

OMH/OASAS TASK FORCE ON CO-OCCURRING DISORDERS: BACKGROUND AND OPENING PHASE RECOMMENDATIONS

December 2007

Background

To better meet the needs of individuals with co-occurring mental health and substance use disorders and their families, the Commissioners of the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) announced the creation of a statewide Task Force on Co-Occurring Disorders on June 13, 2007. The Task Force – composed of consumers, families, broad representation from mental health and chemical dependency organizations, – and staff from OMH and OASAS - has been co-chaired by Lloyd I. Sederer, MD, of OMH and Frank McCorry, PhD, of OASAS.

The Task Force, based on its charge from Commissioners Hogan and Carpenter-Palumbo, unequivocally supports three commitments made by their State agencies:

1. A commitment to identify and address limitations and barriers that people with co-occurring mental and chemical dependency disorders, and their families, experience when seeking care in the OMH and OASAS service systems in NYS.
2. A commitment to recovery-oriented care that is consumer driven, based on hope and delivered with dignity, that recognizes the critical role of family and other relationships in a person's life, and recognizes that the ability to be gainfully employed and contribute to one's community are essential to quality of life and to self-regard.
3. A commitment to culturally and linguistically competent care in light of the great diversity of the population of NYS and the recognition that care cannot be successfully provided unless it is provided with these competencies.

Why focus on improving services for people with co-occurring disorders?

In any given year, 2.5 million adults in the nation have a co-occurring serious mental illness and substance abuse disorder (NSDUH, 2004). Between 40-60 percent of individuals presenting in mental health settings have a co-occurring substance abuse diagnosis and 60-80 percent of individuals presenting in a substance abuse facility have a co-occurring mental health disorder (Mueser, et al. 2006). The Table below depicts the 2003 rate of co-occurring disorders for individuals served in the OMH and OASAS systems. Because OMH and OASAS programs have not been required to report or record more than one diagnosis per individual, the rates identified in the Table are presumed to reflect a significant under-count. Importantly, this Table also does not reflect the number of individuals with co-occurring disorders who are *not* seen in either service system – which we presume to be significant.

Treatment-Based Prevalence Rates of Individuals with Co-occurring Disorders in New York State						
	For Recipients Seen in the Mental Health System During One Week in 2003			For Admissions to the Substance Abuse System During the Year 2003**		
	Total Number	Number with SA Diagnosis or Disability	Rate	Total Number	Number with Mental Illness	Rate
Total*	171,363	30,714	.18	209,365	62,953	.30
Inpatient	14,076	3,814	.27	40,842	16,487	.40
Residential	24,165	8,140	.34	20,669	4,680	.22
Emergency	3,916	1,021	.26	N/A	N/A	N/A
Outpatient	115,142	17,631	.15	131,281	37,316	.28
Comm. Support	48,722	12,333	.25	N/A	N/A	N/A
Methadone Maintenance	N/A	N/A	N/A	16,573	4,470	.27

* Because of overlap among programs, the total is less than the sum of program classes.

** OASAS Client Data System, April 2006

According to Robert Drake, MD, PhD, the consequences of co-occurring disorders, particularly when untreated or poorly treated, are severe. They include: increased risk of heart disease, diabetes, pulmonary disease, HIV/AIDS, hepatitis and other medical conditions; high cost of healthcare due to high inpatient use and inability to adhere to treatment; loss of \$100 billion in productivity; increased risk of suicide; crime victimization; homelessness; incarceration; and juvenile delinquency.

The benefits of treating both disorders are also well documented. Integrated treatment has been found to be more effective than non-integrated care (McHugo et. al, 1999); it has been shown to improve substance use outcomes with the majority of patients receiving integrated care achieving abstinence or substantially reducing harm from substance abuse. Most individuals experience improvements in independent living, control of symptoms, competitive employment, social contacts with non-substance users, and overall expression of life satisfaction (Drake 2006). Unfortunately, Dr. Drake has also stressed that 50 percent of individuals with co-occurring serious mental illness and substance use disorders receive no care; 45 percent receive poor care; and only five percent receive evidence-based care, a disturbing state of affairs.

The Work of the COD Task Force

Representatives from varied constituencies and geographies from throughout NYS were invited to participate in this time-limited and focused Task Force. In addition, experts in the field of co-occurring disorders treatment and evaluation were invited to serve as resources to the Task Force by attending the group's meetings and being available for consultation. They include Robert Drake, MD, PhD, and Mark McGovern, PhD, of Dartmouth Medical School; Stan Sacks, PhD, and Richard Rosenthal, MD, of the Co-Occurring Center of Excellence; and Mary Jane Alexander, PhD, of the Nathan Kline Institute.

At its first meeting on June 29, the Task Force was charged by Commissioners Hogan and Carpenter-Palumbo with considering the current ambulatory system of care within OMH and

OASAS and then providing the Commissioners, in September, a set of meaningful, measurable and actionable recommendations that can be implemented in a timely manner to improve the care of people with co-occurring disorders. At the first (of three) meetings of the Task Force, Dr. McGovern delivered a presentation on “Assessing the Capacity of Treatment Services for Persons with Co-Occurring Disorders.” Consequent discussion at this meeting led to the formation of two workgroups, one clinical and one infrastructure, to each offer a limited number of recommendations for review at the second Task Force meeting. The following list of “Clients and families can...” goals or principles statements for both OMH and OASAS was established at the first meeting to help ensure that the Task Force and workgroup discussions remained faithful to their charge of putting clients and families first. Our common goal is that:

Clients and families can...

- Access care anywhere in OMH and OASAS-licensed programs;
- Receive one evaluation;
- Learn if they have a co-occurring disorder;
- Learn about treatment options;
- Collaborate in establishing a single treatment plan;
- Receive evidence or consensus-based treatment (or referral); and
- Participate in recovery-oriented care.

These client-focused goals served as a touchstone for the Task Force, and we hope will do so hereafter. They will provide a measure by which to examine all action steps to determine if they indeed serve the needs of recipients of care.

At the second meeting of the Task Force on July 17, Dr. Drake delivered a presentation entitled “Co-Occurring Mental Illness and Substance Use Disorder.” He discussed the prevalence of dual disorders in treatment programs and the field’s increased focus and research on the topic. Dr. Drake emphasized the increased success when an integrated treatment approach is utilized for individuals with serious mental illness instead of a parallel treatment approach, and stressed the need for long-term care, which not only improves recovery rates, but saves money. He also stressed that rather than continuing to refine the evidence-based care that only five percent of those in need currently receive, that the emphasis of the Task Force’s effort should be to improve the shameful state of access and care for the remaining 95 percent.

At this meeting, the Task Force reviewed the recommendations of the Clinical and Infrastructure Workgroups, and identified a set of what it refers to as “Phase I” Recommendations – that is, action steps that can be taken by June 30, 2008 as a “down-payment” on a more comprehensive and multiyear effort. The Task Force is committed to fixing what we can now and creating and sustaining momentum for ongoing and systemic changes. The Phase I recommendations are summarized below. These recommendations clearly complement what is well known about the necessity of housing, family involvement, work, and peer and other community supports in the recovery of people with dual disorders. In addition, the Task Force also wishes to highlight the importance of local innovation as brought forward by county government, provider and consumer agencies; there is much that is going on in New York State that can inform and lead efforts at improving the care of people with co-occurring disorders.

The work of the Task Force, and the interagency work that ensues, should be transparent to the public. Regular reports, perhaps issued through the OMH and OASAS websites, may be a good means of communicating the work underway and of helping to assure fidelity to the values, principles and goals put forth by the Commissioners when they undertook to improve the care of people with co-occurring disorders.

The attached Table itemizes the Phase I recommendations of the Task Force, which take us to June 30, 2008. Phase I Recommendations are those the Task Force considered feasible in this time period and are actions that will set the platform for the multi-year efforts needed to meet the full charge of the Commissioners. The recommendations are grouped into four categories: clinical; regulatory; fiscal; and systemic recommendations. While there are likely overlapping aspects of these categories, this construction was thought to best represent the work areas ahead, as well as to practically organize the action steps the Task Force seeks to advance.

REFERENCES

- Alexander, MJ., Haugland, MA., Friedman, MB. (2007) *Co-Occurring Severe Mental Illness and Substance Abuse: A Policy Background Book*. Center for Policy and Advocacy of Mental Health Associations of New York City and Westchester.
- Drake, RE., McHugo, Xie, H., Fox, M., Packard, J., Helmsletter, B. (2006) Ten- Year Recovery Outcomes for Clients with Severe Mental Illness. *Schizophrenia Bulletin* 32: 464-473.
- McHugo, GJ., Drake, RE., Teague, GB., Xie, H. Fidelity to Assertive Community Treatment and Outcome in the New Hampshire Dual Disorders Study. *Psychiatric Services* 50: 818-824.
- Mueser, KT., Drake, RE., Turner, WC., & McGovern, MP. Comorbid Substance Use Disorders and Psychiatric Disorders. In W.R. Miller & K.M. Carroll (Eds.). *Rethinking Substance Abuse: What the Science Shows, And What We Should Do About It.* (pp. 115-133). New York: Guilford Press, 2006.
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- Sacks, S., & Ries, RK., (Eds.) (2005). *Substance Abuse Treatment for Persons with Co-occurring Disorders: A Treatment Improvement Protocol (TIP)* (DHHS Pub. No. [SMA] 05-3992). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

PHASE I RECOMMENDATIONS

SUBJECT: CLINICAL

GOAL	ACTION	POTENTIAL STEPS	RESPONSIBLE ENTITY/PERSON	TARGET COMPLETION DATE
<p>A. Individuals with co-occurring disorders will receive evidence-based practices (EBPs) in mental health and chemical dependency programs</p> <p>B. Develop and support a provider and consumer workforce proficient in identifying, assessing and treating co-occurring disorders</p> <p>C. Lead New York State in its adoption of person-centered planning and treatment</p>	<p>Establish a Clinical Advisory Group to identify and recommend which EBPs and clinical instruments be adopted and implemented in mental health and chemical dependency programs</p> <p>Develop and support treatment planning and service delivery that is person-centered</p>	<ol style="list-style-type: none"> 1. OMH and OASAS adopt standardized tools and protocols (such as IDDT and/or ASAM Dual Disorders placement criteria and the DDCAT) 2. Implement EBPs and standardized screening and assessment instruments by effective technology transfer methods and assess use by measuring processes and outcomes of care 3. Charge the Clinical Advisory Group with recommending initiatives to promote workforce development 4. Establish and implement a training plan using existing curricula focused on clinical agency leadership and clinical supervisors, with a train the trainer strategy 5. Identify and implement a web-based training course for all clinical staff 6. Create and disseminate a common education package for consumers and families 7. Pair all clinical action steps with a summary of expected fiscal implications, to the extent possible, in order to provide practice improvements with the support they will need 8. Increase use of peers as providers 9. Implement dual recovery and mutual support fellowship groups in peer settings 10. Adopt consumer-based decision support as an active component of clinical care (e.g., the work of Dr. Patricia Deegan) 	<p>OMH/OASAS Implementation Committee (co-chairs appointed by agency Commissioners)</p> <p>(Subject matter leads to also be appointed as necessary)</p>	<p>06/30/08</p> <p>(earlier dates may be identified by the Implementation Committee for some steps)</p>

Each of the above recommendations seek to ensure that clients and families can...

- Access care anywhere in OMH and OASAS-licensed programs
- Receive one evaluation
- Learn if they have a co-occurring disorder
- Learn about treatment options
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- Receive evidence or consensus-based treatment (or referral)
- Participate in recovery-oriented care

PHASE I RECOMMENDATIONS SUBJECT: REGULATORY

GOAL	ACTION	POTENTIAL STEPS	RESPONSIBLE ENTITY/PERSON	TARGET COMPLETION DATE
<p>Improve access and provide effective treatment of co-occurring disorders in existing dually and singly licensed OMH and OASAS programs – as a first step towards achieving single site integrated co-occurring disorder programs</p>	<p>Initiate needed regulatory changes pertaining to OMH and OASAS by convening an interagency workgroup, with provider and consumer representation, to review and compare regulations between the two agencies and to construct a plan for needed changes to ensure that clients and families come first</p>	<ol style="list-style-type: none"> 1. Issue a summary of OMH and OASAS regulatory standards and identify needed common standards and requirements, including staff, space, case records and licensure 2. Identify conflicts in regulations and implement needed revisions 3. Identify and implement the regulatory changes needed to support a common screening tool or a limited menu of tools 4. Identify and implement the regulatory changes needed to support a common clinical assessment or set of recommended assessment guidelines 5. Identify and implement the regulatory changes needed to support a common education package for consumers and families 	<p>OMH/OASAS Implementation Committee</p> <p>(Subject matter leads to also be appointed as necessary)</p>	<p>01/15/08</p> <p>(earlier dates may be identified by the Implementation Committee for some steps)</p>

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PHASE I RECOMMENDATIONS

SUBJECT: FISCAL

GOAL	ACTION	POTENTIAL STEPS	RESPONSIBLE ENTITY/PERSON	TARGET COMPLETION DATE
Ensure that programs are fairly and adequately reimbursed for quality services based on the best available evidence	Identify the causes of billing and regulatory barriers to reimbursement and recommend actions for resolution or improvement	<ol style="list-style-type: none"> 1. DOH, OMH, OASAS revise reimbursement methodologies to create appropriate rates to support EBPs 2. Remove fiscal barriers to effective care, for example: <ul style="list-style-type: none"> -Modify no-second-day service rule in OASAS-certified programs - Waive OASAS regulation 822.11 that prohibits collateral visits when collateral is not admitted (present) - Identify and implement reimbursement mechanism(s) for case management services in OASAS settings - Reimburse off-site evaluations for assessment and treatment - Reimburse effective peer services 	OMH/ OASAS Implementation Committee (with DOH participation as necessary) (Fiscal and regulatory leads to be appointed)	Issue report by 01/15/08

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PHASE I RECOMMENDATIONS SUBJECT: SYSTEMIC SUPPORT

GOAL	ACTION	POTENTIAL STEPS	RESPONSIBLE ENTITY/PERSON	TARGET COMPLETION DATE
<p>A. Encourage local innovation</p> <p>B. Promote, advance and sustain the change process by monitoring and advocating for its implementation, as well as providing ongoing consultation and recommendations</p> <p>C. Identify and adopt technology transfer and culture change methodologies</p>	<p>OASAS and OMH issue an RFA for innovation (and reinvestment) from government, provider and professional agencies as well as other constituent groups</p> <p>The Commissioners will appoint an Advisory Panel including consumers, family members, providers, staff from OMH and OASAS, and other concerned stakeholders</p> <p>Identify effective means of supporting system change and plan and implement these methods</p>	<ol style="list-style-type: none"> 1. Allow “braided” (complementary) funding and permit local government units greater flexibility in the use of multiple funding streams, including reinvestment of some of the savings achieved 2. Accept budget-neutral proposals for local innovative programs or models, also allowing for local reinvestment of savings 3. Implement innovative provider program proposals, waiving regulatory requirements when necessary and permissible 4. The Advisory Panel will meet regularly to review implementation of Phase I Recommendations 5. OMH and OASAS will regularly report on the work underway and accomplishments through their respective Commissioners’ Offices. 6. Charge OMH and OASAS with proposing a multi-year plan for technology transfer and for culture change 	<p>OMH/OASAS Implementation Committee</p> <p>(Subject matter leads to also be appointed as necessary)</p> <p>Advisory Panel</p>	<p>Issue RFA by 03/31/08</p>

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