in quadrants II and III. While one provider serves as the primary provider, the client receives treatment for both disorders with a high degree of collaboration among providers.
3. The third level involves more formal combining of services in one setting. This level of integration is appropriate for individuals in quadrant IV who need aggressive, consolidated treatment in a single service setting for both disorders.

### **III. Services for People in Montgomery County who have Co-Occurring Disorders**

#### **Highlights:**

1. FY 2002 State data indicate that approximately 1,900 Montgomery County public mental health system consumers had co-occurring disorders. Data is not currently available on the number of County residents who have co-occurring disorders but do not participate in the public mental health system.
2. Specific County programs assess the needs of people who have co-occurring disorders, including Addiction Services Coordination, the Clinical Assessment and Triage Services Unit, Community Re-Entry Services, outpatient mental health clinic providers, the Core Service Agency, and the Access Team.
3. Staff usually refers co-occurring clients with a more severe substance abuse disorder and a stable mental illness to treatment from Outpatient Addiction Services or the Avery Road Treatment Center. Co-occurring clients with a serious mental illness are usually referred to one of the outpatient mental health clinic providers for treatment.
4. Treatment for co-occurring disorders typically focuses on one disorder or the other, and does not integrate treatment. However some providers are moving towards integration by offering specific therapy or discussion groups for clients who have co-occurring disorders.
5. Three County programs integrate mental health and substance abuse treatment for people with co-occurring disorders, including the Assertive Community Treatment (ACT) Team and the new Avery Road Combined Care (ARCC) facility, and Substance Abuse Services for Women (SASW).

This chapter describes the programs and services in Montgomery County that identify, assess, and treat individuals who have co-occurring disorders. The chapter is organized as follows:

- Part A explains the estimated number of adults in Montgomery County who have co-occurring disorders,
- Part B describes how Montgomery County identifies individuals who have co-occurring disorders (begins on page 12),
- Part C describes the programs that assess the needs of individuals who have co-occurring disorders (begins on page 12),
- Part D describes the programs that treat individuals who have co-occurring disorders (begins on page 17), and
- Part E describes other relevant activities, including two committees addressing co-occurring disorders in Montgomery County and State efforts in this service area (begins on page 32).

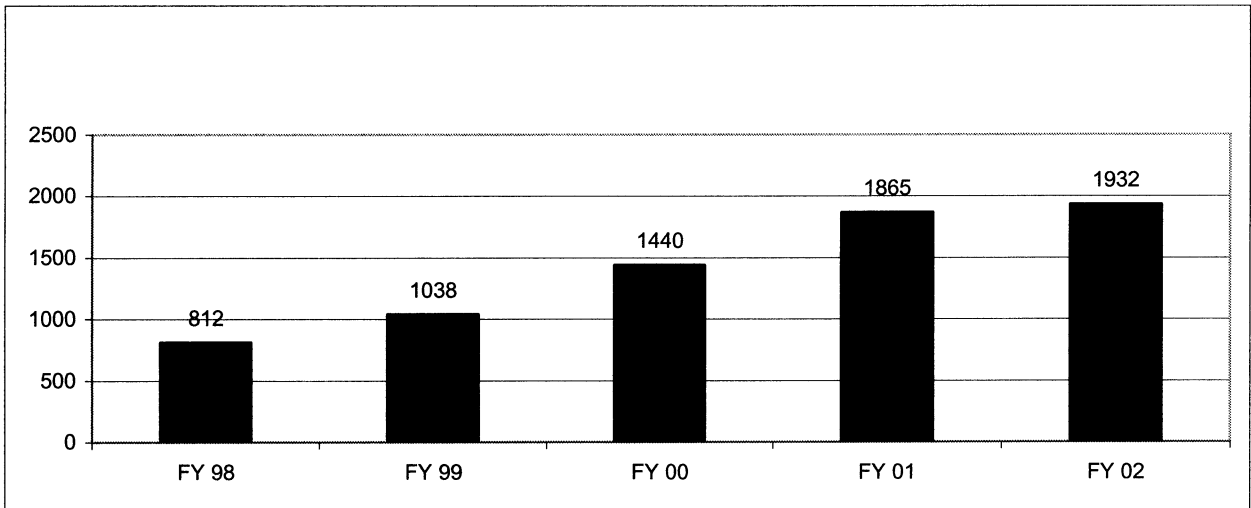
#### **A. Numbers of Adults who have Co-Occurring Disorders**

It is not known exactly how many low income individuals in Montgomery County have co-occurring disorders. DHHS' Core Service Agency collects data from the State on the Montgomery County residents that have co-occurring disorders and receive services through the State public mental health system. As Table 1 (page 11) illustrates, the number of Montgomery County mental health care consumers who have co-occurring disorders increased over the past five fiscal years. In FY 2002, approximately 1,900 Montgomery County public mental health system consumers reportedly had co-occurring disorders.<sup>1</sup>

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<sup>1</sup> The State considers a consumer to have co-occurring disorders if he or she has specific alcohol or substance abuse induced mental health diagnoses. A list of those diagnoses is attached at ©51.

**Table 1: Montgomery County Public Mental Health System Consumers who have Co-Occurring Disorders**



Data is not currently available on the number of individuals with co-occurring disorders who do not participate in the State's public mental health system. Substance abuse and mental health services staff estimates that:

- 90 percent of the 70 Assertive Community Treatment (ACT) Team clients has co-occurring disorders;
- 60 percent of the 1,500 individuals assessed annually at the Detention Center by the Clinical Assessment and Triage Services (CATS) Unit has co-occurring disorders;
- 70 percent of the 45 clients in the Substance Abuse Services for Women (SASW) program has co-occurring disorders;
- 50 percent of the 3,000 individuals assessed annually by Addictions Services Coordination (ASC) for service needs has co-occurring disorders;
- 50 percent of the 160 clients receiving Outpatient Addiction Services (OAS) treatment has co-occurring disorders;
- 40 percent of the 1,000 clients admitted annually to the Avery Road Treatment Center for detoxification self-report that they have co-occurring disorders; and
- 40 to 60 percent of the 700 – 800 Pre-Trial Services Unit clients had co-occurring disorders.

Co-occurring disorders also exist among the homeless population in Montgomery County. The Metropolitan Washington Council of Governments conducted a one day count of people who are homeless in the region in January 2003. Of the 738 homeless single adults identified in Montgomery County, 22 percent self reported that they suffer from co-occurring disorders. This self reported figure most likely undercounts the actual number of homeless individuals that have co-occurring disorders.

The Men's Emergency Shelter staff estimates that 60 percent of the shelter clients has co-occurring disorders. The Mental Health Association (MHA) of Montgomery County estimates that between 25 percent and 35 percent of MHA's Adult Homeless Mental Health Services clients has co-occurring disorders.

## **B. Identifying Individuals who have Co-Occurring Disorders**

Individuals who have co-occurring disorders enter the County's system of services through many "doors". While some individuals enter the substance abuse or mental health service systems directly, others are identified by staff with the:

- Crisis Center/Mobile Crisis Team, Department of Health and Human Services (DHHS),
  - Emergency Services, DHHS,
  - Child Welfare Services, DHHS,
  - Crisis Intervention Teams, Montgomery County Police Department,
  - Department of Correction and Rehabilitation,
  - Court system,
  - Homeless shelters, and
  - Hospitals.
- 
- Individuals entering any of these "doors" to services often have multiple service needs. Initial screening by staff begins to collect information about client needs, and to identify appropriate programs or providers to refer to for further assessment and services.

## **C. Assessing Individuals who have Co-Occurring Disorders**

### **1. Overview**

Staff in the substance abuse, mental health, and criminal justice service systems assesses the needs of individuals who have co-occurring disorders. Table 2 lists the programs described in this part of the chapter, and the organizational location of each program. In general:

- Addiction Services Coordination (ASC) staff assesses individuals with a more severe substance abuse disorder and a stable mental illness.

- Outpatient mental health clinic providers, the Access Team, and the Core Service Agency assess individuals with a more severe mental illness which hinders their ability to function in a substance abuse treatment environment.
- Clinical Assessment and Triage Services (CATS) Unit staff assess individuals entering the detention center who appear to have a mental illness.
- Community Re-Entry Services (CRES) staff assesses individuals leaving the Detention Center.

**Table 2: Programs that Assess Individuals who have Co-Occurring Disorders**

<b>Program</b>	<b>County Department</b>	<b>Described Beginning on Page:</b>
<b>Substance Abuse Services System</b>		
Addiction Services Coordination	DHHS	13
<b>Mental Health Services System</b>		
Public Mental Health System Providers		14
Access Team	DHHS	14
Core Service Agency	DHHS	14
<b>Criminal Justice System</b>		
Clinical Assessment and Triage Services Unit	DHHS	15
Community Re-Entry Services	DHHS	17

## **2. Substance Abuse Services System**

The Department of Health and Human Services (DHHS) provides a continuum of prevention and treatment services for adults that abuse alcohol and other drugs. The philosophy of the Department is to provide a continuum of prevention, early intervention, assessment, evaluation, and treatment services with “on demand” access to care.

Addiction Services Coordination (ASC) staff assesses the substance abuse needs of 2,800 to 3,000 individuals per year. ASC also manages the urine monitoring program and monitors the County’s contracts for addiction treatment services.

**Assessment.** ASC completes a 30 to 60 minute Client Assessment Instrument to assess functional impairment and identify primary needs of new clients. A copy of the Client Assessment Instrument is attached at ©13. It assesses substance use, physical needs, mental health needs, criminal justice involvement, family functioning, and employment history. The Client Assessment Instrument does not provide a strong diagnostic assessment of mental health. ASC staff estimates that 50 percent of the individuals assessed has co-occurring disorders.



**Referral.** ASC uses the results of the assessment to match clients with appropriate substance abuse treatment services. ASC usually refers individuals who have co-occurring disorders to one of the following intensive outpatient treatment programs<sup>2</sup>:

- Outpatient Addiction Services (described beginning on page 19),
- Substance Abuse Services for Women (described beginning on page 21) or,
- Avery Road Combined Care (described beginning on page 23).

ASC usually refers individuals who have co-occurring disorders and require residential treatment or non-hospital detoxification services to the Avery Road Treatment Center (described beginning on page 21). ASC has a small contract with Montgomery General to provide hospital-based detoxification for appropriate medically indigent residents who cannot be safely detoxed in a non-hospital setting.

ASC staff also coordinates with the DHHS Access Team and Core Service Agency to identify appropriate treatment providers when a client's primary need is mental health care. ASC staff works with the Crisis Center when a client is experiencing a mental health crisis.

### **3. Mental Health Services System**

Individuals enter the mental health services system through multiple doors. DHHS' Core Service Agency<sup>3</sup> screens applications to determine eligibility for Residential Rehabilitation Program (RRP) services. Residential Rehabilitation Programs provide supervised housing and rehabilitation services for consumers with severe and persistent mental illness. The RRP application collects demographic, financial, and diagnostic information about the applicant, including history of substance abuse use and treatment.

The CSA maintains a residential services eligibility list and is responsible for referring RRP candidates to an RRP program when a vacancy becomes available. The RRP provider is then responsible for conducting an initial assessment to determine if the applicant is an appropriate candidate for the residential rehabilitation program.

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<sup>2</sup> Intensive outpatient programs serve individuals with a history of substance abuse, poor social functioning and failed attempts at other types of treatment. It involves at least nine hours of treatment services per week.

<sup>3</sup> The Core Service Agency provides overall planning, management, and monitoring of publicly-funded mental health services for Montgomery County consumers across the life span. These mental health treatment and support services include critical response services, child and adolescent services, adult and senior services, homeless and residential services, vocational services, and specialized services for mental health consumers and those consumers with a co-occurring disorder. Attachment D (©19) includes a comprehensive list of CSA services.

In terms of outpatient services, individuals may contact DHHS' Access Team for a referral to a service provider.<sup>4</sup> The Access Team staff completes an initial telephone screening which identifies whether the individual:

- Is in crisis or their safety is at risk,
- Is a Montgomery County resident,
- Is already enrolled in the public mental health system,
- Has private insurance, Medicare, Medical Assistance, or Pharmacy Assistance, and
- Has any medical problems.

Access Team staff reports that it is difficult to identify co-occurring disorders because callers rarely self report them. If the Team determines that an individual is in crisis or is not safe, the Team contacts the Crisis Center, Mobile Crisis Team, or the Police Department. If a caller is not a Montgomery County resident, the Team refers the individual to the appropriate jurisdiction. The Team consults with Addiction Services Coordination when they suspect that an individual can be best served by a substance abuse treatment provider.

The Access Team refers individuals who qualify to participate in the public mental health system to an outpatient provider participating in the system. That provider conducts a full assessment, which involves an interview to collect a history of the client's mental illness and related problems.

#### **4. Criminal Justice System**

##### **a) Clinical Assessment and Triage Services Unit**

The Clinical Assessment and Triage Services Unit (CATS) represents the screening and referral component of the Criminal Justice Behavioral Health Initiative, funded by the Council in FY 2001. The CATS Unit staff, located at the Detention Center in Rockville, screens selected individuals for mental health and substance abuse disorders during the Detention Center intake process. The staff refers individuals to appropriate placement in the Detention Center, or diverts individuals to community-based services.

**Assessment.** Department of Correction and Rehabilitation staff completes a screening form for each individual entering the Detention Center. The form assesses suicide risk, history of mental illness or self-destructive behavior, use of psychotropic medications, and staff observations of the individual's behavior. A copy of the form is attached at ©20. If the staff find any indication of a mental illness, they refer the individual to the CATS Unit for further assessment. The CATS Unit staff estimates that between 50 percent and 80 percent of the individuals booked into the Detention Center proceed to CATS for further assessment.

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<sup>4</sup> Individuals can also contact Maryland Health Partners for a referral to an outpatient mental health provider.

CATS staff completes a Client Assessment Instrument (CAI) for each individual referred to the Unit, which examines substance use, physical needs, mental health needs, criminal justice involvement, family functioning, and employment history. A copy of the Client Assessment Instrument is attached at ©13. CATS developed an addendum to the instrument to collect additional information mental health, including psychiatric history, treatment providers, psychotropic medications, and staff observations of behavior, appearance, attitude and mood. A copy of the addendum is attached at ©22.

The CATS Unit staff reports that 1,426 individuals were assessed between July 2002 and May 2003. Approximately 25 percent had a mental illness, 15 percent had a substance abuse disorder, and 60 percent had co-occurring disorders. The individuals assessed had a variety of types and severity of mental illness and substance abuse disorders. A large proportion was homeless and had committed minor, non-violent crimes.

**Referral.** The CATS Unit attempts to divert as many individuals to community-based services as possible. If diversion is not appropriate or diversion options are not available, the CATS Unit staff recommends appropriate jail placement and services. The staff generally places individuals with less severe mental illnesses in the general jail population. If a mental illness jeopardizes an inmate's safety in the general population, staff refers the inmate to the Detention Center's Crisis Intervention Unit (described beginning on page 29). Inmates can also volunteer to participate in the Jail Addiction Services (JAS) program (described beginning on page 30).

CATS also attempts to divert inmates out of the Detention Center and into appropriate treatment. The CATS Unit staff develops a diversion plan, which the Department of Correction and Rehabilitation's Pre-Trial Services Unit staff presents to the judge at the bond hearing.

If substance abuse treatment is appropriate, CATS staff refers clients to a provider in the County's substance abuse services system. Staff primarily refers individuals to the Avery Road Treatment Center (described beginning on page 21), Outpatient Addiction Services (described beginning on page 19), or the Avery Road Combined Care facility (described beginning on page 23). If mental health services are appropriate, the CATS Unit staff refers directly to outpatient mental health services, or works with the Core Service Agency to access residential mental health services. CATS staff will also refer inmates to Community Re-Entry Services CRES for follow-up and discharge planning.

Many individuals with serious and persistent mental illness are psychiatrically unstable when they enter the Detention Center, making diversion very difficult. CATS Unit staff may request a postponement of the bond hearing, place the individual in the Detention Center for observation and stabilization, and pursue diversion to community-based treatment at a later time.

## **b) Community Re-Entry Services**

Community Re-Entry Services (CRES) provides discharge planning and case management services for inmates participating in the Jail Addiction Services Program and inmates housed in the Crisis Intervention Unit.

CRES staff identifies community-based services and helps inmates prepare for release and transition to community services. CRES activities include:

- Assessing clients' community-based service needs;
- Identifying appropriate services and providers in the community;
- Working with inmates, family members, attorneys, courts, and community providers to get clients accepted into treatment programs; and
- Helping to motivate inmates for participation in community-based treatment.

CRES staff often refers JAS participants to intensive, long-term residential substance abuse treatment. Others are referred to shorter-term residential treatment or to outpatient substance abuse or mental health treatment. CRES often refers CIU inmates to Outpatient Addiction Services, outpatient programs at community hospitals, and to public mental health system providers. Residential treatment programs with close monitoring and support by on-site staff best meet the needs of former CIU inmates, but CRES staff indicates that those programs rarely have space available and have long waiting lists.

CRES staff reports that CIU inmates that refuse to take psychotropic medication are not stable enough for referral to community-based services or are not accepted into community-based mental health programs. Staff also reports that a Federally funded Community Services Aide in CRES provides case management to homeless, mentally ill inmates after release from the Detention Center. The Aide maintains contact with the individual to make sure they have the supportive services they need to remain safely in the community.

## **D. Treating Individuals who have Co-Occurring Disorders**

### **1. Overview**

This section describes the programs that provide treatment to individuals in Montgomery County who have co-occurring disorders. They include programs within the substance abuse, mental health, criminal justice system, and crisis services systems. Table 3 (page 19) lists the treatment programs and the organizational location, and refers to the description of each program in this chapter.

Co-occurring clients with a more severe substance abuse disorder and a stable mental illness usually receive treatment from Outpatient Addiction Services or the Avery Road Treatment Center. Co-occurring clients with a serious mental illness, which hinders their ability to function in a treatment environment, usually receive services from one of the County's outpatient mental health clinic providers or the Springfield Hospital Center.

Some programs focus treatment services on one disorder or the other and do not integrate mental health and substance abuse treatment. In those programs for clients who have co-occurring disorders receive the same services as other clients. Other programs focus treatment services on one disorder, but are beginning to integrate treatment by holding therapy or discussion groups specifically for clients who have co-occurring disorders.

In contrast, three County programs integrate mental health and substance abuse treatment. Multi-disciplinary staff with the Assertive Community Treatment (ACT) Team and the new Avery Road Combined Care (ARCC) facility provides integrated mental health and substance abuse treatment at the same location. The SASW program assigns case managers to each client to assess their service needs, link to community-based mental health and substance abuse services, and provide on-going support.

**Table 3: Programs for Treating Individuals who have Co-Occurring Disorders**

<b>Program</b>	<b>County Program Department</b>	<b>Described Beginning on Page:</b>
<b>Substance Abuse Services System</b>		
Outpatient Addiction Services	DHHS	19
Substance Abuse Services for Women	DHHS	21
Avery Road Treatment Center	DHHS contract	21
Avery Road Combined Care	DHHS contract	23
Montgomery General Hospital		24
Washington Adventist Hospital		24
<b>Mental Health Services System</b>		
Public Mental Health System Providers		25
Multi-Cultural Mental Health Services	DHHS	26
Springfield Hospital Center		26
Mental Health Association of Montgomery County		28
<b>Crisis Services System</b>		
Assertive Community Treatment Team	DHHS	29
<b>Criminal Justice System</b>		
Detention Center Crisis Intervention Unit	DOCR	29
Jail Addiction Services	DHHS	30
Pre-Trial Services Unit Supervision	DOCR	30

## **2. Substance Abuse Services System**

### **a) Outpatient Addiction Services**

Outpatient Addiction Services (OAS) is part of the County's adult addiction treatment services continuum. OAS includes:

- Outpatient services for clients who need less than nine hours of services per week,
- Intensive outpatient services for clients who need more than nine hours of services per week, and
- A Methadone Program that employs methadone in the detoxification and/or treatment of opiate and narcotic drug abusers as part of a treatment regimen.

Individuals enter OAS through a referral from DHHS' Addiction Services Coordination. Participants must be County residents, at least 18 years of age, and have a history of substance abuse. To enter the Methadone Program, individuals must test positive for opiates. OAS places priority on serving people who are:

- Homeless,
- HIV positive,
- Recently released from jail,
- Pregnant,
- Women with children under age 5, and/or
- Suffering from co-occurring disorders.

OAS serves approximately 160 clients at a time. Staff estimates that around 50 percent of the OAS clients has co-occurring disorders. OAS clients also tend to have significant medical problems such as diabetes, kidney disease, or HIV. The staff reports that most of the OAS clients also receive services through the County's homeless services system, and have participated in the OAS program multiple times due to substance abuse relapse fed by lack of employment and homelessness.

**Assessment.** OAS staff completes an Addiction Severity Index, to gather information about new clients' medical history, employment status, drug and alcohol use, legal status, family history, family and social relationships, and psychiatric status. A copy of the Index is attached as ©27. New clients with a mental illness also have an initial meeting with a psychiatrist, who may complete other psychiatrist testing/assessment as needed. OAS has 40 hours of contract psychiatric time per week.

OAS counselors use the results of the assessment to develop a treatment plan that best meets the client's needs. OAS staff reviews the treatment plans weekly, and revises and updates them at least every 90 days. OAS staff also processes applications for Medical Assistance and Pharmacy Assistance when new clients enter the program.

**Treatment Services.** OAS clients attend a variety of treatment groups depending on their needs and treatment plan. Individuals who have co-occurring disorders receive the same services as other OAS clients, except they also participate in a co-occurring disorders group and meet with the psychiatrist for 15 to 30 minutes monthly for medication management. The psychiatrist also sees clients when they have a mental health crisis. A nurse on the OAS staff also helps clients access free or low cost psychotropic medication.

Staff refers clients to on-going substance abuse and mental health services after completing the OAS program. Most clients who have co-occurring disorders receive on-going treatment from Threshold Services or the Mental Health Association, and participate in Alcoholics Anonymous/Narcotics Anonymous meetings.

## **b) Substance Abuse Services for Women**

Substance Abuse Services for Women (SASW) provides substance abuse treatment, case management, and transitional housing for 45 homeless women. Approximately 70 percent of the clients also has a mental illness. Participants may be single, have children, or have a partner that also meets the program criteria.

The goal of the program is to use intensive case management, outpatient substance abuse treatment, and other service linkages (e.g., mental health services) to increase stability and prevent future homelessness. Participants receive intensive services for 6 to 18 months, with less intensive services continuing longer based on each individual's needs. The case management component of SASW involves an initial comprehensive assessment of needs, linkage to other services and resources (e.g., mental health services, substance abuse services, employment services, longer term housing), and on-going support. Case managers also help participants develop good credit, and learn budgeting and money management skills.

Three DHHS Addiction Services Coordination employees provide the case management services, and DHHS contracts out the outpatient substance abuse treatment services. Community-based organizations provide the other supportive services. HOC leases eight units for SASW participants (other participants live in shelters, with family or friends, or in subsidized housing units).

DHHS received a Federal SAMHSA grant totaling approximately \$600,000 to operate SASW in FY 02, FY 03, and FY 04. DHHS has not identified funding to support SASW beyond FY 04. SAMHSA requires DHHS to complete an evaluation of the program, which will include individual interviews, client surveys, and focus groups. DHHS staff reports that portions of the evaluation will be completed this fall, and the remainder will be complete by the end of calendar year 2003.

## **c) Avery Road Treatment Center**

DHHS contracts with Maryland Treatment Centers to operate the Avery Road Treatment Center (ARTC) program. The Avery Road Treatment Center program provides a 20 bed non-hospital detoxification service, and 48 beds for intermediate care services. The detoxification program provides 24 hour medically monitored detoxification, addiction education, lectures, task groups, and family services. The detoxification services last 3 to 10 days.

Individuals enter the intermediate care facility following completion of the detoxification program. They continue to receive 24 hour medical monitoring, addiction education, task groups and family services, as well as therapeutic recreation, life skills, self help skills, and discharge planning. Patients stay at the intermediate care facility for 14 to 21 days.



From July 2002 through April 2003, approximately 38 percent of the individuals admitted for detoxification self-reported having co-occurring disorders. ARTC staff believes that this self-reported figure underestimates the actual number, estimates that closer to 60% of the ARTC patients has co-occurring disorders. Most of the patients who have co-occurring disorders have severe substance abuse disorders and mild to moderate mental health disorder(s). However, some have more severe mental health disorders, such as schizophrenia or major depression.

Staff also reports that many of the patients are homeless or involved in the criminal justice system before entering the Treatment Center. Between July 2002 and April 2003, approximately 40 percent of the patients admitted for detoxification was homeless.

**Assessment.** Patients enter ARTC as walk in/self-referrals, or through referrals from DHHS' Addiction Services Coordination, the criminal justice system, and Springfield Hospital Center. Any ARTC staff person who is available conducts a telephone screening of potential patients to determine eligibility. The telephone screening includes a review of mental health stability and history. Upon admission to the program, all patients receive a more thorough assessment of their addiction, health, and cognitive deficits.

At any time, ARTC staff can request that a psychiatrist further assess and prescribe medication for a patient suspected of having co-occurring disorders.<sup>5</sup> To remain in treatment at ARTC the patients with a mental illness must be able to function in a substance abuse treatment environment, remain mentally stable, and take their medication. If at any time a patient's mental illness exceeds the Center's capacity to manage, staff refers the patient to a hospital. Once stabilized, the patient returns to ARTC to complete the program.

**Treatment Services.** ARTC's patients participate in education groups, task groups and 12-step meetings. ARTC's contract psychiatrist manages psychotropic medication and mental health crises for patients who have co-occurring disorders. Except for these specific psychiatrist services, patients who have co-occurring disorders currently receive the same substance abuse treatment services as other patients. ARTC staff reports that they are looking into other treatment approaches that could better serve people who have co-occurring disorders.

ARTC staff works with the patients to develop a discharge plan. All patients leave ARTC with a referral for on-going services, primarily substance abuse treatment services. Staff refers most patients to Outpatient Addiction Services (OAS) or a less intense outpatient program. Staff refers:

- Patients who need a more structured environment to a residential treatment program;

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<sup>5</sup> A psychiatrist is on contract to ARTC for eight hours a week. Certified addiction counselors make up the remainder of the ARTC staff.

- Patients who are higher functioning and can hold a job to halfway houses (but there are very few halfway house openings available); and
- Patients with very high mental health needs and Medical Assistance to Montgomery General Hospital's co-occurring disorders treatment program (described beginning on page 24).

**d) Avery Road Combined Care Facility (ARCC)**

The Avery Road Combined Care facility (ARCC) is a new component of the County's addiction treatment services continuum. The facility opened in June 2003 and includes:

- A 20 bed medium intensity residential program<sup>6</sup>, and
- A 20 slot intensive outpatient program.

DHHS contracts with Maryland Treatment Centers to operate the facility. A two year Cigarette Restitution Fund Grant from the Maryland Alcohol and Drug Abuse Administration funds ARCC in FY04 and FY05. The grant specifically funds community-based services for adult men and women who have substance abuse and/or co-occurring psychiatric disorders, and who may also have a history of non-violent criminal behavior and homelessness.

The goal of the program is to provide integrated treatment services for clients with multiple service needs or problem areas. While not designed exclusively for people who have co-occurring disorders, ARCC can accommodate individuals with mild to moderate mental illnesses that do not impair their ability to function in a substance abuse treatment environment. Maryland Treatment Centers anticipates that a large proportion of the clients will have co-occurring disorders.

**Assessment.** Referrals to Avery Road Combined Care come from:

- Addiction Services Coordination (ASC),
- Outpatient Addiction Services (OAS),
- Substance Abuse Services for Women (SASW),
- Avery Road Treatment Center,
- Clinical Assessment and Triage Services Unit (CATS),
- Community Re-Entry Services (CRES), and
- Springfield Hospital Center.

The ARCC staff assesses new clients using the Client Assessment Instrument and the Addiction Severity Index (attached at ©13 and ©27).

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<sup>6</sup> The facility has space for 40 beds. DHHS currently has enough grant funding to operate 20 beds for Montgomery County residents. DHHS plans to fill the other 20 beds using other funding sources, primarily by having other jurisdictions in the region pay for beds at the facility for their residents.

**Treatment Services.** Both the outpatient and residential programs provide case management and comprehensive services which focus on substance abuse treatment as well as the social, medical, employment and psychiatric needs of the clients (e.g., vocational training, life skills training, coordination of support services). In addition to certified addiction counselors, the ARTC staff will include a psychiatrist<sup>7</sup> and a part time psychiatric social worker. Those staff members will provide mental health care, including medication management and crisis intervention.

The intensive outpatient program is similar to DHHS' Outpatient Addiction Services program, but includes more hours of programming weekly (20 hours versus approximately 9 hours). The residential program at ARCC is designed to be flexible, but more structured than the services provided at a halfway house. Treatment and programming is slower paced, more repetitive and concrete, and structured to best meet the clients' needs.

#### **e) Montgomery General and Washington Adventist Hospitals**

**Montgomery General.** Montgomery General Hospital implemented a Dual Diagnosis Intensive Outpatient Program eight years ago. The program serves between 10 and 14 clients at a time, whose primary need is substance abuse treatment. Patients generally have a co-occurring mild to moderate mental illness. Patients must be psychiatrically stable, meeting with their own psychiatrist or mental health therapist, and have private health insurance or Medical Assistance. Patients meet for three hours a day, three times a week for educational programming and group counseling. A licensed social worker/therapist and a certified addiction counselor staff the program.

If a patient cannot remain mentally stable or continues to use substances, staff may transfer the patient to Montgomery General's psychiatric unit. The psychiatric unit provides several therapy groups and educational workbooks designed for patients who have co-occurring disorders. Staff may also transfer a patient to Montgomery General's Mental Health Intensive Outpatient Program (IOP). The Mental Health IOP provides outpatient services to address mental health needs (e.g., symptom management, education about mental illness and medication compliance).

**Washington Adventist.** Washington Adventist Hospital has an Intensive Outpatient Program (IOP) specifically designed for clients with co-occurring disorders. The program meets Monday, Tuesday, Thursday and Friday evenings for three and one-half hours. The Program includes an education group, a 12-step group, and group therapy. The clients meet weekly with a psychiatrist and participate in Family Night on Friday. On Wednesday there is an outpatient group which provides ongoing therapy for those individuals who have "graduated" from the IOP. This enables staff to continue to monitor the sobriety, stability and general functioning of the clients.

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<sup>7</sup> The ARCC, Avery Road Treatment Center, Substance Abuse Services for Women, and Avery House (halfway house for women and children) programs will share one full time psychiatrist.

The program serves approximately 20 individuals with all types and levels of substance abuse, and with varying degrees of mental illness. The program serves individuals with private insurance, Medicare and Medical Assistance. Client must be able to work productively in a group treatment setting. Staff sometimes refers less mentally stable clients the Hospital's mental health IOP until they are stable enough to return to the co-occurring disorders program.

Staffing includes a certified addictions counselor and a registered nurse certified in mental health. The Medical Director provides direction to the staff and participates in the treatment planning.

### **3. Mental Health Services System**

#### **a) Public Mental Health System Providers**

State data indicate that approximately 1,900 Montgomery County public mental health system consumers had co-occurring disorders in FY 2002. State data also indicate that the majority of those consumers receive mental health services from outpatient mental health clinic providers, with others served through residential rehabilitation program providers.

**Outpatient Mental Health Clinic Providers.** All of the outpatient clinics in Montgomery County focus treatment services on clients' mental health needs. Staff at St. Luke's, Threshold Services, Institute for Life Enrichment, and Affiliated Sante reports that treatment services include discussion or therapy groups for individuals who have co-occurring disorders. Mental health professional lead the groups. Staff at those four clinics note that clients who participate in these groups generally have more stable mental health and are motivated to work on substance abuse recovery. Other clients with co-occurring disorders work with therapists one on one until the client is ready to participate in group sessions.

**Residential Rehabilitation Programs.** Residential rehabilitation programs (RRP) provide supervised housing and rehabilitation services for consumers with severe and persistent mental illnesses. Clients live in group homes, town homes or apartments leased by the service provider. Clients receive medication management, counseling, case management, and life skills training. There are two levels of RRP support:

- General support involves staff on-call 24 hours a day, seven days a week, and a minimum of one face to face contact per consumer per week, and
- Intensive support involves staff providing at least 40 hours of supervision at the residence per week, and on-call availability 24 hours per day, seven days a week.

According to DHHS' Core Service Agency, RRP providers have expressed a continued interest in treating individuals with co-occurring disorders, and have participated in training on this topic. Clients in Threshold Services' RRP can participate in client-run groups that discuss co-occurring disorders. Clients in the St. Luke's House and Rock Creek Foundation programs can attend the groups for people who have co-occurring disorders held at the providers' affiliated outpatient clinics.

#### **b) Multi-Cultural Mental Health Services**

DHHS' Multi-Cultural Mental Health Services program provides mental health services to Vietnamese and Spanish speaking residents. Staff provides: information, assessment, referral, diagnostic evaluation, psychiatric medication, psychotherapy, and family and psycho-educational support. Staff reports an emphasis at the Center on addressing family issues. The Center serves approximately 200 clients at any one time and approximately 400 over the course of a year. Staff estimates that 10 percent of the women and 50 percent of the men served has co-occurring disorders.

The Center provides the same services to clients who have co-occurring disorders as the other clients receive. Some of the staff has developed skills to treat individuals who have co-occurring disorders, and the Center plans to increase the entire staff's capacity to serve this population.

#### **c) Springfield Hospital Center**

Springfield Hospital Center is the State Department of Health and Mental Hygiene's psychiatric hospital. To be admitted to Springfield, individuals must have a serious mental illness and pose a threat to themselves or others (suicidal or homicidal), or be court ordered for evaluation or treatment. Patients primarily enter Springfield Hospital from:

- Court referrals,
- Emergency rooms, and
- Transfers from other inpatient hospitals.

There were 591 admissions to the hospital in FY 2002. Staff estimates that between 75 percent and 80 percent of the individuals admitted to Springfield has co-occurring disorders. Approximately 50 percent of all the patients admitted to Springfield Hospital is from Montgomery County.

Springfield Hospital Center (SHC) has an Addiction Services program that serves individuals who have co-occurring mental health and substance abuse disorders. The staff assesses patient needs, provides services at Springfield, and connects patients to community-based services upon release. Last year Addiction Services served 307 patients.

**Assessment.** A psychiatrist evaluates patients upon admission to Springfield, and refers to Addiction Services if an addictions assessment is necessary. The results of the addictions assessment help the Addiction Services staff to understand the patients' needs, stabilize the patients' mental health and substance abuse problems, and determine whether it is more appropriate to:

- Transfer the patient to community-based services, or
- Continue providing services at Springfield.

**Referral to Community Based Programs.** Springfield's goal is to transfer patients to appropriate mental health and substance abuse treatment services in the community. Addiction Services staff invests significant time identifying and coordinating with community-based providers, and currently places patients in 60 different mental health and substance abuse programs around the state. Springfield staff refers patients who have a more serious substance abuse disorder to programs that focus on substance abuse treatment. Staff refers patients who have a more serious mental health disorder to programs that focus on mental health treatment. Some patients are placed in programs that provide integrated substance abuse and mental health treatment.

For Montgomery County residents requiring outpatient services, Springfield usually refers to Outpatient Addiction Services (described beginning on page 19). For intermediate care, Springfield staff usually refers to the Avery Road Treatment Center. Springfield has begun to refer to Avery Road Combine Care, and also has relationships with methadone maintenance clinics and halfway houses in Montgomery County.

The Montgomery County Core Service Agency Systems Management and Planning team (SPM) assists in the linkage of mental health consumers and those who have co-occurring disorders to community-based services by offering several informational trainings for Springfield staff and other mental health care providers. Specifically, the CSA provides educational forums to social workers at Springfield, and meets regularly with the Director and Assistant Director of Social Work to prioritize consumers who may be ready to return to community mental health services in Montgomery County.

**Services Provided at Springfield.** Some patients reside at Springfield Hospital Center and participate in the Addiction Services program. They attend morning, afternoon, and evening group therapy sessions (e.g., Anger Management, Addictions Treatment Group, Women's Substance Abuse Group). Addiction Services' MISA program addresses the specific needs of patients with co-occurring disorders. It is a 20-day psycho-educational program designed to address the needs of people diagnosed who have co-occurring disorders. It provides daily seminars on mental illness, substance abuse, how the disorders affect one another, and strategies to manage both disorders.

Springfield also has a Co-Occurring Disorders Consultation Program. The staff conducts in-depth interviews and assessments of the condition and needs of the hardest to serve patients. The staff prepares a thorough report describing the patient's reason for admission, psychiatric condition, medical condition, substance abuse history, trauma history, and work history. The report also includes specific treatment recommendations. It serves as a comprehensive resource for any providers serving the patient within and outside of Springfield. Springfield staff completed approximately 40 of these consultations during FY 03.

Springfield also holds weekly addiction case conferences. Those conferences involve the Clinical Director (an addictions psychiatrist) conducting an in-depth interview of a complicated case of addiction. Case conferences are open for all staff and trainees.

#### **d) Mental Health Association of Montgomery County**

The Mental Health Association of Montgomery County operates an Adult Homeless Mental Health Services Program. The program provides:

- Outreach at shelters, soup kitchens, and the streets,
- Case management to clients at the shelters and soup kitchens, plus some case management to unsheltered individuals,
- Psychiatric services 4 hours per week for individuals referred by the MHA case managers, and
- Case management for individuals in the Shelter Plus Care program<sup>8</sup>.

**Assessment.** Staff interviews new clients to collect information about both mental health and substance abuse issues. Most of the information collected is self-reported, however shelter, soup kitchen, or Crisis Center staff familiar with the client may be able to provide additional information.

Staff estimates that 40 percent of the program clients has co-occurring disorders. All of the clients are homeless, and many have been involved in the criminal justice system. They typically do not have any income or medical insurance. Some clients have received mental health treatment in the past, but are not receiving treatment when they enter MHA's program. In addition, the MHA clients have often not succeeded in other treatment settings or programs.

**Referral.** MHA staff works with clients who have co-occurring disorders to identify appropriate treatment services. Staff usually contacts DHHS' Access Team to connect clients to services through the public mental health system. They refer clients to DHHS' Addiction Services Coordination for access to substance abuse treatment services.

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<sup>8</sup> Shelter Plus Care offers independent apartment living for seriously mentally ill adults who are homeless. Through Shelter Plus Care, the Mental Health Association provides extended case management to formerly homeless people who are living independently with a housing subsidy from the Housing Opportunities Commission.

**Treatment.** MHA received a Community Development Block Grant (CDBG) to fund services for people with co-occurring disorders through FY 03. MHA used the funds to create an in-house expert on co-occurring disorders. That staff person consults with MHA staff that has questions about clients with co-occurring disorders. MHA's in-house expert also ran a weekly group at the Men's Emergency Shelter for people with co-occurring disorders, from February to October 2002. Weekly participation ranged from 2 to 12 shelter residents. The group focused on developing coping skills (e.g., interacting with people in social settings). MHA staff expects to hold a similar group at the shelter in the future.

#### **4. Crisis Services**

##### **a) Assertive Community Treatment Team**

The Assertive Community Treatment (ACT) Team provides comprehensive treatment to people with serious and chronic mental illness, who have not successfully responded to traditional treatment provided by community mental health clinics. The Team serves approximately 70 clients at a time. Staff estimates that 90 percent of the clients suffers from co-occurring disorders. Clients also tend to be homeless and involved with the criminal justice system. They typically do not have a support network in the community, and frequently visit hospital emergency rooms.

The Team collects information about a new client's mental health and substance abuse history in order to assess service needs. ACT Team services include treatment, case management, and support services to assist clients in successful community living. ACT Team interventions take place in community locations, such as the client's residence, neighborhood, place of employment or recreation, shelters, jails, and hospitals. The services are provided by a multi-disciplinary staff which includes psychiatrists, psychiatric nurses, social workers, and an addiction counselor.

The multi-disciplinary nature of the ACT Team ensures that the services address the client's mental health and substance abuse needs. Rather than referring to providers in the public mental health system or substance abuse services system, the Team members provide care directly. By bringing the services to the client, the Team reduces some of the problems associated with serving this population (e.g., missed appointments, lack of transportation).

#### **5. Criminal Justice System**

##### **a) Detention Center Crisis Intervention Unit**

The Crisis Intervention Unit (CIU) at the Detention Center provides observation, stabilization, medication, and counseling for inmates in mental health crisis. The Unit houses up to 28 male inmates and 4 female inmates. While some CIU patients have co-occurring disorders, the Unit does not provide specific services to address co-occurring disorders.



Mental health staff develops treatment plans, provides limited therapy, and distributes medication for CIU inmates. Mental health staff meets individually with the inmates housed in the CIU at least once per week. A psychiatrist on contract with DOCR evaluates inmates referred by CIU staff, assesses the inmates' medication needs, and prescribes medication. The psychiatrist then meets regularly with the inmates to monitor the medication.

The length of stay in the CIU depends on the inmates' mental health status. Some inmates stabilize and return to the general population in a few days or weeks. Others do not attain enough mental stability to return to the general population during their entire incarceration.

#### **b) Jail Addiction Services**

The DHHS Jail Addiction Services (JAS) program is a voluntary program that provides substance abuse treatment services for Detention Center inmates. JAS provides treatment during incarceration and referral to continued treatment after release (through the Department of Health and Human Services' Community Re-Entry Services).

The program currently serves 75 inmates (63 men and 12 women), and has the capacity to serve 80 inmates.<sup>9</sup> Most of the JAS program participants committed minor crimes and have multiple problems in addition to substance abuse, such as mental illness, homelessness, and unemployment.<sup>10</sup> JAS staff reports that 18 percent of the male JAS participants and 58 percent of female JAS participants currently takes psychotropic medication.

JAS clients who have co-occurring disorders do not receive any additional treatment to specifically address the inmates' mental illness. The staff tries to address participants' mental health problems by noting the problems in the inmates' treatment plan and goals. For example, the treatment plan may indicate that a treatment goal is to stay on prescribed psychotropic medication.

#### **c) Pre-Trial Services Unit Supervision**

Department of Correction and Rehabilitation's Pre-Trial Services Unit (PTSU), Supervision Section staff monitors all pre-trial defendants referred by the court. Staff begins supervision by completing an intake assessment, which compile information about the defendant's criminal record, stability in the community, employment, and substance

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<sup>9</sup> Since the program is voluntary, it is often not at capacity. The rigorous demands of the program keep many inmates from volunteering to participate.

<sup>10</sup> To participate in JAS the individual's mental health must be stable. Inmates accused of or sentenced for committing violent crimes are not eligible to participate.

abuse and mental health history. PTSU staff also determines an appropriate level of monitoring for each client, ranging from telephone tracking (one phone call to the PTSU office weekly) to intensive supervision (three face-to-face or telephone contacts each week). PTSU supervision involves:

- On-going assessment of client service needs,
- Connecting clients to service providers,
- Monitoring compliance with pre-trial release conditions,
- Checking in with clients regularly by phone and in person,
- Conducting periodic breathalyzer and urine tests for alcohol or drug use, and
- Reminding clients of court appearances.

Staff estimate that 40-60 percent of PTSU clients has co-occurring disorders. Supervision for those clients usually includes one or two face-to-face contacts per week. If bond conditions require mental health, substance abuse, or other treatment, PTSU staff identifies appropriate providers. Caseworkers call the providers to make initial appointments for the client (usually occurs within two weeks) and help the client arrange transportation. The caseworkers usually refer co-occurring clients to one of the following treatment providers:

- Crisis Center (when the client is in a mental health crisis);
- Outpatient Addiction Services; or
- Private treatment provider (when the client has private health insurance or the client fails to meet the criteria established for acceptance into a County program).

PTSU staff report difficulty meeting the needs of clients with co-occurring disorders because they do not have staff trained to:

- Assess mental health and substance abuse needs,
- Navigate the mental health and substance abuse services system, and
- There are often no appropriate referral resources available.

Staff also report difficulty identifying treatment services that address co-occurring disorders, particularly for clients facing felony generally or sexual assault charges specifically. Treatment services are extremely scarce for defendants charged with or who have a history of violent or sexual offenses. In addition, there are very few, affordable treatment providers who are certified to treat sex offenders.

In June 2003, a post doctoral fellow from Springfield Hospital Center was assigned to PTSU to assess co-occurring clients' needs and develops a treatment plan. However, the fellow only works three days per month, and is limited to working with one client per week. The fellow is not familiar with the community based services in Montgomery County. In addition, since clients often are not specifically court-ordered into treatment, compliance with treatment plans recommended by the fellow is strictly voluntary.

A grant funded Community Services Aide III position in the Department of Health and Human Services is to be assigned to PTSU to help link clients to mental health and substance abuse services in the community. However, that position is frozen. DHHS is submitting a request to the Office of Management and Budget to unfreeze the position. While this position will be helpful, staff do not believe it mitigates the need for higher level on-site mental health and substance abuse screening services at PTSU.

**Intervention Program for Substance Abusers.** DOCR's Intervention Program for Substance Abusers (IPSA) diverts first-time drug possession offenders from jail to education and treatment programs. The State's Attorney Office and Montgomery County Police Department jointly refer people to the program. If the defendant successfully completes the program their criminal record is expunged.

Staff estimates that 45 percent of the IPSA program participants have a co-occurring disorder. Those individuals participate in the IPSA treatment track. The treatment track lasts at least 26 weeks and includes mental health and/or substance abuse treatment from private providers, Outpatient Addiction Services, or public mental health system providers. IPSA staff facilitates transportation for clients when no other options are available. A large portion of IPSA's clients have private insurance and do not use the public mental health or substance abuse systems. Clients also attend weekly Alcoholics or Narcotics Anonymous meetings, submit to urinalysis and breathalyzer testing, and perform community service.

## **E. Other Relevant Activities**

This part of the chapter describes other efforts to address co-occurring disorders. The two community-based committees most directly related to services for co-occurring disorders is the Co-Occurring Disorders Steering Committee and the Montgomery County Coalition for the Homeless' Dual Diagnosis Sub-Committee. Efforts at the State level include establishment of a task force on co-occurring disorders and submission of an application for new federal grant funds.

### **1. Co-Occurring Disorders Steering Committee**

DHHS and community-based providers partnered in the spring of 2003 to develop the Co-Occurring Disorders Steering Committee (CDSC). Committee members represent:

- DHHS (Adult Mental Health and Substance Abuse Services, Core Service Agency, and Crisis, Income and Victim Services),
- Department of Correction and Rehabilitation,
- Community-based service providers (Threshold Services, Mental Health Association, Coalition for the Homeless, National Association for the Mentally Ill)

- Springfield Hospital Center,
- University of Maryland School of Medicine,
- Baltimore Mental Health Systems, Inc., and
- The State Alcohol and Drug Abuse Administration and State Mental Hygiene Administration.

The Committee's stated goal is to "transform separate mental health and addiction systems into an integrated system of care for individuals who have co-occurring psychiatric and substance abuse disorders that ensures that consumers are well served by the Public Mental Health System and are able to achieve and sustain best possible outcomes, i.e. stable housing, high quality personal relationships, steady employment, and remain free of the criminal justice system." The Committee's approach to developing an integrated system of care in Montgomery County involves:

- Facilitating systemic and policy changes that encourage integrated care, and
- Increasing the clinical competencies of existing service providers to address both the mental health and substance abuse needs of their clients.

The Committee is developing a charter with goals, principles, and action plans for the next two years (Draft attached at ©33). The Committee plans to ensure buy-in by getting all of the agencies participating in the Committee's efforts to sign off on the document.

The Committee's approach is based on research conducted by Dr. Kenneth Minkoff. In addition to clinical work, Dr. Minkoff provides consultation and training services on integrated treatment to the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), and systems of care ranging from individual programs to state agencies. His major areas of expertise are co-occurring disorders and public sector managed care.

Dr. Minkoff argues that effective treatment for individuals who have co-occurring disorders must recognize each disorder and integrate appropriate treatment for each disorder. He also notes the importance of individualizing care based on each patient's types of disorders, phases of recovery, and level of functioning. Minkoff developed a model for organizing services for individuals who have co-occurring disorders based on these principles called the Comprehensive, Continuous, Integrated System of Care (CCISC). An overview of the model is attached at ©41.

The Committee plans to purchase three instruments developed by Dr. Minkoff to evaluate performance and track progress of programs and service providers. Based on initial assessments of the current system of services, the Committee will work with Dr. Minkoff to develop a system-wide training plan. The Committee will contract with Dr. Minkoff and other experts to lead training for agency heads and direct care providers both within and outside the County Government on integrating care for individuals who have co-occurring disorders. This training is tentatively scheduled for the spring of 2004. The

trained staff will train other staff in their respective organizations. One aspect of the training will deal with clinical issues directly. The clinical portion will be tied to training and decision making with regard to the policies and procedures within agencies that provide services, the working relationships among these agencies, and the characteristics of the entire county-wide service system.

Threshold Services Inc is an integral partner with DHHS in initiating and implementing this effort. In particular, Threshold pursued and obtained a \$20,000 grant from the Meyer Foundation and a \$20,000 grant from the Weinberg Foundation to fund the Minkoff assessment instruments and training.

## **2. Montgomery County Coalition for the Homeless' Dual Diagnosis Sub-Committee**

The Montgomery County Coalition for the Homeless sponsors a Dual Diagnosis Sub-Committee to serve clients who have co-occurring disorders. Developed in 2000, the Sub-Committee's mission is to "improve services and outcomes for homeless people who have co-occurring substance abuse and mental health disorders, by increasing the skills and knowledge of providers serving the homeless through education, training and consultation."

The Sub-Committee sponsors County-wide and individual shelter-based training on working with clients who have co-occurring disorders. Examples of training topics include:

- Defining dual diagnosis,
- The addictive disease process,
- Models of addiction,
- Families of drugs,
- Mood, thought, personality and anxiety disorders,
- Overview of psychiatric medications,
- De-escalating the aggressive or agitated client,
- Helpful hints in working who have co-occurring disorders, and
- Principles of treatment in working who have co-occurring disorders.

The Sub-Committee is currently developing a training workbook for shelter staff in Montgomery County. The book will be an on-going resource for staff working with clients who have co-occurring disorders. The manual will help staff assess client needs, better understand the disorders, and improve the care provided to this population.

Members of the Sub-Committee include staff from DHHS' Addiction Service Coordination, Outpatient Addiction Services, and Crisis, Income and Victim Services. The Committee also includes representatives from various community-based service providers including, the Coalition for the Homeless, Mental Health Association, Community Ministries of Rockville, Men's Emergency Shelter, Maplewood Safe Haven,

Carroll House, Chase Partnership House, Sophia House, Montgomery Avenue Women's Center, Threshold Services, and Suburban Hospital. A representative from the new Avery Road Combined Care facility also participates.

### 3. State Efforts

**Task Force.** In April 2003, the State of Maryland passed House Bill 433 to establish a Task Force on the Needs of Persons who have Co-Occurring Mental Illness and Substance Abuse Disorders. A copy of the bill is attached at ©47. The Task Force includes representatives from the State Mental Health Administration, Alcohol and Drug Abuse Administration, Department of Housing and Community Development, and the State's Attorney's Office. The Task Force will also include consumers and representatives from faith-based community providers. The task force intends to:

- Study and make recommendations regarding the delivery of services to people who have co-occurring disorders,
- Identify and recommend ways to provide comprehensive integrated services,
- Identify and recommend methods of funding, and
- Recommend strategies for cross training of mental illness and addiction counselors.

**SAMHSA Grant.** The state submitted a proposal this summer for a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to improve treatment for persons who have co-occurring disorders. SAMHSA will award grants to states worth \$500,000 to \$1.1 million per year for up to five years.

The proposal indicates the Maryland will use the grant to develop comprehensive State-wide screening and assessment services for individuals with co-occurring disorders. The State-wide system will be implemented in phases, beginning with regions that have the most infrastructure already in place, including Baltimore City, Worcester County, Montgomery County, Garrett County, and St. Mary's County. As part of the grant, the State recommends having Dr. Kenneth Minkoff to provide technical assistance in integrating county developments with State integration efforts.

Stakeholders at the State, Regional and local level will be involved. A Project Implementation Committee will work in collaboration with the Task Force and a Project Advisory Board to establish State and regional-level partnerships and to develop and implement action plans. Estimated costs for this project are:

- \$580,576 in year one,
- \$574,576 in year two,
- \$574,576 in year three,
- \$99,398 in year four, and
- \$99,398 in year five.

The bulk of these grant dollar fund project staffing, evaluation, and technical assistance for infrastructure building and service integration across the state.

#### **IV. Examples of Integrated Treatment Programs in Other Jurisdictions**

##### **Highlights:**

1. Worcester County, Maryland is using Dr. Kenneth Minkoff's Comprehensive, Continuous, Integrated System of Care (CCISC) model to integrate already existing mental health and substance abuse service systems.
2. Fairfax County, Virginia's substance abuse services system operates a residential rehabilitation facility that is specifically designed for treating individuals with co-occurring disorders. It is staffed by a combination of substance abuse and mental health professionals. Two facilities in the County's mental health system provide intensive residential treatment for people with co-occurring disorders.
3. In 2002, the Baltimore Mental Health Systems and Baltimore Substance Abuse Systems, Inc. partnered to integrate treatment at six existing substance abuse and mental health clinic sites. At the substance abuse clinics, a specialized team of mental health professionals serves people with co-occurring disorders. The mental health clinics offer varying levels of treatment integration.
4. Arlington County, Virginia is developing a Dual Diagnosis Unit and program within the Behavioral Health Division. It includes staff from both the mental health and substance abuse services system. The goal is to help the County better provide comprehensive treatment and rehabilitation services to individuals who have co-occurring disorders.
5. San Diego County and Santa Cruz County are part of California's Dual Diagnosis Demonstration Project. San Diego provides integrated treatment at an outpatient clinic, and Santa Cruz provides integrated treatment at a residential treatment program.
6. Philadelphia, Pennsylvania operates ACCESS West Philly which offers case management, substance abuse treatment, psychiatric services, supportive housing and other services to chronically homeless people with a mental health and/or substance abuse disorder.
7. San Francisco, California operates The Village Integrated Services Agency which is an outpatient program that integrates services to meet clients' mental health and substance abuse needs. Staff includes psychiatrists, social workers, nurses, housing specialists, and substance abuse professionals.

This chapter describes examples of integrated mental health and substance abuse treatment approaches other jurisdictions use to serve individuals who have co-occurring disorders. The examples include strategies for financing, cross-training staff, and meeting the clients' other needs, such as housing and employment. The examples of integrated treatment are located in:

- Worcester County, Maryland;
- Fairfax County, Virginia;
- Baltimore City, Maryland;
- Arlington County, Virginia;
- San Diego County and Santa Cruz County, California;
- Philadelphia, Pennsylvania; and
- San Francisco, California.

#### **A. Worcester County, Maryland**

In December 2000, the Worcester County Human Service Leadership began an assessment of the need for an integrated treatment and recovery support system for people with co-occurring mental health and substance abuse disorders. In 2001 the Worcester County Leadership agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change. In December 2002 all members of the Leadership signed onto the plan to implement an integrated system.

The goal of Worcester County's initiative is to provide accessible, integrated, continuous, and comprehensive services to persons with co-occurring disorders. The Worcester County Health Department, including the Mental Health Clinic, Addictions Services, Case Management, Core Service Agency, and many of the local human service and non-profit mental health organizations have agreed to adopt the plan to improve integration of services. The plan includes:

- Improving outcomes within the context of existing resources,
- Building integration into policy manuals for county operated behavioral health programs, and into contracts, memoranda of understanding, and affiliation agreements that define the relationship between the County Health Department and the other participating entities, and
- Training existing service providers in treating people with co-occurring disorders.

Worcester County has used two professional consultants (Drs. Kenneth Minkoff and Chris Cline) to facilitate the training of staff and general project consultation. The administration of the project is focused at four levels: The Leadership, The Clinical Development Team, The Trainers, and Consumers. The Leadership focus on the policy and procedure development of the model. System policy changes are in the initial stages and will include a county-wide Quality Assurance Policy.



The Clinical Development Team is made up of three clinicians from mental health, addictions, and case management. This team will ensure that the policies and procedures are implemented. The Consumers also have a group and will focus on implementation of a support model.

There are 25 trainers representing the participating agencies. The Trainers receive clinical training from Minkoff and Cline on using integrated treatment in their daily work with consumers. The trainers will then train the staff at each of the participating agencies. Currently the trainers have completed introductory training.

Worcester County has also opened a community-based office for the administration of the project, resource center for professionals, work site for consumers employed by the project, training site, and meeting place for professionals and consumers.

## **B. Fairfax County, Virginia**

Fairfax County provides integrated treatment for co-occurring clients in both the mental health and substance abuse systems. Two of the mental health day treatment facilities in Fairfax County serve co-occurring clients, with specific treatment tracks and substance abuse groups designed to meet their needs. Fairfax County's mental health services system also treats co-occurring clients in two highly intensive residential treatment centers:

- The Franconia Road Treatment Center is a transitional program for adult males in need of up to 18 months of intensive mental health and/or substance abuse treatment and support services; and
- The Residential Extensive Dual Diagnosis program provides the same services for adult females.

In the substance abuse system, treatment facilities have added psychiatric services to treatment regimes. In addition, Fairfax County's Alcohol and Drug Services funds the Cornerstone Dual Diagnosis Facility which opened in 1999. The goal of the program is to stabilize and treat people with co-occurring disorders on-site, and then integrate them into existing community-based substance abuse or mental health programs (e.g., a residential rehabilitation program, halfway house, or day program).

Mental health and substance abuse clinics, as well as the criminal justice system, refer clients to Cornerstone. The Cornerstone program has 16 beds, and serves approximately 40 individuals annually. Cornerstone focuses on individuals with serious mental health and substance abuse needs. Because there are significant challenges in treating these individuals, Cornerstone's staff has adapted a fluid programming approach to best meet

the treatment needs of individual clients. In addition to providing 24-hour supervision, the services provided include individual, group and family counseling; education on substance abuse and mental illness; comprehensive case management; and medication management. Individuals can stay at the facility for up to six months. Both substance abuse and mental health services staff run the program.

Cornerstone staff report that clients who are not motivated to stop using substances are particularly challenging. Often these clients have serious and persistent mental illnesses, such as borderline personality disorder. While every attempt is made to help these clients, the staff can decide to have them leave the program. Unlike other programs, Cornerstones does everything they can to place clients who leave early into services that will help them. If a client is mentally functional but not ready to stop using substances, staff often transfers them to substance abuse residential treatment. Those clients whose mental needs are not best served by Cornerstone's services are placed in more traditional residential mental health services.

### **C. Baltimore City, Maryland**

The Baltimore Mental Health Systems (BMHS) and Baltimore Substance Abuse Systems, Inc. (BSAS) formed a partnership in 2002. The partnership included a joint project to establish integrated treatment for both mental health and substance abuse disorders at six existing substance abuse and mental health treatment sites.

The level of integration of mental health and substance abuse services varies. At the substance abuse clinics, a specialized team of mental health professionals provides services for people who have co-occurring disorders. Counselors at the mental health clinics report becoming more comfortable treating clients who have co-occurring disorders, but there is still a need for specialized substance abuse treatment at the mental health clinics. Staff also report a need for mental health residential and inpatient rehabilitation services that integrate treatment.

Baltimore City also addresses the needs of co-occurring clients through the Baltimore Capitation Project, which began in 1993. The goal is to remove categorical funding barriers in an effort to facilitate high quality comprehensive care to clients, through individualized and flexible treatment plans. The capitation project assigns a provider to be responsible for each client, and a single rate of payment per client that integrates state funds and Medicaid dollars. The provider uses this payment to provide a comprehensive set of services that addresses all the client's needs (e.g. substance abuse, mental health, housing, employment).

Since funds are flexible they can be used to pay for goods and services which would not ordinarily be covered. This allows for funding of education courses, job training, furniture and other personal needs. Evaluation is a key component of the program with

each client's outcomes assessed annually. Because the capitation program allows for more flexible funding, mental health patients in need of substance abuse services can more easily flow between the two systems of care.

Two mental health service providers participate in the Baltimore Capitation Project: the North Baltimore Center (Chesapeake Connections) and Johns Hopkins Bayview Medical Center (Creative Alternative). The staff reports that approximately 275 clients are enrolled and receiving services.

#### **D. Arlington County, Virginia**

Arlington County is developing a Dual Diagnosis Services program within the Behavioral Healthcare Division. The goal of this new program is to provide comprehensive treatment and rehabilitation services to individuals who have co-occurring disorders.

Arlington's dual diagnosis program focuses on those patients with serious mental health and substance abuse needs. It is an outpatient program with one full-time case manager from the County's mental health service system and two part-time case managers from the substance abuse system. Arlington County also has several psychiatrists on staff that will see patients with co-occurring disorders. Arlington is currently advertising for a Dual Diagnosis Unit Coordinator who will be responsible for overseeing this new unit.

The outpatient program will see approximately 60 to 80 clients a year. Upon referral to the program, case managers will conduct an interview to determine the clients' needs and ability to participate in a group therapy setting. Services provided will include community-based case management, psycho-educational groups, counseling, medical services, and skill development to assist the patients to live productively in the community. Clients will receive substance abuse treatment once a week and group therapy five times a week (group therapy topics include both substance abuse and mental health issues). Clients will meet with a psychiatrist for an initial evaluation, and for monthly medication management. The County anticipates clients will remain enrolled in the program for six months to two years.

#### **E. San Diego County and Santa Cruz County, California**

In 1995 the Governor of California directed the State Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (ADP) to work together to develop integrated services for persons who have co-occurring disorders. In response, the two departments created the Dual Diagnosis Task Force (DDTF) in May of 1995.

The Task Force includes DMH and ADP representatives, as well as consumers, family members, and key personnel from other involved agencies. Using Federal Substance Abuse and Mental Health Services Administration (SAMHSA) money, the two departments jointly funded four demonstration projects of integrated services.

All four sites conducted thorough evaluations using a standard set of measures. In three of the projects, the results indicate that integrated treatment improved the clients' psychiatric functioning. All four projects found statistically significant improvements in substance abuse disorders. The initial project evaluations found that the programs did not decrease overall service costs; in fact, physical health care costs increased in San Diego and Santa Cruz Counties. Staff reports that this cost increase may be attributed to the fact that so many clients had serious health needs when they entered the program.

The **San Diego County Dual Diagnosis Demonstration Project** is an outpatient clinic that provides integrated mental health and substance abuse services for approximately 90 clients. The goal of the program is to provide an integrated mental health and substance abuse treatment and recovery environment that offers psychiatric, medical, psychotherapeutic, social, self-help, recovery, family, life skills, and case management in a group setting. Most of the program staff are from the University of California, San Diego (UCSD). Care Coordinators assist clients with additional needs such as housing.

Approximately 41 percent of the clients are diagnosed with a psychotic disorder. The most common diagnosis is schizophrenia, followed by depressive disorders. The majority of clients have a polysubstance abuse diagnosis, usually involving alcohol and marijuana or amphetamine use. While less than 14 percent of the project's clients has spent time in jail, 80 percent has been homeless.

The **Santa Cruz County Dual Diagnosis Demonstration Project** is a 90-day residential intensive integrated treatment program located at the Paloma House. The Paloma House is a 12-bed, co-ed treatment facility operated by the Santa Cruz Community Counseling Center, Incorporated. The goal of the program is to provide integrated mental health and substance abuse treatment and services, including psychiatric, medical, social, life skills, case management, recovery/relapse, and family services.

Paloma House receives referrals through County mental health services, crisis workers, health clinics, the local jail discharge planner, and the alcohol and drug jail transition counselor. In addition, the local drug court refers individuals to Paloma House. If detoxification is required before Paloma House admission, staff refers clients to a local detox center that reserves two beds for this demonstration project. Clients participate in residential treatment for 60-90 days, followed by 60-90 days of transitional services provided at two locations within walking distance of Paloma House.

Over two thirds of the clients participating in the demonstration project have schizophrenia. The second most frequent diagnosis is bipolar disorder. The most common substance abuse disorders are polysubstance abuse and alcohol dependence.

## **F. Philadelphia, Pennsylvania**

The Access to Community Care and Effective Services and Supports (ACCESS) program is an 18-site, five-year demonstration project funded by the U.S. Department of Health and Human Services (DHHS). The purpose of ACCESS is to compare two approaches towards helping persons with mental illness and/or chemical addictions avoid homelessness and improve their clinical outcomes, and quality of life. One approach provides systems-level integration, as well as outreach and case management. The second approach provides outreach and case management alone.

ACCESS West Philly was one of the SAMHSA demonstration projects providing systems-level integration, as well as outreach and case management. The goal of ACCESS West Philly is to improve the quality of life for chronically homeless people in Philadelphia who have both a severe mental illness and an addiction. The Mental Health Association of Southeastern Pennsylvania operates the program. It offers case-management, psychiatric, supportive housing and other services. Specific services include:

- Case managers who work with the clients to locate needed services including employment, housing, and legal assistance. They also teach the clients how to care for themselves and their homes;
- Psychiatrists, psychologists, doctors, and nurses to treat the mental and physical health needs of the participants. There is also a staff nurse who specializes in substance abuse treatment;
- Support groups for both mental illness and substance abuse problems;
- A drop-in center which provides phones, showers, laundry facilities a mailing address, and information and community support; and
- Community outreach workers to encourage individuals to participate in ACCESS.

After the initial SAMHSA grant ended, funding for ACCESS West Philly came from both the Pennsylvania and Philadelphia Offices of Mental Health and the Federal Center for Mental Health Services.

## **G. San Francisco, California**

The Village Integrated Services Agency is an outpatient program that integrates services to meet clients' mental health, substance abuse, health, and housing needs. Most of the clients live on their own, while some live in sober living homes or other living arrangements. Patients must be adults living in the Long Beach area, have a serious mental illness and be homeless or incarcerated, or at risk of homelessness or incarceration.

The Village serves approximately 475-500 clients at any one time. There are three service teams with the capacity to handle between 125-140 clients each. Each team includes a part-time psychiatrist, licensed clinical social worker, nurse and four psychosocial specialists. The Village also has a full time housing specialist and a dual recovery coordinator who serves as a resource to staff and clients. There is also an employment department which assists clients in finding jobs and learning job skills.

Clients work with a Personal Service Coordinator, who helps them to identify and develop their Personal Service Plan. The service plan is tailored to meet all the client's employment, recreation, psychiatric, substance abuse, health, housing and financial choices and needs. Substance abuse services include an in-house support group which follows a 12 step model. The group also informs clients about the effects of alcohol and drugs on their prescribed psychotropic medications. If a client who has co-occurring disorders is reluctant to join the groups they meet individually with the substance abuse counselor until they are comfortable in a group setting.

## V. Findings

### Highlights:

1. People with co-occurring disorders have at least one mental disorder as well as an alcohol or drug use disorder.
2. People with co-occurring disorders have traditionally received disjointed treatment from separate mental health and substance abuse service systems. Research supports a shift to integrated treatment interventions that address both mental health and substance abuse disorders simultaneously.
3. State data indicate that 1,900 of the County's public mental health system consumers have co-occurring disorders. Data are not currently available on the number of County residents who have co-occurring disorders but do not participate in the public mental health system.
4. Individuals in Montgomery County who have co-occurring disorders receive an assessment of service needs through programs structurally housed in the mental health, substance abuse, and criminal justice services systems.
5. Individuals in Montgomery County who have co-occurring disorders receive treatment in the County's substance abuse, mental health, crisis and/or criminal justice services systems.
6. The level of integration of substance abuse and mental health treatment services in the County varies.
7. The Assertive Community Treatment (ACT) Team and the Avery Road Combined Care facility both have a multi-disciplinary staff that provides comprehensive integrated treatment for individuals who have co-occurring disorders. The Substance Abuse Services for Women (SASW) program includes case managers to connect individuals with co-occurring disorders to the mental health, substance abuse, and other services they need.
8. County Government and community-based providers are working together to improve the existing system of services for people who have co-occurring disorders.
9. A variety of issues that impact how Montgomery County identifies, assesses, and treats individuals who have co-occurring disorders need to be considered as providers work to improve the integration of services.
10. Innovative programs across the country provide different types of integrated services for individuals who have co-occurring disorders.

**Finding 1. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines people who have co-occurring disorders as individuals who have at least one mental disorder, as well as an alcohol or drug use disorder.**

Co-occurring disorders emerged as a public health concern in the early 1980s, as it became more evident that many people with a serious mental illness also had substance abuse problems. While substance abuse and mental health disorders may interact differently in different people, at least one disorder of each type can be diagnosed independently of the other. The disorders vary by severity and degree of impairment in functioning, and the disorders in one individual may change over time.

SAMHSA estimates that co-occurring disorders affect seven to ten million adults in the U.S. each year. Co-occurring disorders are particularly common among individuals who are homeless and individuals involved in the criminal justice system.

**Finding 2. People who have co-occurring disorders have traditionally received disjointed treatment from separate mental health and substance abuse service systems. Research supports a shift to integrated treatment interventions that address both mental health and substance abuse disorders simultaneously.**

Typically, individuals who have co-occurring disorders receive ineffective treatment from two separate systems of care, one designed to treat people with substance abuse disorders and the other designed to treat people with mental health disorders. Under this structure, individuals who have co-occurring disorders may be excluded from mental health programs due to their substance abuse disorder, or excluded from substance abuse treatment programs because of their mental disorder. They often bounce back and forth between the two systems of care, resulting in incomplete and/or disjointed treatment.

Research supports a shift to integrated treatment interventions that address both mental health and substance abuse disorders simultaneously. Integrated treatment is broadly defined as “any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting”. Integrated treatment can range from coordination and communication between separate mental health and substance abuse providers, to a formal combination of mental health and substance abuse services in one service setting.



**Finding 3. State data indicate that 1,900 of the County's public mental health system consumers have co-occurring disorders. Data are not currently available on the number of additional County residents who have co-occurring disorders but do not participate in the public mental health system.**

State data indicate that, in FY 2002, approximately 1,900 Montgomery County public mental health system consumers had co-occurring disorders. There are, undoubtedly, additional individuals who have co-occurring disorders who do not participate in the public mental health system. A variety of County service providers estimate that the number of their clients who have co-occurring disorders ranges from 25 percent to 90 percent of their total clientele.

Some individuals who have co-occurring disorders are identified, or enter the County's system of services, through the substance abuse or the mental health services systems. In other cases, the DHHS Crisis Center, Emergency Services, or Child Welfare Services; the Police Department's Mobile Crisis Team; the Department of Correction and Rehabilitation; the court system; homeless shelters; or hospitals identify individuals who have co-occurring disorders.

**Finding 4. Individuals in Montgomery County who have co-occurring disorders receive an assessment of service needs and referral to treatment services. Assessment involves a variety of clinical instruments and takes place in separate programs structurally housed in the mental health, substance abuse, and criminal justice services systems.**

Staff in the following programs assess the needs of individuals in Montgomery County who have co-occurring disorders and refer them to additional services:

- DHHS' Addiction Services Coordination staff assesses individuals in the substance abuse services system.
- Public mental health system treatment providers assess individuals in the mental health services system. In some cases, DHHS' Access Team and Core Service Agency conduct an initial screening, and then refer individuals to a mental health treatment provider for additional assessment.
- The Clinical Assessment and Triage Services Unit (CATS) staff assesses individuals entering the County Detention Center. Community Re-Entry Services (CRES) staff assesses the service needs of individuals preparing to leave the Detention Center.

Addiction Services Coordination (ASC) and Clinical Assessment and Triage Services Unit (CATS) staff uses the Addiction Severity Index and Client Assessment Instrument to assess substance abuse disorders. The instruments include questions about mental health, but staff does not consider them strong diagnostic assessments of mental health disorders. CATS Unit staff supplements the instruments with additional questions about mental health history and needs.

The Access Team and Core Service Agency conduct a cursory screening that does not involve a formal assessment instrument. Public mental health clinic staff usually conduct in-depth interviews of new clients to collect information about mental health history and service needs.

**Finding 5. Individuals in Montgomery County who have co-occurring disorders receive treatment in the County's substance abuse, mental health, crisis and/or criminal justice services systems.**

Co-occurring disorders clients with a severe substance abuse disorder and a stable mental illness generally receive services from a substance abuse treatment provider, including:

- Intensive outpatient treatment in DHHS' Outpatient Addiction Services (OAS) program,
- Intensive outpatient and medium intensity residential care at the Avery Road Combined Care facility,
- Non-hospital detoxification and intermediate residential care at the Avery Road Treatment Center, and
- Outpatient treatment and case management through DHHS' Substance Abuse Services for Women.

Co-occurring disorders clients with a serious and persistent mental illness (which hinders their ability to function in a group treatment environment) usually receive services from a public mental health system outpatient clinic. Some individuals receive treatment for mental health and substance abuse disorders from DHHS' Assertive Community Treatment (ACT) Team.

In terms of the criminal justice system, incarcerated individuals receive services from the Detention Center Crisis Intervention Unit or DHHS' jail-based Jail Addiction Services. DOCR's Pre-Trial Services Unit refers individuals on pre-trial release who have co-occurring disorders to treatment services. Some pre-trial clients received treatment through DOCR's Intervention Program for Substance Abusers (IPSA).

**Finding 6. The level of integration of substance abuse and mental health treatment services in the County varies. Some treatment programs acknowledge both disorders, but focus treatment on one of the disorders. Other programs are beginning to integrate treatment by operating special therapy or discussion groups.**

Treatment for people with co-occurring disorders in Montgomery County often focuses on one disorder or the other, and does not integrate mental health and substance abuse treatment. In these programs, clients who have co-occurring disorders receive the same services as other clients. Examples include the Avery Road Treatment Center, Washington Assessment and Therapy Services, and the Detention Center Crisis Intervention Unit.

DHHS' Outpatient Addiction Services and four public mental health clinics (Threshold Services, St. Luke's, Institute for Life Enrichment, and Affiliated Sante) also focus services on treatment of one disorder or the other. However, these programs are beginning to integrate treatment by operating therapy or discussion groups specifically for individuals who have co-occurring disorders. These groups typically meet once per week and provide a forum for discussion of co-occurring disorders.

**Finding 7. The Assertive Community Treatment (ACT) Team and the Avery Road Combined Care facility both have a multi-disciplinary staff that provides comprehensive integrated treatment for individuals who have co-occurring disorders. The Substance Abuse Services for Women (SASW) program includes case managers to connect individuals with co-occurring disorders to the substance abuse, mental health, and other services they need.**

The Assertive Community Treatment (ACT) Team and the new Avery Road Combined Care program provide more formal integrated services than the other programs described in this report. The programs are designed to serve individuals who have not succeeded in other substance abuse and mental health treatment programs. The clients are typically seriously mentally ill, homeless, involved in the criminal justice system, and frequent users of hospital emergency rooms.

The ACT Team serves approximately 70 clients at a time, and staff estimates that 90 percent has co-occurring disorders. The Team provides treatment, case management, and support services in community locations, such as the client's residence, neighborhood, place of employment or recreation, shelters, jails, and hospitals. A multi-disciplinary staff that includes psychiatrists, psychiatric nurses, social workers, and an addiction counselor provide the services.

The new Avery Road Combined Care (ARCC) facility includes a 20 bed medium intensity residential program,<sup>1</sup> and a 20 slot intensive outpatient program. Staff expects that the majority of the clients served will have co-occurring disorders. Clients receive case management and substance abuse treatment as well as social, medical, employment and psychiatric services. Treatment and programming is slower paced, more repetitive and concrete, and structured to best meet the needs of these hard to serve clients. Substance abuse treatment professionals, as well as a psychiatrist and psychiatric social worker provide the services.

The Substance Abuse Services for Women (SASW) program also provides housing, intensive case management, and linkage to other services for people with multiple needs, including individuals who have co-occurring disorders. The goal of the program is to increase stability and prevent future homelessness. SASW differs from the ACT Team and ARCC because SASW staff links clients to services rather than providing treatment services directly.

**Finding 8. County Government and community-based providers are working together to improve the existing system of services for people who have co-occurring disorders.**

County and community-based providers report difficulty identifying treatment services for co-occurring disorders clients with serious mental illnesses that hinder their ability to function in a treatment environment. These clients often have serious health problems and lack stable housing. Staff reports even more difficulty placing clients who have been involved in the criminal justice system.

Recognizing the need to continue improving the current system of services for individuals who have co-occurring disorders, the Department of Health and Human Services and community-based providers partnered this spring to create the Co-Occurring Disorders Steering Committee. The Committee includes representatives from DHHS, community-based providers, and the State of Maryland. The Committee is charged with developing an integrated system of care in the County, including:

- Facilitating systemic and policy changes that encourage integrated care, and
- Increasing the clinical competencies of existing service providers to address both the mental health and substance abuse needs of their clients.

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<sup>1</sup> The facility has space for 40 beds. DHHS currently has enough grant funding to operate 20 beds for Montgomery County residents. DHHS plans to fill the other 20 beds using other funding sources, primarily by having other jurisdictions in the region pay for beds at the facility for their residents.

The Coalition for the Homeless also established a committee to improve services within the homeless services system for people who have co-occurring disorders. This committee provides training and consultation to homeless service providers to help staff assess client needs, better understand the disorders, and provide the best care possible. The committee includes representatives from community-based providers and DHHS staff.

**Finding 9. A variety of issues impact how Montgomery County identifies, assesses, and treats individuals who have co-occurring disorders. These issues need to be considered as providers work to improve the integration of mental health and substance abuse services in the County.**

A number of issues came up during OLO's research that impact the delivery of services to people who have co-occurring disorders, and the County's efforts to improve integration of services. In sum:

- Traditionally, professional schools of social work, mental health services, and substance abuse services have not prepared students for treating individuals who have co-occurring disorders. In addition, professional licensing rules do not recognize the need for combining mental health and substance abuse competencies to improve service delivery.
- The different methods of funding mental health services and substance abuse services do not facilitate an integrated system of care. Substance abuse services are grant funded through the State Alcohol and Drug Abuse Administration. Mental health services are funded based on a State fee-for-service system, with providers requesting reimbursement from the State for services provided to eligible clients.
- Eligibility requirements limit access to the State's Medical Assistance and Pharmacy Assistance programs. This makes identifying treatment programs for uninsured clients and accessing psychotropic medications more difficult.
- Some service providers continue to experience difficulty accessing services through the public mental health system. Staff also reported problems associated with: limited reimbursement for case management services; no reimbursement for missed appointments; and delays in obtaining a referral and a first appointment with a mental health provider.

- Finding housing for homeless clients who have co-occurring disorders is difficult. Staff report a need for emergency shelter for people using substances, as well as shelter with the support and supervision individuals need to maintain stable mental health. Stable housing is particularly important for individuals to maintain any progress they make in substance abuse treatment and other programs.<sup>2</sup>

**Finding 10. Innovative programs across the country provide different types of integrated services for individuals who have co-occurring disorders.**

While many jurisdictions are beginning to examine the issue of co-occurring disorders and how to best treat patients with these disorders, most are still at the early planning stages. OLO identified some programs across the U.S. which currently integrate mental health and substance abuse treatment services.

Jurisdictions place integrated treatment programs in both the substance abuse and mental health service systems. In some cases they develop separate organizations to manage the services (e.g., Arlington County's Dual Diagnosis unit). The programs tend to individualize services based on specific client needs. In addition to substance abuse and mental health treatment, many of the programs provide other supportive services such as case management, housing support and life skills training. A multi-disciplinary staff, including mental health and substance abuse professionals, familiar with co-occurring disorders provides the services.

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<sup>2</sup> DHHS recently applied for a federal grant to provide housing for chronically homeless adults, many of whom have co-occurring disorders.

## VI. Recommendations

### Highlights:

1. The County's mental health and substance abuse services must be integrated in order to effectively treat the more than 1,900 individuals in Montgomery County who have co-occurring disorders.
2. The Council should closely track the Co-Occurring Disorders Steering Committee's efforts to improve the system of services for individuals who have co-occurring disorders.
3. The Council should request that the County Government submit a report by March 1, 2004 on the new Avery Road Combined Care facility, and use the information in discussions of potential future funding, including non-County dollars.
4. The Council should review the evaluation of the Substance Abuse Services for Women program, and use the information in discussions of potential future funding, including non-County dollars.

**Recommendation #1: The County's mental health and substance abuse services must be integrated in order to effectively treat the more than 1,900 individuals in Montgomery County who have co-occurring disorders.**

Integrated treatment is broadly defined as "any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting." Research indicates that integrated treatment is successful in retaining individuals who have co-occurring disorders in substance abuse treatment, reducing substance abuse disorders, and reducing symptoms of mental disorders.

Effective treatment for the County's more than 1,900 individuals who have co-occurring disorders requires integration of substance abuse and mental health services. Some providers in the County are beginning to integrate treatment by holding therapy or discussion groups designed specifically for individuals who have co-occurring disorders. However, only the Assertive Community Treatment (ACT) Team and the Avery Road Combined Care facility currently use multi-disciplinary staff to provide comprehensive integrated services for people with co-occurring disorders. In addition, the Substance Abuse Services for Women case managers link clients to substance abuse, mental health, and other services that meet their needs; provide on-going support; and track client progress.

OLO recommends that the Council support efforts by the County Government and community-based providers to improve the integration of services for individuals who have co-occurring disorders. This requires support from all the services providers involved, and communication and coordination among the relevant programs. It also requires ensuring flexibility in funding and operations to meet the changing needs of the population who have co-occurring disorders.

**Recommendation #2. The Council should closely track the Co-Occurring Disorders Steering Committee's efforts to improve the system of services for individuals who have co-occurring disorders. Specifically, the Council should:**

- **Request quarterly written updates on the Committee's work, and**
- **Schedule a Health and Human Services (HHS) Committee worksession in early 2004 to discuss the Steering Committee's progress and provide an opportunity for input from HHS Committee members.**

Recognizing the need to improve services for individuals who have co-occurring disorders, the Department of Health and Human Services and community-based providers established the Co-Occurring Disorders Steering Committee in the spring of 2003. The goal of this Committee is to:

“... develop an integrated system of care for individuals who have co-occurring psychiatric and substance disorders that ensures that these clients are well served by public mental health services and that these clients are able to achieve and sustain good outcomes.” (CCISC Charter Document)

The Co-Occurring Disorders Steering Committee effort is focused on facilitating systemic and policy changes that encourage integrated care, and increasing the clinical capacity of existing substance abuse and mental health service providers to integrate treatment for individuals who have co-occurring disorders.

OLO recommends that the Council closely track the Steering Committee's efforts. First, OLO recommends that the Council request quarterly written updates on:

- The status of the Co-Occurring Disorders Steering Committee's work,
- How the Committee uses the \$40,000 of foundation grants,
- Participation by County Government and community-based providers on the Steering Committee and in training sessions organized by the Steering Committee,
- Problems or challenges encountered by the Committee, and
- Coordination between the Co-Occurring Disorders Steering Committee and other groups working in this area (e.g., Coalition of the Homeless Dual Diagnosis Subcommittee and Criminal Justice Behavioral Health Initiative Committee).



OLO also recommends that the Health and Human Services (HHS) Committee schedule a worksession in early 2004 to discuss progress to date, and to provide an opportunity for the HHS Committee's input as the Steering Committee moves forward.

**Recommendation #3. The Council should request that the County Government submit a report by March 1, 2004 on the new Avery Road Combined Care facility, and use the information in discussions of potential future funding, including non-County dollars.**

Individuals with co-occurring disorders are often homeless, involved in the criminal justice system, and frequent users of hospital emergency rooms. Many also have participated unsuccessfully in multiple treatment programs in the past.

The Avery Road Combined Care (ARCC) facility represents a new program focused on integrating treatment to address the substance abuse, mental health, and other needs of this hard-to-serve population. OLO recommends that the Council request information about the activities and results of this new facility. Specifically, OLO recommends that the Council request a report by March 1, 2004 that includes the following information:

- Number and source of referrals to the facility,
- Number and specific characteristics of the individuals served by the facility,
- Use of the 20 residential beds not currently funded through Montgomery County<sup>1</sup>,
- The specific substance abuse, mental health, and other services provided to the clients,
- The average length of stay,
- A list of programs that staff refer clients to after completion of the ARCC program,
- Data on the results of the services, and
- Any problems or challenges encountered.

DHHS received a State Cigarette Restitution grant to contract with Maryland Treatment Centers to operate the ARCC facility for FY 04 and FY 05. OLO also recommends that the Council use the information reported in the March 2004 in discussions of all potential future funding for this new facility. OLO recommends that the Council:

- Assess the results of the services provided at the ARCC,
- Begin to consider funding options for FY 06 and beyond, and
- Assess the value and feasibility of identifying additional funding to use to fund currently unfunded capacity at the facility.

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<sup>1</sup> The facility has space for 40 beds. DHHS currently has enough grant funding to operate 20 beds for Montgomery County residents. DHHS plans to fill the other 20 beds using other funding sources, primarily by having other jurisdictions in the region pay for beds at the facility for their residents.

**Recommendation #4. The Council should review the evaluation of the Substance Abuse Services for Women program, and use the information in discussions of potential future funding, including non-County dollars.**

The Substance Abuse Services for Women (SASW) program also provides services for individuals with multiple service needs. All participants have substance abuse disorders and approximately 75% have mental illnesses. SASW clients receive housing, case management, and referral to other needed services, including mental health care and substance abuse treatment.

DHHS received a Federal grant totaling approximately \$600,000 to operate SASW in FY 02, FY 03, and FY 04. DHHS has not identified funding to support SASW beyond FY 04. The Federal government requires DHHS to complete a comprehensive evaluation at the completion of the federal grant funded period. DHHS staff reports that portions of the evaluation will be completed this fall, and the remainder will be completed by the end of calendar year 2003. OLO recommends that the Council use the evaluation in discussion of all potential future funding for SASW.

## **VII. County Government Comments**

OLO circulated a draft of this report in July 2003 to the Chief Administrative Officer (CAO) and the Department of Health and Human Services. The written comments received from the CAO are included in their entirety, beginning on the following page.

OLO appreciates the time taken by Executive Branch staff to review and comment on the draft report. OLO looks forward to a continuing discussion of this topic with the Executive Branch Staff as the Council reviews the report in the coming months.



OFFICES OF THE COUNTY EXECUTIVE

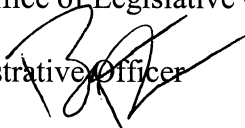
Douglas M. Duncan  
*County Executive*

Bruce Romer  
*Chief Administrative Officer*

MEMORANDUM

July 17, 2003

TO: Karen Orlansky, Director, Office of Legislative Oversight

FROM: Bruce Romer, Chief Administrative Officer 

SUBJECT: Draft Office of Legislative Oversight Report 2003-6 Services for People with Co-Occurring Mental Health and Substance Abuse Disorders

Thank you for the opportunity to comment on the draft of the Office of Legislative Oversight (OLO) Report 2003-6. The Department of Health and Human Services (DHHS) has worked closely with the OLO staff during the last several months as the study was carried out.

The Department concurs with the overriding premise that the most effective means of treating individuals with co-occurring disorders requires an integrated treatment approach. We believe that the establishment of the Co-Occurring Disorders Steering Committee is a solid first step in improving the integration of mental health and substance abuse services for this population.

We look forward to participating in the County Council Committee worksessions that will be scheduled shortly.

CWC:kr



## Office of Legislative Oversight Report 2003-6

### Services for People in Montgomery County who have Co-Occurring Mental Health and Substance Abuse Disorders

Attachment	Document	Circle Number
A	Office of Legislative Oversight Report 2003-6, Resource List	1
B	Drake, Robert et al. 1991, "Homelessness and Dual Diagnosis." <i>American Psychologist</i> . 46: 1149-58.	3
C	Montgomery County, Client Assessment Instrument (CAI)	13
D	Montgomery County Core Service Agency, Mental Health Services in Montgomery County	19
E	Montgomery County Detention Center, Central Processing Unit Screening Form	20
F	Montgomery County CATS Program, CAI Addendum	22
G	Addiction Severity Index	27
H	Montgomery County, CCISC Committee Draft Charter and Consensus Document	33
I	Dr. Kenneth Minkoff, CCISC Model Description	41
J	State of Maryland, House Bill 433	47
K	Mental Health Core Service Agency, Alcohol and Substance Abuse Disorders	51

**OFFICE OF LEGISLATIVE OVERSIGHT REPORT 2003-6  
RESOURCE LIST**

American Association of Community Psychiatrists. (Approved: February 26, 2002). *Principles for the care and treatment of persons with co-occurring psychiatric and substance disorders*. Available at: [www.wpic.pitt.edu/aacp/finds/dualdx.html](http://www.wpic.pitt.edu/aacp/finds/dualdx.html).

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Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In Minkoff, K., & Drake, R.E. (Eds.). *Dual diagnosis of major mental illness and substance disorders*. San Francisco, CA: Jossey-Bass.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services* 52(5): 597-595.

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Montgomery County Charter and Consensus Document: Co-Occurring Psychiatric and

National Mental Health Association. "Model Programs – Access West Philly." [www.nmha.org](http://www.nmha.org)

Osher, Fred and Lisa Dixon. 1996. "Housing for Persons with Co-Occurring Mental and Addictive Disorders" *New Directions for Mental Health Services* 70 53-65.

State of California. "Final Report of the Dual Diagnosis Demonstration Products" <http://www.adp.ca.gov/PDF/ddFinalRpt.pdf>

State of Maryland. Text of House Bill 433. Passed by the Maryland State Legislature April 1, 2003. (attached)

Substance Abuse and Mental Health Services Administration. "Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders." 2003.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System. [www.giansctr.com](http://www.giansctr.com)

The Village – Integrated Service Agency. [www.village-isa.org](http://www.village-isa.org)

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/summary.html>.

# Homelessness and Dual Diagnosis

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Fred C. Osher <sup>2</sup>*National Institute of Mental Health, Rockville, MD*  
Michael A. Wallach <sup>3</sup>*Duke University*

*People who are dually diagnosed with severe mental illness and substance use disorders constitute 10%–20% of homeless persons. They are a heterogeneous and extremely vulnerable subgroup with complex, poorly understood needs. In this article recent research on the epidemiology, subject characteristics, and service needs of the dually diagnosed homeless population is reviewed. Also, the range of evolving approaches to providing social services, housing, and mental health and substance-abuse treatments; the relevant system issues and legal issues; and problems with current research, as well as future research directions, are discussed. The importance of the distinction between providing appropriate living environments and mental health treatments emerges throughout.*

Homeless persons who are dually diagnosed with severe mental illness and substance use disorders constitute a particularly vulnerable subgroup with complex service needs (Breakey, 1987; Fischer, 1990). Few studies address their particular characteristics, needs, and treatment specifically. This oversight results from several difficulties.

One problem is definition. *Dual diagnosis* is defined in different ways, and homeless mentally ill substance abusers are, in reality, multiply impaired, with the impairments having consequences on multiple levels. In addition to mental illness and substance use disorders, many homeless persons have general medical illnesses, legal problems, histories of trauma, behavioral problems, skill deficits, and inadequate or antisocial support systems (Fischer, 1990; Koegel & Burnam, 1988; Rosenheck, Gallup, Leda, Thompson, & Errera, 1988; Wright & Weber, 1987).

Another difficulty is assessment. Because instruments have not been validated for use with homeless or dually diagnosed populations, case ascertainment depends on varied and uncertain procedures (Lovell & Shern, 1990). Research efforts are further hampered by the disorder-specific organization of services. Service systems tend to view clients in corresponding unidimensional terms (i.e., as mentally ill or chemically dependent), despite the complicated realities of co-occurrence (Ridgely, Goldman, & Willenbring, 1990).

A final problem is that dually diagnosed individuals are an extremely heterogeneous population (Lehman, Myers, & Carty, 1989). This heterogeneity includes demographics, pathways to homelessness, type and severity of nonaddictive mental disorder, and type and pattern of

substance use disorder(s). All of these problems, and particularly the issue of heterogeneity, make generalizations about the dually diagnosed homeless population difficult.

Substance abuse, as well as housing instability and homelessness, has increased dramatically among people with severe mental illness in the postinstitutional era (Bachrach, 1984; Minkoff, 1987). As awareness of the problem of dual diagnosis has grown (Boyd et al., 1984; Galanter, Castaneda, & Ferman, 1988; Ridgely, Goldman, & Talbott, 1986), models for integrating mental health and substance abuse treatments have begun to emerge (Minkoff, 1989; Osher & Kofoed, 1989; Ridgely, Osher, & Talbott, 1987; Teague, Schwab, & Drake, 1990) but have not been specifically applied to homeless persons. Similarly, models for intervening with the homeless mentally ill population (Burwell et al., 1989) and with homeless substance abusers (Argeriou & McCarty, 1990) are being developed, but these may not be sufficient for the dually diagnosed homeless population.

Addressing dually diagnosed homeless persons forces us to confront clinical issues, service system issues, legal issues, and housing issues. In this review we will briefly address the existing literature in each of these areas, critique the current research, and suggest directions for future clinical and research efforts. One goal is to improve our understanding of distinctions between protected living arrangements and treatment—distinctions that were blurred when patients were institutionalized.

## Epidemiology

Approximately one third of homeless persons suffer from severe and disabling mental illnesses (Morrissey & Dennis, 1986; Morrissey & Levine, 1987; Tessler & Dennis, 1989), 30% to 40% have alcohol problems (Fischer & Breakey, 1987; Koegel & Burnam, 1987; Wright, Knight, Weber-Burdin, & Lam, 1987), and 10% to 20% have problems with other drugs (Milburn, 1989). Approxi-

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The views presented are those of the authors and do not necessarily reflect the position or policies of the National Institute of Mental Health.

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mately 10% to 20% of homeless persons are dually diagnosed with severe mental illness and alcohol or other drug problems (Tessler & Dennis, 1989).

In a recent comprehensive review of the literature on homelessness for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Mental Health (NIMH), Fischer (1990) identified 10 studies that differentiated between individuals with a single diagnosis of alcohol, drug, or mental health problems and those with dual or multiple diagnoses. The rate of mental disorder plus alcohol use disorder ranged from 3.6% to 26% in 7 studies, the rate of mental disorder plus other drug use disorder ranged from 1.7% to 2.5% in 3 studies, and 3 studies reported mental disorders co-occurring with alcohol or drug use disorders in a range of 8% to 31.1%. In a similar review for the National Institute of Mental Health, Tessler and Dennis (1989) reviewed NIMH-funded studies of homelessness and found that mental disorder plus substance abuse (alcohol or other drug use disorder) ranged from 8% to 22% in the 5 studies that reported comorbidity. Four of the 5 studies reported that nearly one half of those persons with mental disorders had co-occurring substance use disorders. Even with the lack of standardization in reporting categories, assessment methods, and sampling, both reviews support the 10% to 20% rate of dual diagnosis for the homeless population.

Few studies have examined the relationship between dual diagnosis and homelessness. Koegel and Burnam (1988) found that the rate of schizophrenia was nine times as high in homeless alcohol-dependent persons compared with the household sample of alcohol-dependent persons in the Epidemiologic Catchment Area study. Similarly, bipolar disorder was seven times as prevalent in homeless alcohol-dependent individuals as in their housed counterparts.

Reports from clinical samples indicate that dually diagnosed individuals are particularly vulnerable to housing instability and homelessness. Drake, Wallach, and Hoffman (1989) found that 27% of an urban state hospital aftercare sample had unstable housing and were at least temporarily homeless over a six-month evaluation period. Both alcohol use and other drug use were strongly correlated with homelessness, and more than one half of the dually diagnosed subgroup experienced homelessness during this interval (Drake & Wallach, 1989). In a prospective study, Belcher (1989) found that 36% of the mentally ill patients discharged from a state hospital became homeless, at least temporarily, within six months of their discharge. Use of alcohol and other drugs strongly predicted homelessness, so the rate of homelessness among dually diagnosed individuals was considerably higher than 36%. Drake, Wallach, et al. (1991) found that even in a rural area with extensive family supports and available low-cost housing, dual diagnosis was strongly correlated with housing instability: More than one half of the schizophrenic patients with alcohol problems experienced housing instability during a six-month period.

## Subject Characteristics of Dually Diagnosed Homeless Persons

Fischer (1990) reviewed characteristics of dually diagnosed homeless persons in 10 federally funded epidemiologic studies of homelessness that identified them as a separate subgroup, albeit using several different definitions of dual diagnosis. Compared with homeless persons who had single or no diagnoses, dually diagnosed individuals were more likely to be older and male and were less likely to be working. Along with alcoholics, dually diagnosed individuals were more likely to be local residents and to have longer durations of homelessness than were other subgroups. In one study (Fischer & Breakey, 1990), dually diagnosed individuals were more likely to experience extremely harsh living conditions, such as living on the streets rather than in shelters. Various health status indicators show that dually diagnosed individuals have greater difficulties and receive more services than other subgroups (Fischer, 1990). Koegel and Burnam (1987) found that dually diagnosed individuals (defined as those suffering from severe mental illness and chronic alcoholism) were more likely than other homeless groups to suffer from psychological distress and demoralization, to grant sexual favors for food and money, and to be picked up by the police and to become incarcerated. They were less likely to have contacts with and receive help from their families, and like primary alcoholics, they were highly prone to victimization. According to Blankertz, Cnaan, White, Fox, & Messinger (1990), dually diagnosed homeless persons are particularly prone to isolation, mistrust of people and institutions, and resistance to accepting help.

Several critical correlates of dual diagnosis such as risk of homelessness, prognosis for recovery, and response to specific interventions were not studied in the first generation of NIMH-funded research. Koegel and Burnam (1987) did find that a majority of dually diagnosed homeless persons reported that their first alcoholic symptoms preceded their homelessness by at least five years. Clinical studies suggest that dually diagnosed individuals are strongly predisposed to homelessness because their substance abuse and treatment noncompliance lead to disruptive behaviors, loss of social supports, and housing instability (Belcher, 1989; Benda & Dattalo, 1988; Drake, Osher, & Wallach, 1989; Drake & Wallach, 1989; Drake, Wallach, & Hoffman, 1989; Drake, Wallach, et al., 1991). Interviews with families and third parties confirm this view (Lamb & Lamb, 1990).

## Service Needs

Programs for the dually diagnosed homeless population generally offer an amalgam of service elements adopted from mental health or substance abuse treatment programs for homeless people (National Resource Center on Homelessness and Mental Illness, 1990). In recognition of the difficulty in attracting and rehabilitating these individuals, programs generally accept the need for a lengthy engagement process that emphasizes outreach, help with

basic needs, and slowly building a trusting relationship. Common program elements include comprehensive assessment, intensive case management, supported housing, peer groups for support and therapy, training in independent living skills, and mental health and substance abuse treatment. Program philosophy includes acceptance and tolerance of relapses, an emphasis on structured approaches, clear expectations within residential programs, and a commitment to long-term care.

As more programs for dually diagnosed homeless people evolve, these basic service elements are being developed in a variety of settings (National Resource Center on Homelessness and Mental Illness, 1990). Examples of well-described programs include the Salvation Army Clitheroe Center Shelter in Anchorage, Alaska (Dexter, 1990), the Phoenix Drop-in Center in Somerville, Massachusetts (Wittman & Madden, 1988), and residential services in several areas (Blankertz & White, 1990; J. Kline, Bebout, Harris, & Drake, 1991; Wittman & Mad-den, 1988).

Despite their extensive treatment needs, as perceived by others, dually diagnosed homeless persons are unlikely to have received recent treatment for either mental illness or substance abuse (Koegel & Burnam, 1987). Dual diagnosis is underidentified (Helzer & Pryzbeck, 1988), but even when identification occurs, other formidable reasons prevent care.

### Barriers to Care

Barriers to care for homeless mentally ill people and for homeless substance abusers have been detailed in previous articles in this section of the special issue of the *American Psychologist*. Because clinicians, programs, institutions, and funding mechanisms have developed over time within disability-specific categories, barriers between these categorical services have arisen (Ridgely et al., 1990) and add to the accumulated burden of multiple disabilities (Bachrach, 1987). Even stably housed clients with co-occurring disorders are often refused admission to or prematurely discharged from categorical programs (Galanter et al., 1988).

Alcohol and drug treatment developed outside the traditional medical care system and, to a significant extent, in reaction to the perception that the medical community, and particularly mental health providers, viewed substance abuse as a moral or characterological problem (Vaillant, 1983). Not until the 1950s did the American Medical Association and the World Health Organization recognize alcoholism as a disease. Despite the recent push of alcohol- and drug-treatment providers to relocate services within hospitals for purposes of reimbursement, historical barriers remain largely unaffected (Ridgely et al., 1990).

On the federal level, the administration of alcohol, drug abuse, and mental health research and treatment is organized into three separate institutes—the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse—and two newly created offices—the Of-

fice of Treatment Improvement and the Office of Substance Abuse Prevention. This fragmentation mirrors and reinforces administrative structures in most states, which are separated into at least two categories without a single authority to oversee, coordinate, develop, and fund integrated services for clients who need them (Ridgely et al., 1990). At the program level, categorical administration and funding, particularly in times of limited or shrinking financial resources and increasing demand, promote the identification of single disorders, for the purpose of either treatment or shunting to another system, and thereby institutionalize the denial of dual disorders. Differences in treatment philosophy, training, and credentialing of clinicians reinforce these barriers.

Funding barriers are particularly problematic. Alcohol and drug programs are now profitable enterprises in general hospitals, and like mental health units, they may exclude the indigent, unmotivated, or complicated client in order to protect the homogeneity or profit margin of the program (Ridgely et al., 1990). In the recent past, people with severe mental illness have had difficulty obtaining entitlements (Goldman & Gattozzi, 1988). Those with alcohol and drug problems now face similar barriers to obtaining benefits. The Social Security Administration currently provides benefits only if a substance abuser is in treatment and has a protective payee, both of which are in short supply. Many insurance programs still fail to provide for treatment of alcohol and drug problems. Current trends toward prospective payment also complicate the treatment of those with dual disorders because they tend to underpay for complicated cases (Scherl, English, & Sharfstein, 1988). The current emphasis on funding according to diagnosis-related groups encourages short hospital stays, which may be ineffective for complicated cases.

Similar comments can be made regarding housing. Because of the dramatic decrease in low-cost housing, anyone with uncertain income, rental payment, or behavior may be unable to secure housing (Hopper, 1989). Illness exacerbation and disruptive behavior related to substance abuse make dually diagnosed individuals particularly visible and difficult tenants who are especially subject to community resistance described as the not-in-my-backyard syndrome (Robert Wood Johnson Foundation, 1990). Those with dual disorders encounter more than double jeopardy because of the combination of their problems and the categorical nature of supported housing arrangements. Housing programs for mentally ill persons often exclude substance abusers, and those for substance abusers often exclude severely mentally ill individuals. Asking housing personnel to cooperate with more than one treatment system may be impossible in practical terms. Special housing programs that utilize new housing regulations, funding streams, and administrative oversight may need to be created. The protective functions that institutions traditionally offered may need to be more seriously addressed on the outside.

Another barrier to service utilization is the mismatch between available resources and individual client pref-

erences. Homeless persons, even those with psychiatric and addictive impairments, want help with basic amenities like food, clothing, shelter, and jobs, but may have little interest in mental health treatment (Mulkern & Bradley, 1986). Even those who seek hospitalization are typically interested in the basic comforts of food and shelter rather than treatment (Drake, Wallach, & Hoffman, 1989; M. V. Kline, Bacon, Chinkin, & Manov, 1987). As Mulkern and Bradley (1986) observed, the problem is often acceptability rather than accessibility. The realities of what clients want may need to be taken more into account in what professionals offer.

## Housing

Adequate housing is the cornerstone, and perhaps the *sine qua non*, of care for homeless persons, and particularly for those with multiple impairments such as dually diagnosed individuals (Hopper, 1989). Homeless people with either mental illness or substance abuse problems are more likely to return to institutional care if they are not provided with adequate housing (M. V. Kline et al., 1987; Lipton, Nutt, & Sabatini, 1988; Wittman, 1989). For those with alcohol and drug problems, including those dually diagnosed, maintaining sobriety may be impossible practically without adequate housing (Teague et al., 1990; Wittman, 1989).

Clinicians and researchers who work with dually diagnosed individuals advocate both a range and a continuum of housing options to meet needs that vary across individuals and over time. Blankertz and White (1990) suggested that individual characteristics of dually diagnosed persons such as acceptance of restrictive environments, desire for self-determination, tolerance of high expectations in several areas simultaneously, and willingness to strive for abstinence determine their housing preferences at any time.

A continuum of housing can be conceptualized in terms of either the level of expectation for program participation or phases of treatment (defined later as engagement, persuasion, active treatment, and relapse prevention). Living on the streets or in shelters presents a complicated set of demands for survival rather than treatment. Shelters may provide an opportunity for screening and assessment, but they often fail to offer basic security and cleanliness that would allow engagement to take place (Dockett, 1989; Martin, 1989). In addition, long-term placement in shelters tends to socialize clients into dependency on nontherapeutic, institutional care (Grunberg & Eagle, 1990). More adequate alternatives should provide safety, individual space, cleanliness, and dignity.

Engagement is more likely to take place in supported housing or "low-demand" residences, although clients will sometimes need hospitalization or detoxification to make the transition to housing. Although the concept of *wet housing* is controversial within traditional chemical dependency settings, proponents argue that all clients have a right to decent and safe housing and that treatment should be a second-order consideration (Hopper, 1989). As Baumohl (1989) expressed it, we must explore "the

limits of toleration without making it a euphemism for neglect" (p. 294). Low-demand settings may at least reduce morbidity and permit the development of trusting relationships (i.e., engagement) so that residents can be persuaded to participate in treatment and to pursue abstinence. The low-demand approach for the dually diagnosed population is currently being tried in group-home settings (Blankertz & White, 1990) and has been proposed as an intervention in single-room-occupancy settings (Coalition of Voluntary Mental Health, Mental Retardation and Alcoholism Agencies, 1989). Our experience suggests that the housing system must be maximally flexible during this phase of treatment; clients often leave housing precipitously if too much pressure is placed on them, and they are often extruded by landlords. The tolerance of a housing system (e.g., allowing shifts from one housing situation to another) may be helpful in the long-term process of preventing homelessness and promoting stabilization (J. Kline et al., 1991).

For those dually diagnosed clients who become committed to abstinence, alcohol and drug-free living alternatives are essential. New York City has developed the concept of transitional living communities—specialized transitional care settings analogous to halfway houses, in which clients receive integrated treatment to facilitate abstinence, develop sober living skills, make connections to self-help providers in the community, establish medication compliance, and develop realistic goals (Hannigan & White, 1990). New Hampshire uses specialized halfway houses for dually diagnosed clients at this stage (Drake, Antosca, Noordsy, Bartels, & Osher, 1991). Community Connections in Washington, DC, uses highly supervised apartments staffed by housing personnel with substance-abuse-treatment backgrounds and guarded by security officers (J. Kline et al., 1991).

The next step might be alcohol and drug-free living settings with less structure and more independence. Attendance at self-help groups would be required, and the use of alcohol and other drugs off-site would not be tolerated. Ultimately, the success of transitional facilities depends on the availability of permanent housing. Numerous mechanisms for the development of permanent housing, discussed elsewhere in this issue, although not specific to the dually diagnosed, are clearly essential for this vulnerable population.

At least two controversies need to be addressed as we develop housing programs for the dually diagnosed population. First is linking treatment to housing. Given the complex clinical problems of dually diagnosed individuals, providing housing and clinical services without treatment can be seen as naive by clinicians (Drake & Adler, 1984); requiring participation in treatment can be construed as essential. On the other hand, treatment and support are separate issues, and acceptance of treatment may have more to do with the values of professionals than of clients. Many feel that all people have a right to decent housing, regardless of their problems and willingness to participate in treatment. Clearly, many dually diagnosed clients seek hospitals, shelters, and other insti-

tutional settings for their basic amenities rather than for treatment (Drake & Wallach, 1988; M. V. Kline et al., 1987). Moreover, decent housing may be a necessary first step in engaging clients and persuading them to participate in treatment. Research data on the use of low-demand housing for dually diagnosed clients are not available.

Another controversy with relevance for the dually diagnosed population concerns the use of permanent versus transitional housing. Some (Blanch & Carling, 1988; Carling, 1990) have advocated normal permanent housing (with necessary supports) rather than transitional housing, which requires moves that may themselves be stressful. Others, as described earlier, have developed programs with transitions according to clinical status and needs (National Resource Center on Homelessness and Mental Illness, 1990). Despite strong opinions on this issue, solid research evidence is again lacking.

### **Mental Health and Substance Abuse Treatment**

Few programs have developed services designed specifically for homeless dually diagnosed clients. A small number of homeless demonstration programs funded by NIMH or NIAAA focus on those with dual disorders (Argerious & McCarty, 1990; Burwell et al., 1989). Emerging programs reflect two currents of developing clinical experience: services for homeless persons with a single categorical disorder and services for dually diagnosed individuals.

As to categorical services, mental health services for homeless mentally ill persons and substance-abuse services for homeless substance abusers have been reviewed in previous articles in this section. Within each category, outreach and access to a full and continuous range of categorical services have been emphasized. Those who are dually diagnosed must be brought in touch with alcohol, drug, and mental health services that in turn are linked together.

We next turn to services for the dually diagnosed population. On the basis of the Alcohol, Drug Abuse, and Mental Health Administration's review of dual-diagnosis programs (Ridgely et al., 1987), our review of the 13 demonstration programs for young adults with co-occurring disorders funded by NIMH in 1987 (Teague et al., 1990), the dual-diagnosis programs funded by NIMH in 1989 (NIMH, 1989), and our New Hampshire dual-diagnosis program (Drake, Teague, & Warren, 1990; Teague & Drake, 1990), several principles have emerged. The convergence of opinion by experienced clinicians and administrators can be summarized as follows:

1. *Integrated treatment.* Treatment for co-occurring severe mental illness and substance-abuse problems should be concurrent and carefully coordinated (Lehman et al., 1989; Minkoff, 1989; Osher & Kofoed, 1989; Ridgely et al., 1987). Many clinicians and administrators advocate integrating treatment within one system or setting, rather than linking services in separate settings by two systems. Proponents of the integrated treatment

model argue that integration must occur at all levels: increasing individual clinicians' capacities to treat severe mental illnesses and addictive disorders; consolidating alcohol, drug, and mental health treatment at the local level under one roof and supervisory authority; and coordinating administration, monitoring, funding, and other aspects of intersection at the state level. Exactly how to modify existing clinical systems is the subject of several current studies. Traditional methods of parallel or sequential treatments (i.e., linkage) may be less effective because they place too much of the burden of integration on the client. However, the linkage model has the distinct advantage of making use of an extensive self-help system that is free and in place. Several current studies are examining the issue of integrated versus linked treatment for dual diagnosis (NIMH, 1989).

2. *Intensive case management.* Coordination of care by clinicians with small caseloads and an orientation toward assertive outreach and providing treatment in the community has been termed *intensive case management*. Because dually diagnosed clients are difficult to engage and retain in treatment, regardless of their housing status, even programs that do not focus on homeless persons usually prescribe intensive case management as the central treatment vehicle (Teague et al., 1990). Intensive case managers engage clients through outreach, crisis intervention, and practical assistance; they are able to access for clients the entire community support services model (Stroul, 1989); they are in a unique position to assess dual disorders (Drake, Osher, et al., 1990); and they are able to steer and support clients through the stages of addiction treatment (defined later). Several current studies are examining aspects of intensive case management for the dually diagnosed population and for the homeless population (NIMH, 1989).

3. *Group treatment.* The assertive case-management approach, by itself, may not be a sufficient treatment for chemical dependency (Bond, McDonel, Miller, & Pensec, in press). Clinicians across a wide variety of programs agree that dual-diagnosis groups of some type are essential treatment components. This view is supported by open clinical trials (Hellerstein & Meehan, 1987; Kofoed, Kania, Walsh, & Atkinson, 1986; Kofoed & Keys, 1988). Different types of groups may be effective. They range from purely educational to interactive to behavioral skill-building to the Alcoholics Anonymous/Narcotics Anonymous social program model, but all are peer-oriented and integrated into a comprehensive dual-diagnosis program.

4. *Phases of treatment.* Many of the controversies about treatment of dual diagnosis, such as when to insist on abstinence, can be resolved by conceptualizing treatment as a process with different phases (Osher & Kofoed, 1989). We have proposed four phases: *engagement*, *persuasion*, *active treatment*, and *relapse prevention*. During engagement, the emphasis is on developing a trusting, collaborative relationship with the client. The clinician (or clinical team) accomplishes this through providing practical help as well as companionship. Crisis interven-

tion and detoxification may occur during this phase. Few demands for compliance or participation are made.

Once the client is engaged, the clinician attempts to persuade the client to participate in programs and treatment, and particularly to consider abstinence-oriented treatment. Persuasion is accomplished in the context of providing for basic needs, gradual stabilization, and increasing awareness, often in peer groups, of the relationship between substance use and problems in living.

For clients who are persuaded that abstinence is a goal, active treatment concentrates on attaining the skills, supports, and life-style changes that promote abstinence. Peer group treatment is also a key aspect of this phase. The active treatment phase has higher expectations, and external supports such as laboratory monitoring and alcohol and drug-free living settings are frequently helpful. Clients who have attained and maintained sobriety for six months to a year graduate to a relapse prevention phase, in which they continue to monitor risk factors and participate in some aspect of maintenance treatment such as group, self-help group, or case management.

5. *Substitute activities.* Clinicians from a variety of programs agree that dually diagnosed clients, like other substance abusers, must develop substitute activities and relationships. These vary greatly across programs but typically emphasize skill-building, group-identity formation, self-esteem enhancement, and focusing on an abstinent life-style (Teague et al., 1990).

6. *Cultural relevance.* Minorities are overrepresented among the dually diagnosed homeless population (Koegel & Burnam, 1987). Cultural relevance is frequently cited as one critical aspect of programs that serve ethnic and racial minorities. These programs attempt to incorporate the values, styles, language, and other characteristics of local groups. Hiring staff from the same cultural group clearly facilitates this process, as does emphasis on larger proportions of nonprofessionals in the staff. Some programs also hire former consumers to participate in outreach and engagement (Teague et al., 1990).

7. *Training.* Because there are few clinicians well trained in both mental health and substance-abuse treatment, current programs are dependent on their own internal training mechanisms. Training should be longitudinal rather than episodic; outside speakers raise interest and enthusiasm but not skills. Clinicians must instead struggle daily with dually diagnosed clients in the context of regular supervision with other clinicians who will question their assumptions, provide information and perspective from another discipline, and encourage them to try new approaches. To benefit from longitudinal training, clinicians must be flexible, willing to try new approaches, and of course interested in the overlap of severe mental illness and addictive disorders.

8. *Families.* Dually diagnosed homeless persons are often significantly estranged from their families. When families can be accessed, they need education about substance abuse as well as mental illness and should be referred to Al-Anon, as well as the Alliance for the Mentally Ill (Osher & Kofoed, 1989). Experience indicates that

these families are often reluctant to participate with the mental health system and may need considerable outreach and assistance (Lehman, Herron, & Schwartz, 1991).

## Legislative and Legal Issues

Dually diagnosed homeless persons are, with respect to legal issues, affected by legislation that targets the homeless population, the mentally ill population, or substance abusers. Key legislative issues regarding access to entitlements, housing, or treatment for any of these three groups will influence them. For example, they have been excluded at times from entitlements because of their status as homeless, mentally ill, or substance abusing.

The Fair Housing Amendment of 1988 extended protections of federal fair housing legislation to people with disabilities. Although it forbids discriminatory intent or effects of regulations concerning housing for mentally ill individuals, dually diagnosed individuals may still be vulnerable because the language does not cover people who are currently using unlawful controlled substances unless they are participating in drug-treatment programs (Mental Health Law Project, 1989). In addition, involvement with illicit drugs raises issues of liability that dissuade many potential landlords.

As reviewed in previous articles in this section, mental health, public assistance, or adult protective service legislation in some states has been effective in securing shelter for homeless persons. Nevertheless, a national strategy for assuring shelter has not developed. Langdon and Kass (1985) proposed comprehensive federal legislation that would create a nationwide shelter system and centers for those with specific needs, among them dually diagnosed individuals.

The movement to abridge rights of self-determination of homeless persons will strongly affect those dually diagnosed, inasmuch as they are prone to disruptive behaviors (Drake & Wallach, 1989) and particularly likely to be involved in illegal activities and to have contacts with the police (Koegel & Burnam, 1987). A variety of states have proposed or instituted legislation to broaden the criteria of involuntary hospitalization, to provide outpatient commitment, to permit transportation to hospital or shelter, or to impose limited guardianship (Parry & Beck, 1990). Such legislation may protect dually diagnosed individuals from inappropriate shunting into jails and prisons, and hospitalization (voluntary or involuntary) may provide an opportunity for engagement with the community treatment team (Bennett, Gudeman, Jenkins, Brown, & Bennett, 1988). The necessity of involuntary measures is, however, unclear. Because many of the dually diagnosed population may themselves want protective living, even as they reject mental health treatment (Drake, Wallach, & Hoffman, 1989), it seems important to sort out carefully what can be voluntary, before expanding involuntary measures.

## Current Research Issues

A number of research foci can be identified for further work.

1. *Assessment validity.* Many of the issues highlighted in previous articles are relevant as well to the dually diagnosed homeless population. The issue of valid assessment, for example, is critical for this group. Standardized instruments have not been validated for use with them; more work needs to be done to validate the assessment of severe mental illness (Susser & Struening, 1990), substance abuse (Drake, Osher, et al., 1990), and other key dimensions. Not the least of these is living preference—a complex attitude not easily assessed by simple, face-valid questions (Drake & Wallach, 1979, 1988). Validity can be increased by aggregating observations over time and situation (Drake, Osher, et al., 1990), by collecting information from collaterals (Drake, Wallach, & Hoffman, 1989; Lamb & Lamb, 1990) and by modifying standard instruments so that they assess behavioral dimensions that are relevant for this population (Drake, Osher, et al., 1990).

2. *Qualitative methods.* In some areas, our understanding of key issues is so inchoate that qualitative approaches are essential. Koegel (in press; Koegel & Ovrebo, 1990) has argued persuasively for ethnographic approaches—proceeding in context, over time, from the insider's perspective—in studying homelessness. For example, intensive participant observation with a few homeless individuals over time might counterbalance current reliance on cross-sectional self-report data and allow us to learn more about how homeless people actually survive and make decisions regarding living situations, treatment participation, and substance abuse. In addition to Koegel, Schwab from our New Hampshire group and Quimby in our Washington, DC, project are currently using ethnographic approaches in studies of the homeless (Teague & Drake, 1990).

3. *Longitudinal studies.* Numerous coping efforts, support systems, and societal protections must fail before people become homeless, and dual diagnosis interacts complexly in this longitudinal process (Benda & Dattalo, 1988; Lamb & Lamb, 1990). The dearth of longitudinal data impedes our efforts to understand when and how to intervene to prevent and reverse homelessness. High-risk populations such as the dually diagnosed population should be followed longitudinally to clarify patterns of homelessness, the risk factors and protective factors that are associated with developing and recovering from homeless episodes, and the patterns of adjustment while homeless that should be construed as constructive coping rather than as psychopathology.

4. *Prevention.* Studying and treating end-stage diabetes is considerably more difficult than understanding and intervening early in the course of the illness. Analogously, even complex biopsychosocial processes like homelessness may be more amenable to intervention at early stages or convenient points. For example, arranging for housing alternatives at the time of hospital discharge may be more effective than trying to engage severely disorganized individuals on the streets. This is not to say that those on the streets should be ignored, but rather that strategies that may be more clinically effective and

cost-effective should be explored vigorously. Longitudinal research will facilitate identifying and implementing these strategies.

5. *Separating protection and treatment.* Considerable evidence indicates that homeless people, including dually diagnosed individuals, are interested in help with meeting their basic needs much more than treatment (Mulhern & Bradley, 1986) and that obtaining decent housing is a primary objective (Hopper, 1989). Even their contacts with the mental health system may be intended to meet more basic needs (Drake, Wallach, & Hoffman, 1989; Morrissey, Gounis, Barrow, Struening, & Katz, 1986). This finding suggests not only the primacy of housing but also the importance of separate consideration of protective and treatment functions of service providers. Housing arrangements should be the first priority for research as well as services; experiments with variations in protection, structure, and treatment are meaningful only when housing is available (Hopper, 1989).

6. *Housing.* Although clearly the cornerstone of care for the dually diagnosed homeless population, housing is considerably more difficult to study than treatment (Goldman & Newman, 1990; Wittman, 1989). Just the practical problems of accessing housing for this population are enormous. The heterogeneity of the dually diagnosed population, the problems related to categorical programs, and the issue of context (e.g., whether the housing is in a drug-infested area) all complicate research. Numerous issues need to be studied: the usefulness of transitional versus permanent housing, group versus independent settings, congregate versus scattered site alternatives, when and how to institute drug-free housing, and how to use Section 8 vouchers most effectively. Current ideologies and hypotheses should be tested with designs that are as scientifically rigorous as possible.

7. *Engagement.* We know relatively little about engaging the dually diagnosed client and even less about what to do once the process of disaffiliation from people and institutions has eventuated in homelessness. Nearly all programs for dual diagnosis and for clinical subpopulations of the homeless recommend assertive case management, but there are few studies of how case management should be organized, staffed, and performed. Perhaps, as G. Morse in St. Louis is currently investigating, these services should be provided to the homeless population by nonprofessionals who share some key background experiences with the clients (NIMH, 1990).

8. *Treatment services.* Current studies of services for dually diagnosed individuals focus on models of integrating alcohol, drug, and mental health treatments (NIMH, 1989, 1990; Teague et al., 1990). Which service models to offer, when and how to link clients to these services, and how the services themselves should be integrated, are critical issues for the dually diagnosed homeless population. Many of these treatment hypotheses were reviewed earlier.

9. *Assessing implementation and service utilization.* At this early point in the development of mental health services research, the field is limited by our knowledge

of assessing implementation and services (Brekke, 1988; Teague et al., 1990). Negative results may often be due to failure to implement the intended models (Olsson, 1990). Researchers are essentially inventing the techniques for measuring services as they proceed (Drake, Teague, & Freeman, 1990). Critical methodological studies should allow the field to move forward.

### Commentary on Future Directions

The preceding discussion suggests concentrating on clinical and research directions that emphasize more humble, mundane goals rather than heroic ones. Goals associated with the protective, healthful functions of structured communities and residences seem important to implement and evaluate, in contrast to goals associated with reducing mental illness. As Koegel and Burnam (1988) pointed out, we must concentrate on creating environments rather than instituting treatment programs. Such a shift from the heroic to the humble—from trying to mitigate mental illness to offering protection against the elements and against substances of abuse—may be misconstrued by professional caregivers, who are prone to see clinical needs as equally or more salient. In this sense, professionalization can blur common sense, as in the absurd notion that we can provide adequate mental health care for people who are homeless. We must guard against “fostering the myth that more and better clinical programs will eventually solve the problem” (Lewis, Shadish, & Lurigio, 1989, p. 184).

Meeting basic priorities of safety and protection may call for the creation of living environments that provide secure housing and reduced availability of abused substances. Given the reality of American streets and shelters in the 1990s, the people we are concerned with will not find community there, but they may find it in more structured settings. Positive virtues of community may be better fulfilled in protective settings, given the reality of American cities. Thus, the Community Connections housing program for dually diagnosed individuals in Washington, DC, finds it necessary to hire security guards to protect their dually diagnosed clients from drug dealers in the local neighborhood (J. Kline et al., 1991).

Structure, support, and protection may be particularly critical for the most vulnerable subgroups of the homeless population, and homeless persons themselves often seek these elements (Drake, Wallach, & Hoffman, 1989). Certainly patients' preferences for structure should be honored when present, although not necessarily by reopening psychiatric hospitals. Strategies for research that involves assessing patients' preferences and studies of different housing arrangements with degrees of protection, structure, and support separated from treatment have been indicated in this article.

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## CAI REPORT

DATE: 5/13/2003

Client Name/ID:

AGENCY: MD-90296708 Mont Co Health HS Clin. Asses/Triage(CATS) RECORD: 22524  
 INTERVIEW DATE: 05/13/2003 SSN: 578-82-7995  
 REFERRAL: Corrections GENDER: Male  
 STAFF: 128 Salomon, Jim

GENERAL INFORMATION

County of Residence: 15- Montgomery Birth Date: 09/06/1977 Race: Black not of Hispanic origin  
 What brought Client here today: eval

SUBSTANCE ABUSE HISTORY/SUBSTANCE ABUSE TREATMENT HISTORY

Drugs Which Have Been Used or Are Being Used by Client:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heroin                    | <input type="checkbox"/> Methamphetamine    | <input type="checkbox"/> Other Tranquilizers    |
| <input type="checkbox"/> NonPresc. Methadone       | <input type="checkbox"/> Other amphetamines | <input type="checkbox"/> Inhalant               |
| <input type="checkbox"/> Other Opiates/Synthetics  | <input type="checkbox"/> Crack              | <input type="checkbox"/> Over-The-Counter Drugs |
| <input checked="" type="checkbox"/> Alcohol        | <input type="checkbox"/> Cocaine            | <input type="checkbox"/> Other Drugs            |
| <input type="checkbox"/> Barbiturates              | <input type="checkbox"/> Other Stimulants   | <input type="checkbox"/> Marijuana              |
| <input type="checkbox"/> Other Sedatives/Hypnotics | <input type="checkbox"/> Benzodiazepine     | <input type="checkbox"/> None                   |

	Primary Drug Used:	Secondary Drug Used:	Tertiary Drug Used:
Age 1st Used:	5- Alcohol 16		
Frequency Last 30 Days:	4- 3-6 Times/Week		
Route of Intake:	1- Oral		
Most Recent Use:	05/12/2003		

Has Client ever used a needle to inject drugs to get high: No  
 Has Client ever shared a needle with someone to get high: No  
 When Client has been drinking, about how much did Client drink:  
 Beer:  
 Wine:  
 Liquor:

What was the longest period of time Client went without using drugs after first using drugs regularly: 18 Month(s)

Reason of why did Client stop using drugs at that time:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Entered Treatment         | <input type="checkbox"/> Cost Too Much             | <input type="checkbox"/> Moved (New City/Neighborhood)    |
| <input checked="" type="checkbox"/> In Jail/Prison | <input type="checkbox"/> Switched Drugs            | <input type="checkbox"/> Family Pressure/Responsibilities |
| <input type="checkbox"/> Drug Not Available        | <input type="checkbox"/> Want to Change Life Style | <input type="checkbox"/> Health Concerns/Problems         |
| <input type="checkbox"/> Other:                    | <input type="checkbox"/> Got a Job                 | <input type="checkbox"/> Drug Caused Health Problems      |

Has Client ever overdosed on drugs: No  
 What did Client overdosed on:  
 Has Client ever had alcohol Dt's: No  
 Has Client ever had alcohol blackouts: Yes  
 Has Client ever been in treatment for drug or alcohol abuse: No  
 How many times has Client overdosed on drugs:  
 Did Client ever overdosed on purpose: No  
 How many times has Client had alcohol Dt's:  
 How many times Client had alcohol blackouts: 2  
 Number of treatment episodes:

	Name of Service Agency 1	Name of Service Agency 2	Name of Service Agency 3
Type of Agency:			
How Long in Program:			
Discharge Date:			
Reason For Leaving:			

Is Client a child of an alcoholic or substance abuser: 1- No

CAI REPORT

DATE: 5/13/2003

Client Name/ID:

EDUCATION-EMPLOYMENT-MILITARY SERVICE-CRIMINAL JUSTICE

How much education does Client have: 2- High School Diploma/Certificate

Was Client ever left back in school: No

Did Client ever go to school on drugs: No

Did Client ever miss or was Client ever late for school because of drugs or alcohol: No

Did Client ever get into trouble in school because of drugs or alcohol: No

What is the primary source of Client's income now: 2- Wages/Salary

What is the Client's current employment Status: 2- Employed Part Time (<35 Hrs/WK)

If currently employed, how many hours does Client work during a typical week: 30

Has Client ever worked at a full or part-time job including working for him(her)self: Yes

When was Client last employed at a full-time job: 2- Within the past month

What is the longest Client has ever worked at any one full-time job: 2- Less than One month

When was Client last employed at a part-time job: 4- Seven to Twelve months

What is the longest Client has ever worked at one part-time job: 5- More than twelve months

What type of full or part-time job did Client hold the longest: 6- Laborer

What was your most recent job: furniture mover

How long have you worked at your most recent job:

Has Client ever gone to work high on drugs or alcohol: No

Has Client ever missed work or was Client ever late for work because of drugs or alcohol: No

Has client ever gotten into trouble at work because of drugs or alcohol: No

What was Client doing most of the time last week: 1- N/A

Did Client ever serve on active duty in the armed forces: No

If yes, what kind of discharge did Client receive:

Veteran Status:

Had Client ever been arrested: Yes

If yes, on what charges: DUI, POSS BURG TOOLS, 2ND DEGR ASSAULT, 4TH DEGREE BURGLARY

If yes, has Client ever been convicted: Yes

If yes, of what crime: SEE ABOVE

Current Criminal Status: 4- Incarcerated

If on pretrial, probation or parole, name, address and telephone number of the pretrial, probation or parole officer:

Name:

Address:

Telephone No.: ( ) \_\_\_\_\_

Client Name/ID:

**CURRENT FAMILY COMPOSITION - LIVING ARRANGEMENTS**

With whom does Client live: 7- Alone  
 What kind of a residence does Client live in: 1- House, apartment, condominium, co-op, mobile, mobile home  
 Other Client's Residence:

Current Marital 6- Never Married

Does Client have any children: No If yes, how old are they now and how many are living with Client:

Age of Children	Total No. of Children	No. Living with Client
Children age birth - 2 years		
Children age 3 - 5 years		
Children age 6 - 17 years		
Children 18 years and older		

Has Client ever been abused: No Did Client experience physical abuse: No  
 Did Client ever experience sexual abuse: No Was Client abused by a relative or someone Client knows: No  
 Is Client concerned he (she) may be Physically abused again: No  
 Is Client concerned he (she) may be Sexually abused again: No  
 Was Client ever abused by a stranger: No When did this happen:  
 How was this problem handled:

Has Client ever been victim of a violent attack, including rape: No Has Client ever committed arson: No  
 Has Client ever committed a violent attack, including rape: No

**PHYSICAL AND MENTAL HEALTH**

Has Client ever had any of the following serious medical problems such as:

- |   |   |
|---|---|
| <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> For Female clients, Breast problems (lumps, recent changes, pain)  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> For male clients, Prostate or urinary problems                     |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Sexually transmitted diseases (gogorrhea, syphilis, herpes, other) |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Physical handicap that requires a wheelchair                       |
| <input type="checkbox"/> Heart attack   | <input type="checkbox"/> Sight impaired   |
| <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Speech or hearing impaired   |
| <input type="checkbox"/> Skin problems (rashes, sores, burns)   | <input type="checkbox"/> Sickle cell anemia or trait  |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Hepatit - Type:  |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Cirrhosis of the liver   |
| <input type="checkbox"/> Chronic back problems  | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Cancer - Type (if known)   |   |
| <input type="checkbox"/> Diabetes - How long  |   |
| <input type="checkbox"/> Neurologic problems (seizures, blackouts, paralysis, stroke)   |   |
| <input type="checkbox"/> Stomach or digestive problems (ulcer, colitis, persistent diarrhea, vomiting)                                    |   |
| <input type="checkbox"/> Significant weight loss  |   |
| <input type="checkbox"/> For female clients, Gynecological problems severe bleeding, endometiosis, fibriosis, fibroids, cysts, or cancer) |   |
| <input type="checkbox"/> Other (Specify)  |   |

In general, would Client say his (her) health is : 2- Good  
 Is Client covered by any health insurance such as Medicaid, Blue Cross or other insurance: No  
 Type of Insurance:

Client Name/ID: \_\_\_\_\_

**PHYSICAL AND MENTAL HEALTH (continued)**

Has Client ever been hospitalized for any physical health problem or injuries: No  
Details on problems or injuries sustained:

Has Client ever had surgery: No  
For what problem and when:

During the past 12 months has Client ever been treated for a medical condition: No  
What condition:

Has Client ever had any bad reactions or allergic responses to medication: No  
What happened:

During the past year was Client prescribed medications on a regular basis for a longstanding physical problem (Do not include methadone or medications for emotional or psychological problems.): No

Did Client take these medications: No  
If so, what were they:

For Female clients, is Client currently No Had this been verified by a doctor: No  
How many months? How often Client seen a doctor or nurse for prenatal checkup:

For Female clients, how many previous pregnancies has Client had:

Were any of Client's babies born with a positive toxicology for drugs or alcohol: No

Does Client have any of the following physical health-related conditions?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pregnant          | <input type="checkbox"/> Hearing impairment  | <input type="checkbox"/> Sight impairment (legally blind)       |
| <input type="checkbox"/> Speech impairment | <input type="checkbox"/> Mobility impairment | <input type="checkbox"/> Other major physical health conditions |

Has Client ever received outpatient treatment for an emotional or psychiatric illness: Yes

Has Client ever had an emotional problem or psychiatric illness: Yes  
What problem was Client having: DEPRESSION

How old was Client when he (she) first received outpatient treatment or counseling for an emotional or mental health problem: 20

Did Client ever received treatment for an emotional or mental health problem as an outpatient from any of the following:

Type of Treatment	Ever Admitted	No. of Treatment Admissions	Date of Last Discharge
Community Mental Health Center	No		
Private Therapist, Psychiatrist, Psychologist, Social Worker, or Counselor	Yes	3	
State Psychiatric Hospital or VA Hospital	No		
Any other place	No		

Is Client receiving outpatient treatment or counseling for an emotional or mental health problem: No

Did Client ever stay overnight in a facility for treatment of an emotional or mental health problem? Yes  
(Do not include drug abuse or alcohol treatment)  
DEPRESSION

How old was Client when he (she) first stayed overnight in a facility for treatment of an emotional or mental health problem:

CAI REPORT

DATE: 5/13/2003

Client Name/ID:

**PHYSICAL AND MENTAL HEALTH (continued)**

Has Client ever stayed at a psychiatric hospital for 30 days or more? Yes

Did Client received treatment for an emotional or mental health problem where Client had to stay overnight at (Type of Treatment)

Type of Treatment	Ever Admitted	No. of Admissions	Total Weeks in	Date of Last Discharge
Community Mental Health Center	No			
Private Psychiatric Hospital	No			
State Psychiatric Hospital	Yes	2	7	
General or VA Hospital	No			
Emergency Room	No			

During the past year, did Client take any medications (on a regular basis) for an emotional or psychological problem? No

What were these medications:

Where did Client get these medication?

Did Client take these medications? No When did Client take these medications?

Does/Did Client feel the medication was helpful? No

Does Client have any disability having to do with Client's ability to remember facts, read, or figure out problems such as dyslexia, or learning disorder? No

Has Client ever had serious thoughts about ending his (her) life or committing suicide? No

How often has Client had these thoughts:

When was the last time Client thought seriously about committing suicide?

Have Client's thoughts about suicide always been the result of drugs and/or alcohol? No

In Client's lifetime, has Client ever attempted suicide? No

How many times has Client attempted suicide? When Client attempted suicide:

How Client attempted suicide:

When was the last time Client attempted suicide?

In the past year, has Client attempted suicide with a clear and distinct plan to end his (her) life? No

What was a problem at that time:

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Client Name/ID:

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CLIENT NARRATIVE

Demographic

25 YEAR OLD, SINGLE, EMPLOYED, A.A.

Drug Abuse (History to Current)

LONG HX OF ALCOHOL USE. REFUSES TO GIVE THE AMOUNT THAT HE USES. HIS RESPONSE TO QUESTIONS IS WHATEVER

Previous Drug Abuse Treatment

NONE

Education

HIGH SCHOOL EDUCATION

Employment Status (History to Current)

EMPLOYED AS A FURNITURE MOVER

Criminal

HX OF CRIMINAL OFFENSES

Family Composition

NO FAMILY IN THIS AREA

Physical Health Problems (History to Current)

NONE

Mental Health Problems (History to Current)

HX OF DEPRESSION. CT. WANTS TO TAKE PAXIL AT THIS TIME.

Other Issues

Impressions of the Client (Including Motivation for Treatment)

CLEAR FOR HOUSING IN GENERAL POPULATION

Recommendations (Including Reasons for Recommendations)

Client would like to be on Paxil while he is incarcerated. Refer to psych



**Montgomery County Mental Health Services**  
**Fee-For-Service and County, State & Federal Grant Funds**

**Critical Response Services**

- Access Team Services
- Crisis Services
- Hot Line and Youth Suicide Line
- Crisis Residential Alternative to Hospitalization for Adults
- Inpatient Hospitalization

**Child and Adolescent Services**

- Outpatient Mental Health Services
- Therapeutic Nursery Services
- Respite Services
- In-Home Crisis and Intervention Services
- Mental Health Targeted Case Management
- Adolescent Therapeutic Group Homes
- Residential Treatment Centers (RTC)
- Psychiatric Rehabilitation Programs (PRP)
- Partial Hospitalization Services
- Rapid Evaluation & Court Reporting Services
- Mental Health Treatment at NOYES
- Children's Assessment Center

**Adult and Senior Treatment Services**

- Outpatient Mental Health Services
- Case Management (targeted and grant funded)
- Psychiatric Rehabilitation Programs (PRP)
- Consumer Education & Focus Groups

**Homeless and Residential Services**

- Outreach Services, Vocational Services, and Transitional Housing for the homeless
- Supportive Housing
- Landlord Based Housing
- Assisted Living
- Permanent Housing
- Residential Rehabilitation Programs (RRP)

**Vocational Services**

- Career Transition / Supported Education for Young Adults
- Supported Employment / Mental Health Vocational Services
- Computer Training

**Specialized Consumer Services**

- Consumer-Operated Drop In Center
- Financial Support for Special Consumer Needs
- Transportation between Montgomery County and Springfield Hospital Center
- Transportation between Montgomery County and identified State Planning Committees



SUICIDE SCREENING FORM

Inmate's Name: \_\_\_\_\_ Date: \_\_\_\_\_
MCPID# (CPU) \_\_\_\_\_ MCDC # \_\_\_\_\_

Is there anything about this individual that would warrant a referral to Mental Health Services based on any of the questions below? If you check YES to any questions, please ELABORATE AND FILL OUT A REFERRAL TO MENTAL HEALTH AND A DCA 36. Write NO if not applicable. All items MUST be filled out.

(1) Did you obtain any information about this individual from family, staff, transporting officers, attorneys, health care providers or any other individual(s) suggesting that he/she may be a high risk for suicide or are you aware of any issues that MCDC needs to be concerned with?

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

(2) Does the individual respond YES to the following question: "Are you thinking about killing yourself"? ( If answer is YES, PLACE ON SUICIDE WATCH IMMEDIATELY until cleared by MH staff)

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

(3) Do you have any information (self report or from any other source) that this individual has a history of mental illness or history of self destructive behavior indicating that he/she may be a high risk for mental health de-compensation, suicide, or self-destructive behavior?

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

(4) Does this individual report being on anti-depressants or any other psychiatric medication and/or currently under the care of a mental health provider?

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

(5) Have you observed behaviors during the interview with this individual that may suggest to you that he/she is depressed or suicidal? ( appears withdrawn, depressed, crying, teary eyed, quiet, non-communicative, expresses not wanting to live for any reason, expresses extreme shame and not able to live with it, gives possessions away )

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

(6) Do you have any knowledge of any medical/physical/ social situation that may suggest to you that the individual may be unable to adjust or cope with this incarceration? (Does he/she appear overly anxious/ angry/despondent, or is he talking or acting in strange manner, disoriented, talking to himself, appears under the influence of substances, is worried about major losses including job or relationships to the extent that he/she can't see a way out?)

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_  
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_  
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

(7) Do you have other relevant information suggesting to you that the individual may pose a suicide risk?

CPU: \_\_\_\_\_ Comments: \_\_\_\_\_  
R&D: \_\_\_\_\_ Comments: \_\_\_\_\_  
MED: \_\_\_\_\_ Comments: \_\_\_\_\_

**If any YES responses: Did you submit a referral for Mental Health?**

CPU: YES \_\_\_\_\_ NO \_\_\_\_\_  
R&D: YES \_\_\_\_\_ NO \_\_\_\_\_  
MED: YES \_\_\_\_\_ NO \_\_\_\_\_

**Was Shift Commander Notified? If applicable, indicate other action taken:**

CPU: YES \_\_\_ NO \_\_\_ Other action taken: \_\_\_\_\_  
R&D: YES \_\_\_ NO \_\_\_ Other action taken: \_\_\_\_\_  
MED: YES \_\_\_ NO \_\_\_ Other action taken: \_\_\_\_\_

**Staff Signature:**

CPU \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ I.D. # \_\_\_\_\_ Date: \_\_\_\_\_  
R&D \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ I.D. # \_\_\_\_\_ Date: \_\_\_\_\_  
MED \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ I.D. # \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY CATS OR MH STAFF ONLY:**

Assessment Performed by (PRINT) \_\_\_\_\_ ID # \_\_\_\_\_  
Date \_\_\_\_\_

**Disposition Recommendation:**

IMMEDIATE SUICIDE WATCH \_\_\_\_\_ Staff notified (PRINT) \_\_\_\_\_ Date: \_\_\_\_\_

Refer to MHS to evaluate for CIU housing \_\_\_\_\_ Date \_\_\_\_\_

Cleared for General. Population. \_\_\_\_\_ Place on HSDB \_\_\_\_\_ Staff notified re: HSDB: \_\_\_\_\_

Referred to HHS psychiatrist \_\_\_\_\_

Referral Submitted for DOCR Psychiatrist \_\_\_\_\_ Date: \_\_\_\_\_

FORM REVIEWED BY: \_\_\_\_\_ I.D. # \_\_\_\_\_  
DATE: \_\_\_\_\_

MH / C / SA

Date: \_\_\_\_\_

# CATS CAI ADDENDUM

CATS Staff Name \_\_\_\_\_

Referral Source \_\_\_\_\_

Client Last Name \_\_\_\_\_

Client First Name \_\_\_\_\_

MI \_\_\_\_\_

MCDC ID# \_\_\_\_\_

SS# \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

\_\_\_\_\_  
D.O.B.

Male  Female

Race \_\_\_\_\_

Residency \_\_\_\_\_

Single  Married

Employed?  Yes  No

Most Recent (When/Where) \_\_\_\_\_

Health Insurance?  Yes  No Type of insurance? \_\_\_\_\_ Rx Coverage  Yes  No

Primary Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Phone number \_\_\_\_\_

Yes  No

Current Charge \_\_\_\_\_

Current Bond \_\_\_\_\_

Sentenced?

Any active Child Welfare Involvement?  Yes  No

Reason for referral (specific):

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Client complaints/ Therapist's observations:

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**Mental Status Examination:** (Circle all that apply and describe with specific examples)

Sensorium: Alert Oriented to: hr, month, day, year  
 Impaired consciousness Oriented to: person  
 Fluctuations in level of consciousness Oriented to: place

Comments: \_\_\_\_\_

Appearance: Neat Casual Bizarre/idiosyncratic  
 Clean Formal Involuntary movements/tics  
 Well-groomed Self neglect Inappropriately dressed  
 Physical handicaps Evidence of physical dx

Comments: \_\_\_\_\_

Attitude Toward Examiner: Friendly Aloof Hostile Impatient  
 Cooperative Seductive Evasive Suspicious  
 Superior Uncooperative Apathetic Humorous  
 Withdrawn Guarded Threatening

Comments: \_\_\_\_\_

Behavior: Motor activity Invades Personal Space Bizarre Giggly  
 Hyperactive Good Eye Contact Posturing Tearful  
 Hypoactive Poor Eye Contact Mannerisms Compulsions  
 Distractible Hypervigilant Catalepsy Impulsivity

Comments: \_\_\_\_\_

Affect: Full Range La Belle Indifference Irritable Fearful  
 Labile Mood Congruent Euphoric/Elated Suspicious  
 Flat/Blunted Mood Incongruent Hostile Ambivalence  
 Constricted Anxious/Panicky Depressed Panic Attacks

Comments: \_\_\_\_\_

Mood: Euphoric Excited Euthymic Calm  
 Happy Sad Irritable  
 Expansive Grandiose Apathetic

Comments: \_\_\_\_\_

Thought Content: Flight of ideas Delusional Grandiose Coherent  
 Tangential Paranoid Illogical

Comments: \_\_\_\_\_

**CATS Recommendations:**

Diversion:

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Classification:

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Strengths:

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Liabilities:

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Priorities of Care:

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Family:

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Education:

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Substance Abuse HX & Treatment:

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Medical History:

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Other:

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**INSTRUCTIONS**

1. Leave No Blanks - Where appropriate code items:  
 X = question not answered  
 N = question not applicable  
 Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments

**ADDICTION SEVERITY INDEX**

**SEVERITY RATINGS**

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. Note: These severity ratings are optional.

**Fifth Edition**

**SUMMARY OF PATIENTS RATING SCALE**

- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

I.D. NUMBER

LAST 4 DIGITS OF SSN

DATE OF ADMISSION

DATE OF INTERVIEW

TIME BEGUN  :

TIME ENDED  :

CLASS:  
 1 - Intake  
 2 - Follow-up

CONTACT CODE:  
 1 - In Person   
 2 - Phone

GENDER:  
 1 - Male   
 2 - Female

INTERVIEWER CODE NUMBER

SPECIAL:  
 1 - Patient terminated   
 2 - Patient refused  
 3 - Patient unable to respond

**GENERAL INFORMATION**

NAME \_\_\_\_\_

CURRENT ADDRESS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

GEOGRAPHIC CODE

1. How long have you lived at this address?  YRS.  MOS.

2. Is this residence owned by you or your family?   
 0 - No 1 - Yes

3. DATE OF BIRTH

4. RACE   
 1 - White (Not of Hispanic Origin)  
 2 - Black (Not of Hispanic Origin)  
 3 - American Indian  
 4 - Alaskan Native  
 5 - Asian or Pacific Islander  
 6 - Hispanic - Mexican  
 7 - Hispanic - Puerto Rican  
 8 - Hispanic - Cuban  
 9 - Other Hispanic

5. RELIGIOUS PREFERENCE   
 1 - Protestant 4 - Islamic  
 2 - Catholic 5 - Other  
 3 - Jewish 6 - None

6. Have you been in a controlled environment in the past 30 days?   
 1 - No  
 2 - Jail  
 3 - Alcohol or Drug Treatment  
 4 - Medical Treatment  
 5 - Psychiatric Treatment  
 6 - Other \_\_\_\_\_

7. How many days?

**ADDITIONAL TEST RESULTS**

Shipley C.Q.

Shipley I.Q.

Beck Total Score

SCL-90 Total

MAST

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SEVERITY PROFILE**

9							
8							
7							
6							
5							
4							
3							
2							
1							
0							
PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUG	LEGAL	FAM/SOC	PSYCH



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### MEDICAL STATUS

\* 1. How many times in your life have you been hospitalized for medical problems?     
(Include o.d.'s, d.i.'s, exclude detox.)

5. Do you receive a pension for a physical disability? (Exclude psychiatric disability.)   
0 - No  
1 - Yes \_\_\_\_\_  
Specify

8. How important to you now is treatment for these medical problems?

2. How long ago was your last hospitalization for a physical problem   YRS.   MOS.

6. How many days have you experienced medical problems in the past 30?

INTERVIEWER SEVERITY RATING  
9. How would you rate the patient's need for medical treatment?

3. Do you have any chronic medical problems which continue to interfere with your life?   
0 - No  
1 - Yes \_\_\_\_\_  
Specify

FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

CONFIDENCE RATINGS  
Is the above information significantly distorted by:

4. Are you taking any prescribed medication on a regular basis for a physical problem?   
0 - No 1 - Yes

7. How troubled or bothered have you been by these medical problems in the past 30 days?

10. Patient's misrepresentation?   
0 - No 1 - Yes

11. Patient's inability to understand?   
0 - No 1 - Yes

Comments

### EMPLOYMENT/SUPPORT STATUS

\* 1. Education completed (GED = 12 years)   YRS.   MOS.

10. Usual employment pattern, past 3 years.   
1 - full time (40 hrs/wk)  
2 - part time (reg. hrs)  
3 - part time (irreg., daywork)  
4 - student  
5 - service  
6 - retired/disability  
7 - unemployed  
8 - in controlled environment

18. How many people depend on you for the majority of their food, shelter, etc.?

\* 2. Training or technical education completed   MOS.

19. How many days have you experienced employment problems in the past 30?

3. Do you have a profession, trade or skill?   
0 - No  
1 - Yes \_\_\_\_\_  
Specify

FOR QUESTIONS 20 & 21 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

4. Do you have a valid driver's license?   
0 - No 1 - Yes

11. How many days were you paid for working in the past 30? (include "under the table" work.)

20. How troubled or bothered have you been by these employment problems in the past 30 days?

5. Do you have an automobile available for use? (Answer No if no valid driver's license.)   
0 - No 1 - Yes

How much money did you receive from the following sources in the past 30 days?

21. How important to you now is counseling for these employment problems?

6. How long was your longest full-time job?   YRS.   MOS.

12. Employment (net income)

INTERVIEWER SEVERITY RATING

\* 7. Usual (or last) occupation.   
\_\_\_\_\_  
(Specify in detail)

13. Unemployment compensation

22. How would you rate the patient's need for employment counseling?

8. Does someone contribute to your support in any way?   
0 - No 1 - Yes

14. DPA

CONFIDENCE RATINGS  
Is the above information significantly distorted by:

9. ONLY IF ITEM 8 IS YES) Does this constitute the majority of your support?   
0 - No 1 - Yes

15. Pension, benefits or social security

23. Patient's misrepresentation?   
0 - No 1 - Yes

16. Mate, family or friends (Money for personal expenses).

24. Patient's inability to understand?   
0 - No 1 - Yes

17. Illegal

Comments

**DRUG/ALCOHOL USE**

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PAST 30      LIFETIME USE

	Days	Yrs.	Rt of adm.
01 Alcohol - Any use at all			
02 Alcohol - To Intoxication			
03 Heroin			
04 Methadone			
05 Other opiates/analgesics			
06 Barbiturates			
07 Other sed/hyp/tranq.			
08 Cocaine			
09 Amphetamines			
10 Cannabis			
11 Hallucinogens			
12 Inhalants			

13 More than one substance per day (Incl. alcohol).

Note: See manual for representative examples for each drug class

\* Route of Administration: 1 = Oral, 2 = Nasal, 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

14 Which substance is the major problem? Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient.

15. How long was your last period of voluntary abstinence from this major substance? (00 - never abstinent)

MOS.

16. How many months ago did this abstinence end? (00 - still abstinent)

17 How many times have you:

Had alcohol d.t.'s

Overdosed on drugs

18 How many times in your life have you been treated for:

Alcohol Abuse:

Drug Abuse:

19 How many of these were detox only?

Alcohol

Drug

20 How much would you say you spent during the past 30 days on:

Alcohol

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Drugs

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Comments

21 How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (Include NA, AA).

22 How many days in the past 30 have you experienced: Alcohol Problems


Drug Problems

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

23 How troubled or bothered have you been in the past 30 days by these: Alcohol Problems

Drug Problems

24 How important to you now is treatment for these: Alcohol Problems

Drug Problems

**INTERVIEWER SEVERITY RATING**

25 How would you rate the patient's need for treatment for:

Alcohol Abuse

Drug Abuse

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

26 Patient's misrepresentation? 0 - No 1 - Yes

27 Patient's inability to understand? 0 - No 1 - Yes

**LEGAL STATUS**

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1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.)

0 - No 1 - Yes

2. Are you on probation or parole?

0 - No 1 - Yes

How many times in your life have you been arrested and charged with the following:

- \* 03 - shoplifting/vandalism
- \* 04 - parole/probation violations
- \* 05 - drug charges
- \* 06 - forgery
- \* 07 - weapons offense
- \* 08 - burglary, larceny, B & E
- \* 09 - robbery
- \* 10 - assault
- \* 11 - arson
- \* 12 - rape
- \* 13 - homicide, manslaughter
- \* 14A - prostitution
- \* 14B - contempt of court
- \* 14C - other


15 How many of these charges resulted in convictions?

How many times in your life have you been charged with the following:

- \* 16 Disorderly conduct, vagrancy, public intoxication
- \* 17 Driving while intoxicated
- \* 18 Major driving violations (reckless driving, speeding, no license, etc.)




19 How many months were you incarcerated in your life?

MOS.

20. How long was your last incarceration?

MOS.

21. What was it for?

(Use code 3-14, 16-18.

If multiple charges, code most severe)

22 Are you presently awaiting charges, trial or sentence?  
0 - No 1 - Yes

23 What for (If multiple charges, use most severe).

24 How many days in the past 30 were you detained or incarcerated?

Comments

25 How many days in the past 30 have you engaged in illegal activities for profit?

FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

26 How serious do you feel your present legal problems are?  
(Exclude civil problems)

27 How important to you now is counseling or referral for these legal problems?

INTERVIEWER SEVERITY RATING

28 How would you rate the patient's need for legal services or counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29 Patient's misrepresentation?  
0 - No 1 - Yes

30 Patient's inability to understand?  
0 - No 1 - Yes

**FAMILY HISTORY**

Have any of your relatives had what you would call a significant drinking, drug use or psych problem- one that did or should have led to treatment?

Mother's Side

Father's Side

Siblings

	Alc	Drug	Psych
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Alc	Drug	Psych
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Alc	Drug	Psych
Brother #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Direction: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category. Code most problematic relative in cases of multiple members per category.

**FAMILY/SOCIAL RELATIONSHIPS**

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① Marital Status

- 1 - Married
- 2 - Remarried
- 3 - Widowed
- 4 - Separated
- 5 - Divorced
- 6 - Never Married

2 How long have you been in this marital status?   YRS.   MOS.  
(If never married, since age 18).

③ Are you satisfied with this situation?   
0 - No  
1 - Indifferent  
2 - Yes

④ Usual living arrangements (past 3 yr.)   
1 - With sexual partner and children  
2 - With sexual partner alone  
3 - With children alone  
4 - With parents  
5 - With family  
6 - With friends  
7 - Alone  
8 - Controlled environment  
9 - No stable arrangements

5. How long have you lived in these arrangements.   YRS.   MOS.  
(If with parents or family, since age 18).

⑥ Are you satisfied with these living arrangements?   
0 - No  
1 - Indifferent  
2 - Yes

Do you live with anyone who:  
0 = No 1 = Yes

6A. Has a current alcohol problem?

6B. Uses non-prescribed drugs?

⑦ With whom do you spend most of your free time:  
1 - Family 3 - Alone   
2 - Friends

⑧ Are you satisfied with spending your free time this way?  
0 - No 1 - Indifferent 2 - Yes

⑨ How many close friends do you have?

Direction for 9A-18: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

9A. Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

- Mother
- Father
- Brothers/Sisters
- Sexual Partner/Spouse
- Children
- Friends

Have you had significant periods in which you have experienced serious problems getting along with:

- |                                  | PAST 30 DAYS         | IN YOUR LIFE         |
|----------------------------------|----------------------|----------------------|
| ⑩ Mother                         | <input type="text"/> | <input type="text"/> |
| ⑪ Father                         | <input type="text"/> | <input type="text"/> |
| ⑫ Brothers/Sisters               | <input type="text"/> | <input type="text"/> |
| ⑬ Sexual partner/spouse          | <input type="text"/> | <input type="text"/> |
| ⑭ Children                       | <input type="text"/> | <input type="text"/> |
| ⑮ Other significant family _____ | <input type="text"/> | <input type="text"/> |
| ⑯ Close friends                  | <input type="text"/> | <input type="text"/> |
| ⑰ Neighbors                      | <input type="text"/> | <input type="text"/> |
| ⑱ Co-Workers                     | <input type="text"/> | <input type="text"/> |

Did any of these people (10-18) abuse you: 0 = No; 1 = Yes

- 18A. Emotionally (make you feel bad through harsh words)?
- 18B. Physically (cause you physical harm)?
- 18C. Sexually (force sexual advances or sexual acts)?

⑲ How many days in the past 30 have you had serious conflicts:

- A with your family?
- B with other people? (excluding family)


FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

- ⑳ Family problems
- ㉑ Social problems

How important to you now is treatment or counseling for these:

- ㉒ Family problems
- ㉓ Social problems

**INTERVIEWER SEVERITY RATING**

⑳ How would you rate the patient's need for family and/or social counseling?

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

- ㉔ Patient's misrepresentation? 0 - No 1 - Yes
- ㉕ Patient's inability to understand? 0 - No 1 - Yes

Comments

**PSYCHIATRIC STATUS**

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① How many times have you been treated for any psychological or emotional problems?

In a hospital

As an Opt. or Priv. patient


② Do you receive a pension for a psychiatric disability?

0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes

PAST 30 IN  
DAYS YOUR  
LIFE

③ Experienced serious depression

④ Experienced serious anxiety or tension

⑤ Experienced hallucinations

⑥ Experienced trouble understanding, concentrating or remembering

⑦ Experienced trouble controlling violent behavior

⑧ Experienced serious thoughts of suicide

⑨ Attempted suicide

⑩ Been prescribed medication for any psychological/emotional problem


⑪ How many days in the past 30 have you experienced these psychological or emotional problems?

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FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

⑫ How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

⑬ How important to you now is treatment for these psychological problems?

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient:

0 - No 1 - Yes

⑭ Obviously depressed/withdrawn

⑮ Obviously hostile

⑯ Obviously anxious/nervous

⑰ Having trouble with reality testing thought disorders, paranoid thinking

⑱ Having trouble comprehending, concentrating, remembering.

⑲ Having suicidal thoughts

Comments

**INTERVIEWER SEVERITY RATING**

⑳ How would you rate the patient's need for psychiatric/psychological treatment?

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

㉑ Patient's misrepresentation?  
0 - No 1 - Yes

㉒ Patient's inability to understand?  
0 - No 1 - Yes

**MONTGOMERY COUNTY, MARYLAND  
CHARTER AND CONSENSUS DOCUMENT:**

**CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS**

**July 24, 2003**

**Problem**

Individuals with co-occurring psychiatric and substance disorders are recognized as a population with high costs and poor outcomes in multiple clinical domains. They tend to be less well served in both mental health and substance abuse treatment settings than singly diagnosed individuals. Consequently, they overutilize resources in the criminal justice system, the primary health care system, the homeless services system, and the child and adult protective services systems.

Individuals with co-occurring disorders are sufficiently prevalent in all behavioral health settings that they can be considered an expectation, rather than an exception. Effective care for people with co-occurring disorders is continuous, comprehensive and integrated. Current care often is episodic, partial and fragmented.

**Best Practice Model: CCISC**

Public and private behavioral health care, homeless services, primary health care and social service agencies, serving people with co-occurring disorders in Montgomery County, along with consumers and advocates, are determined to provide a more welcoming, accessible, continuous, comprehensive and integrated continuum of services to these individuals. To that end, they have agreed to adopt the Continuous, Comprehensive, Integrated Systems of Care (CCISC) model for designing systems change and guiding practices in order to improve outcomes.

Participating agencies will integrate this model into all current and future policy manuals and cooperative agreements, as well as all current and future contracts, memoranda of understanding and affiliation agreements that define the relationship between the County Department of Health and Human Services (HHS) and the other participating entities, in cooperation with consumers and advocates.

**CCISC Participating Entities**

Participating entities include but are not limited to:

- HHS, specifically the following programs within HHS: the Core Services Agency (CSA), the Child and Adolescent Mental Health Clinic, the Multicultural Program, the Crisis Center, the HHS Assertive Community Treatment (ACT)

Team; Addictions Services including Addiction Services Coordination, Outpatient Addiction Services (OAS), and Behavioral Health Criminal Justice Services based in the Montgomery County Detention Center; Child Welfare, including Child Protective Services; Aging and Disability Services, including Adult Protective Services; Income and Victim Services, including Emergency Services, Victim Services and Homeless Services;

- all behavioral health contractors of HHS or CSA who provide mental health and/or addiction treatment services, as well as those agencies that serve people who are homeless;
- the Primary Care Coalition and its member organizations, Housing Opportunities Commission (HOC), Montgomery County Collaboration Council, Montgomery County Circuit Court, Montgomery County Department of Correction and Rehabilitation, Mental Hygiene and Alcohol and Drug Abuse Administrations of the State Department of Health and Mental Hygiene, Maryland Human Resources Department, and Maryland Department of Juvenile Services;
- Springfield Hospital Center and the local hospitals with addictions and/or psychiatric units;
- Montgomery County Public Schools and Montgomery College;
- On Our Own of Montgomery County, consumers recovering from co-occurring disorders, the National Alliance for the Mentally Ill (NAMI) Montgomery County Chapter, the Mental Health Association of Montgomery County and the Montgomery County Coalition for the Homeless.

### **CCISC Principles**

The CCISC model is based on the following eight clinical consensus best practice principles, which espouse an integrated clinical treatment philosophy that makes sense from the perspective of the mental health system, the substance disorder treatment system and other systems of care.

1. Co-occurring disorders are an expectation, not an exception. This expectation must be included in every aspect of system planning, program design, clinical procedure, and clinician competency, and it must be incorporated in a welcoming manner into every clinical contact.
2. The core of success in any setting is the availability of empathic, hopeful treatment relationships that provide integrated treatment and coordination of care during each episode of care, and, for people with the most complex needs, provide continuity of care across multiple treatment episodes.

3. Assignment of responsibility for provision of such relationships can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of the psychiatric and substance disorder.
4. In any treatment relationship, case management and care must be based on the client's impairment or disability. Case management and care must be balanced, including empathic detachment, confrontation, contracting, and opportunity for contingent learning. The specific manner in which these techniques are balanced must be based on the client's goals and strengths and the availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.
5. When mental illnesses and substance disorders co-exist, each disorder should be considered primary, and integrated dual primary treatment is required.
6. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that can be understood using a disease and recovery model. Each disorder has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. Treatment must be matched not only to diagnosis, but also to phase of recovery and stage of change. Appropriately matched interventions may occur at almost any level of care.
7. Consequently, there is no one correct co-occurring disorders program or intervention. For each individual, the proper treatment must be matched according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In continuous, comprehensive, integrated systems of care, **all programs are dual diagnosis programs** that at least meet minimum criteria of co-occurring disorders capability, but each program has a different "job", that is matched, using the above model, to a specific cohort of individuals.
8. Similarly, outcomes also must be individualized, including reduction in harm, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills, and treatment adherence.

### **CCISC Core Characteristics**

Using the above stated CCISC Principles, the participating entities have agreed to implement continuous, comprehensive, integrated systems of care in Montgomery County, with the following five core characteristics.

1. CCISC requires: that all of the listed participating entities are active in the CCISC development process; that all behavioral health (mental health and substance



disorders) service providers achieve at least Co-occurring Disorders Capability standards and in some instances Co-occurring Disorders Enhanced capacity; that cooperative arrangements are made, so that entities such as homeless service providers have access to clinicians with co-occurring disorders capabilities; and that **all service providers** plan services that respond to the needs of an appropriately matched cohort of individuals with co-occurring disorders.

2. CCISC will be implemented within the context of existing operational resources, by maximizing the capacity to provide continuous, comprehensive, integrated care proactively within each funding stream, contract, and service code.
3. CCISC will utilize, integrate and appropriately match the full range of evidence-based best practices and clinical consensus best practices for individuals with co-occurring psychiatric and substance disorders.
4. CCISC will incorporate an integrated treatment philosophy and common language using the eight principles listed above, and will develop specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the system of care.
5. CCISC will incorporate coordination and cooperation among behavioral health care providers (mental health and substance disorders), primary health care providers, other health care providers, housing providers, homeless service providers, the criminal justice system, protective services, consumers and advocates, and will consistently include consumers and advocates in decision-making processes.

### **CCISC Implementation Process as a Quality Improvement Initiative**

The participating entities will develop the implementation process for CCISC as a Quality Improvement (Q.I.) initiative in the system. The Q.I. initiative will:

- use a formal project evaluation component based on CO-FIT, a systems evaluation tool, to measure fidelity of the county-wide system to the CCISC model, at six month intervals during the course of the project;
- identify the prevalence and service utilization patterns of individuals with co-occurring disorders in Montgomery County; and
- measure outcomes, including but not necessarily limited to the outcomes described in CCISC Principle number eight above. Other outcomes may include reduced encounters with the criminal justice system, homeless shelters and hospitals, as well as increased consumer satisfaction and perceived quality of life. Consumers will be actively involved in the measurement and evaluation of outcomes.

## Agenda for Action

The participating agencies agree to the following agenda for action. Details, such as the exact timing of events, may vary.

1. The Co-occurring Disorders Steering Committee will organize implementation of this CCISC initiative by the participating entities. CDSC was appointed by the Director of the HHS Adult Addictions and Mental Health Division. It is chaired by the HHS Behavioral Health Manager. It includes: key HHS leadership; service provider, consumer and advocate representation; State behavioral health officials; and other individuals with specific knowledge that is applicable to the initiative.
2. During the Summer or early Fall of 2003, several representatives of the CDSC will identify and visit one or two sites in other States, where continuous, comprehensive, integrated systems of care are well established, to learn from their experience. CDSC representatives also will establish contact with those and other locations to discuss specific issues that Montgomery County faces and the manner in which others have addressed those issues.
3. During the Summer and Fall of 2003, the CDSC will begin to plan a co-occurring disorders training program for clinicians, other direct service staff, and managers, in cooperation with Dr. Ken Minkoff, Dr. Chris Cline, and a group of Maryland-based trainers with expertise in co-occurring disorders. (The CDSC's task for the Summer and and Fall of 2003 will be to begin planning a training program. The training program will be finalized by the CCISC Council in December, 2003.)

The training program, when it is finalized by the CCISC Council and then implemented, will be consistent with the CCISC model. The training will vary for each group (clinicians, other direct service staff, and managers). It will emphasize practical applications for direct service staff. It will address the varying roles of participating entities in implementation of the CCISC model. The approach will be to train groups of individuals within appropriate participating entities, so that they in turn will be able to train the people with whom they work.

The training program will include, but not be limited to, the following issues that relate to the development of policies and procedures: attitudes and values; welcoming policies; empathic, hopeful treatment relationships; the longitudinal approach; levels of care; phases of recovery; the four quadrant model for system level planning; scope of service guidelines; and matching behavioral health programs with cohorts of individuals.

The training program also will include, but not be limited to, the following clinical issues: matching specific best practice treatment techniques with individuals; screening and assessment; harm reduction principles, features and strategies; treatment planning; motivational interviewing and enhancement; cognitive behavioral therapy for people with co-occurring disorders; and

psychoeducational intervention techniques for people with co-occurring disorders and their families.

4. CDSC will begin convening meetings of a CCISC Council in October, 2003. The CCISC Council will be the forum for integrated system planning and program development activities. Each participating entity will appoint an appropriately empowered representative to the CCISC Council by August 31, 2003.
5. At the October, 2003 CCISC Council meeting, questions concerning CCISC and this Charter and Consensus Document will be addressed and discussed. The discussion will include but not be limited to: the CCISC model; CCISC principles and core characteristics; the varying roles of participating entities in implementation of the CCISC model; and the applicability or inapplicability of some specific action steps to specific entities. Also at the October meeting, the experiences of other jurisdictions will be discussed.

By November 30, 2003, each participating agency's CCISC Council representative will circulate this Charter and Consensus Document to his/her agency's staff and orient his/her agency's staff to it.

By December 31, 2003, each participating entity's Board of Directors, similar governing body, or other appropriate authority will adopt this Charter and Consensus Document as an official policy statement of the agency, and each participating agency will adopt the goal of achieving co-occurring disorders capability as part of the agency's short and long range strategic planning and quality improvement processes.

6. At the December, 2003 CCISC Council meeting, CCISC Council representatives will be oriented to three instruments: CO-FIT, COMPASS, AND CODECAT. CO-FIT is a systems evaluation tool, which measures a variety of indicators (such as multiple programs and locations) for their presence across the system. COMPASS is a program self evaluation tool, which is used by individual programs to develop their self assessments of their co-occurring disorders competencies and then to design specific action plans. CODECAT is a self survey instrument to assess the core co-occurring disorders competencies of clinicians.

The CCISC Council will discuss the purpose and content of the instruments, how they are completed, how to apply the information that they provide, and the meaning of that information for agencies, staff members and the overall system. The CCISC Council also will discuss and agree upon any adaptations of the instruments which may be necessary due to the varying roles of participating entities in implementation of the CCISC model. By January 30, 2004, each participating entity's representative will circulate the instruments to his/her staff and orient his/her staff to them.

7. Also at the December, 2003 CCISC Council meeting, the CCISC Council will begin discussing a process for identifying the prevalence, service utilization patterns and progress of individuals with co-occurring disorders in Montgomery County as part of the above-described quality improvement initiative. Data collection efforts, such as identifying prevalence, documenting matched treatment, and tracking client outcomes are core elements of the CCISC model, which anchor systemic change in the system. The discussion beginning at the December, 2003 meeting will address the first steps as a system: the kind of data on co-occurring disorders prevalence that is currently reported and the format and data base in which it is currently reported. That initial discussion also will address targets for identification and reporting. The full process will be developed incrementally by the CCISC Council.

At that meeting, the CCISC Council also will finalize the content of the training program.

Finally, at the December, 2003 meeting, the CCISC Council will begin discussing County contract revisions consistent with implementation of CCISC, and begin discussing reconciliation of CCISC with accreditation standards, regulations and funders' requirements.

8. In January, 2004, participating entities will administer CO-FIT, COMPASS, and CODECAT as a self survey to establish a baseline. Each entity will administer the instruments again at six month intervals to evaluate its own current status of co-occurring disorders capability. The findings will be used to identify entity specific training needs.
9. In February, 2004, the training program will begin for clinicians, other direct service staff, and managers. Training will be provided by Dr. Minkoff, Dr. Cline and the group of Maryland-based trainers. The training will occur over an extended period of time, rather than intensively over a short period of time. Training will be tied to implementation of systemic changes, such as development of welcoming policies, screening and assessment, and development of integrated teams, and will, therefore, be ongoing, rather than "front loaded". In keeping with this approach, the redesigning of policies, procedures and other structures will begin in or shortly after February, 2004. Thereafter, training sessions and system redesigning meetings will be held approximately every two months.
10. The participating entities further commit to the following ongoing action steps.
  - Develop an agency specific action plan outlining measurable changes at the agency level, the program level, the clinical practice level, and the clinician competency level to move toward co-occurring disorders capability. Monitor the progress of the action plan at six-month intervals.

Participate in system wide training and technical assistance with regard to implementation of the action plan.

- Participate in system wide efforts to improve welcoming access for individuals with co-occurring disorders by adopting agency specific welcoming policies, materials, and expected staff competencies.
- Participate in system wide efforts to promote the availability of integrated access and assessment at each treatment location by a) removing arbitrary access barriers; b) identifying staff with appropriate expertise in performing co-occurring disorder assessment (including psychopharmacologic assessment where applicable) on site in each service location; and c) developing specific procedures for providing integrated assessments in each service location.
- For one or more selected settings in which mental health and addiction treatment services are provided in one location, to participate in developing a model for implementation of an “integrated treatment team” for treatment planning and oversight in that location, as a pilot for implementation in the system as a whole.
- Participate in system wide efforts to promote consumer/peer involvement in providing dual recovery services by identifying concrete steps to promote the implementation of dual recovery meetings and/or dual recovery peer counseling activities in each program.
- Assign staff to participate in system wide efforts to develop co-occurring disorders capability standards, and systemic policies and procedures to support welcoming access in both emergency and routine situations.
- Assign appropriate clinical leadership to participate in interagency care coordination meetings as they are developed and organized.
- Participate in system wide efforts to identify required attitudes, values, knowledge, and skills for **all clinicians** regarding co-occurring disorders, and adopt the goal of co-occurring disorders competency for all clinicians as part of the entity’s long range plan.

# Kenneth Minkoff, M.D.

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## CCISC MODEL - COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

### Description

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

- 1. System Level Change:** The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.
- 2. Efficient Use of Existing Resources:** The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services to ICOPSD within the context of each funding stream, program contract, or service code, rather than requiring blending or braiding of funding streams or duplication of services. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance, and training.
- 3. Incorporation of Best Practices:** The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of ICOPSD. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system.
- 4. Integrated Treatment Philosophy:** The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder treaters.

## Principles

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating ICOPSD with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH - high CD (Quadrant III), high MH - low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting.

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)

7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

## Implementation

Implementation of the CCISC requires utilization of system change strategies (e.g., continuous quality improvement), in the context of an organized process of strategic planning, to develop the specific elements of the CCISC. Minkoff (2001) has described a "12 Step Program for Implementation of a CCISC" that defines this process sequentially, and, in collaboration with Cline, has organized a CCISC Implementation Toolkit that promotes the successful accomplishment of many of the specific steps. Implementation of the CCISC occurs incrementally in complex systems, over a period of years, and is characterized by establishment of the following elements, which reflect fidelity to the model.

**1. Integrated system planning process:** Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning



process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families.

**2. Formal consensus on CCISC model:** The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

**3. Formal consensus on funding the CCISC model:** CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.

**4. Identification of priority populations, and locus of responsibility for each:** Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

**5. Development and implementation of program standards:** A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stagewise implementation. Program competency assessment tools (e.g., COMPASS (Minkoff & Cline, 2001)) can be helpful in both development and implementation of DDC standards.

**6. Structures for intersystem and interprogram care coordination:** CCISC

implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

**7. Development and implementation of practice guidelines:** CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (Minkoff, 1998; Arizona DHS, 2001) are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation, (See items 8 and 9).

**8. Facilitation of identification, welcoming, and accessibility:** This requires several specific steps: 1. modification of MIS capability to facilitate and incentivize identification, reporting, and tracking of ICOPSD. 2. development of "no wrong door" policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible. 3. Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

**9. Implementation of continuous integrated treatment:** Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected "scope of practice" for singly licensed clinicians regarding co-occurring disorder, and incorporated into standards of practice for reimbursable clinical interventions - in both mental health and substance settings - for individuals who have co-occurring disorders

**10. Development of basic dual diagnosis capable competencies for all clinicians:** Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for

beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT, Minkoff & Cline, 2001) can be utilized to facilitate this process.

**11. Implementation of a system wide training plan:** In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career ladders for advanced certification, and opportunities for experiential learning. Train-the-trainer curricula have been developed, or are being developed, in a variety of states, including Connecticut, New York, New Mexico, and Arizona.

**12. Development of a plan for a comprehensive program array:** The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:

- a. **Evidence based best practice:** There needs to be a specific plan for initiating at least one Continuous Treatment Team (or similar service) for the most seriously impaired individuals with SPMI and substance disorder. This can occur by building dual diagnosis enhancement into an existing intensive case management team.
- b. **Peer dual recovery supports:** The system must identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous, Double Trouble in Recovery) and establish a plan to facilitate the creation of these groups throughout the system.
- c. **Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:
  1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs).
  2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.
  3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
  4. Consumer - choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness
- d. **Continuum of levels of care:** All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization.

**CCISC implementation requires a plan which includes attention to each of these areas in a comprehensive service array.**

HOUSE BILL 433

Unofficial Copy  
J1

2003 Regular Session  
(3lr1362)

**ENROLLED BILL**

-- *Health and Government Operations/Finance* --

Introduced by **Delegates Nathan-Pulliam, Barkley, Burns, C. Davis, Harrison, Jones, McDonough, Murray, Paige, and ~~V. Turner~~ V. Turner, Hurson, Hammen, Benson, Boutin, Bromwell, Costa, Donoghue, Elliott, Goldwater, Haynes, Hubbard, Kach, Mandel, Morhaim, Oaks, Pendergrass, Redmer, Rosenberg, Rudolph, Smigiel, and Weldon**

Read and Examined by Proofreaders:

\_\_\_\_\_  
Proofreader.

\_\_\_\_\_  
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this \_\_\_\_\_ day of \_\_\_\_\_ at \_\_\_\_\_ o'clock, \_\_\_\_\_ M.

\_\_\_\_\_  
Speaker.

CHAPTER \_\_\_\_\_

1 AN ACT concerning

2 **Task Force on the Needs of Persons with Co-Occurring Mental Health**  
3 **Illness and Substance Abuse Disorders**

4 FOR the purpose of establishing a Task Force on the Needs of Persons with  
5 Co-Occurring Mental Health Illness and Substance Abuse Disorders; providing  
6 for the composition of the Task Force; requiring the Task Force to elect a  
7 chairman and vice-chairman of the Task Force from among the Task Force's  
8 members; requiring the Mental Hygiene Administration and the Alcohol and  
9 Drug Abuse Administration to provide staffing for the Task Force; prohibiting  
10 members from receiving compensation but entitling members to reimbursement  
11 of expenses under a certain law; requiring the Task Force to study and make  
12 recommendations regarding certain ways of delivering certain services, securing  
13 funding, and providing certain training to a certain population; requiring the

1 Task Force to submit certain reports to the Governor and certain committees on  
 2 or before certain dates; requiring the Mental Hygiene Administration to conduct  
 3 a certain study and submit a certain report to certain committees on or before a  
 4 certain date; providing for the termination of this Act; and generally relating to  
 5 a Task Force on the Needs of Persons with Co-Occurring Mental Health Illness  
 6 and Substance Abuse Disorders.

7 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF  
 8 MARYLAND, That:

9 (a) There is a Task Force on the Needs of Persons with Co-Occurring Mental  
 10 Health Illness and Substance Abuse Disorders.

11 (b) The Task Force consists of the following members appointed by the  
 12 Governor:

- 13 (1) one representative of the Mental Health Administration;
- 14 (2) one representative of the Alcohol and Drug Abuse Administration;
- 15 (3) one representative of the Department of Human Resources;
- 16 (4) one social worker from the Department of Social Services;
- 17 (5) one representative of the Department of Rehabilitative Services;
- 18 (6) one representative of the AIDS Administration;
- 19 (7) one representative of the Department of Juvenile Justice;
- 20 (8) one representative of the Faith-Based Community Providers;
- 21 (9) one representative of the Department of Housing and Community  
 22 Development;
- 23 (10) one representative of the Department of Public Safety and  
 24 Correctional Services;
- 25 (11) one State court judge;
- 26 (12) one representative of the State's Attorney's Office;
- 27 (13) one representative from the Public Defender's Office;
- 28 (14) one representative who is a consumer of co-occurring disorder  
 29 services or who has a family member who uses such services;
- 30 (15) one representative of the Co-Occurring Disorders Workgroup of the  
 31 National Council on Alcoholism and Drug Dependence, Inc. - Maryland and Mental  
 32 Health Association of Maryland;

1 (16) one representative from the Maryland Psychiatric Society;

2 (17) one representative from the Maryland Nurses Association; ~~and~~

3 (18) one representative from the Maryland Hospital Association;

4 (19) one representative from the Community Behavioral Health  
5 Association of Maryland;

6 (20) one representative from the Maryland Legislative Council of Social  
7 Workers; and

8 (21) one representative from the Maryland Psychological Association;

9 (22) one representative from the State's Public Academic Health Center;  
10 and

11 ~~(18)~~ ~~(21)~~ ~~(23)~~ two consumers.

12 (c) The members of the Task Force shall elect the chairman and  
13 vice-chairman from among the Task Force's members.

14 (d) The Mental Hygiene Administration and the Alcohol and Drug Abuse  
15 Administration shall provide staff for the Task Force.

16 (e) A member of the Task Force:

17 (1) may not receive compensation; but

18 (2) is entitled to reimbursement for expenses under the Standard State  
19 Travel Regulations, as provided in the State budget.

20 (f) The Task Force shall:

21 (1) identify and recommend creative ways to provide and deliver  
22 comprehensive, integrated, cost-effective services to the population with co-occurring  
23 mental health *illness* and substance abuse disorders;

24 (2) identify and recommend various methods of funding services through  
25 private and public sources;

26 (3) make recommendations regarding both short-term and long-term  
27 residential services for people with co-occurring disorders, including  
28 recommendations on the number of units needed and a timeline for providing  
29 residential services;

30 (4) make recommendations regarding how the Mental Hygiene  
31 Administration and Alcohol and Drug Abuse Administration may implement  
32 cross-training for mental health *illness* and addiction counselors; and

1 (5) make recommendations regarding necessary legislation to implement  
2 the Task Force's recommendations.

3 (g) (1) The Task Force shall issue an interim report of its findings and  
4 recommendations to the Governor and, subject to § 2-1246 of the State Government  
5 Article, the Senate Education, Health, and Environmental Affairs Committee and the  
6 House Health and Government Operations Committee on or before December 1, 2004.

7 (2) The Task Force shall issue a final report on its findings and  
8 recommendations to the Governor and, subject to § 2-1246 of the State Government  
9 Article, the Senate Education, Health, and Environmental Affairs Committee and the  
10 House Health and Government Operations Committee on or before December 1, 2005.

11 SECTION 2. AND BE IT FURTHER ENACTED, That:

12 (a) The Mental Hygiene Administration shall conduct or commission a study  
13 on the relationship between substance abuse and mental illness among counties in  
14 Maryland.

15 (b) When appropriate, the study shall utilize existing resources and data  
16 available from such entities as the Maryland Health Care Commission and the Task  
17 Force to Study Increasing the Availability of Substance Abuse Treatment.

18 (c) The Mental Hygiene Administration shall report to the Governor, the  
19 Maryland Legislative Black Caucus, the Senate Education, Health, and  
20 Environmental Affairs Committee, *the Senate Finance Committee*, and the House  
21 Health and Government Operations Committee on or before January 1, 2004, in  
22 accordance with § 2-1246 of the State Government Article, on the findings and  
23 recommendations of the study.

24 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect  
25 October 1, 2003. It shall remain effective for a period of 2 years and 3 months and, at  
26 the end of December 31, 2005, with no further action required by the General  
27 Assembly, this Act shall be abrogated and of no further force and effect.

## Diagnosis Categories and ICD-9 Codes Per Maryland Health Partners

### Alcohol and Substance Abuse Disorders

Diagnosis Category Description	ICD Code	ICD Description
Alcohol-Induced Disorder	291.0	Alcohol withdrawal delirium
Alcohol-Induced Disorder	291.1	Alcohol amnesic syndrome
Alcohol-Induced Disorder	291.2	Other alcoholic dementia
Alcohol-Induced Disorder	291.3	Alcohol withdrawal hallucinosis
Alcohol-Induced Disorder	291.4	Idiosyncratic alcohol intoxication
Alcohol-Induced Disorder	291.5	Alcoholic jealousy
Alcohol-Induced Disorder	291.8	Other specified alcoholic psychosis
Alcohol-Induced Disorder	291.9	Unspecified alcoholic psychosis
Alcohol-Induced Disorder	303.0	Acute alcoholic intoxication
Alcohol-Induced Disorder	303.7	Alcohol dependence syndrome
Alcohol-Induced Disorder	303.9	Other unspecified alcohol dependence
Alcohol-Induced Disorder	305	Alcohol abuse
Alcohol-Induced Disorder	305.0	Alcohol abuse
Substance-Induced Disorder	292.0	Drug withdrawal syndrome
Substance-Induced Disorder	292.1	Paranoid and/or hallucinatory states induced by drugs
Substance-Induced Disorder	292.2	Pathological drug intoxication
Substance-Induced Disorder	292.8	Other specified drug-induced mental disorders
Substance-Induced Disorder	292.9	Drug-induced mental disorder
Substance-Induced Disorder	304	Substance abuse related disorder
Substance-Induced Disorder	304.0	Opioid type dependence
Substance-Induced Disorder	304.1	Barbiturate and similarly acting sedative or hypnotic dependence
Substance-Induced Disorder	304.2	Cocaine dependence
Substance-Induced Disorder	304.3	Cannabis dependence
Substance-Induced Disorder	304.4	Amphetamine and other psycho stimulant dependence
Substance-Induced Disorder	304.5	Hallucinogen dependence
Substance-Induced Disorder	304.6	Other specified drug dependence
Substance-Induced Disorder	304.7	Combinations of opioid type drug with any other
Substance-Induced Disorder	304.8	Combinations of drug dependence
Substance-Induced Disorder	304.9	Unspecified drug dependence
Substance-Induced Disorder	305.1	Tobacco use disorder
Substance-Induced Disorder	305.2	Cannabis abuse
Substance-Induced Disorder	305.3	Hallucinogen abuse
Substance-Induced Disorder	305.4	Barbiturate or hypnotic abuse
Substance-Induced Disorder	305.5	Opioid abuse
Substance-Induced Disorder	305.6	Cocaine abuse
Substance-Induced Disorder	305.7	Amphetamine abuse
Substance-Induced Disorder	305.8	Antidepressant type abuse
Substance-Induced Disorder	305.9	Other, mixed or unspecified drug abuse