Florida Department of Children and Families
Policy Paper on
Co-occurring Mental Health and Substance Abuse Disorders

Jeb Bush, Governor **Jerry Regier, Secretary**

LETTER FROM THE DIRECTORS

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Acknowledgement

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Purpose 1

Background 1

The National Perspective on

Florida Department of Children and Families (DCF)

Policy Paper on

Co-occurring Mental Health and

Substance Abuse Disorders

***GUIDING QUESTION**: "If I were an individual with co-occurring mental health and substance abuse disorders in Florida, what type of service delivery system would best meet my needs?"*

PURPOSE

BACKGROUND

- **10 million people in the U.S. have co-occurring substance abuse and mental health disorders**

- **up to 65.5% of those with a substance dependence disorder had at least one mental disorder, and 51% of those with a mental disorder had at least one substance**

dependence disorder. These percentages tend to be even higher in clinical treatment settings, especially in public mental health and substance abuse treatment settings.

- **clients with co-occurring disorders should be the "expectation, not the exception,"**

- **The majority of people with co-occurring disorders receive no treatment . Treatment that is received typically only addresses one type of disorder, which has been found to be less effective than integrated treatment of both types of disorders at the same time in the same setting.**

- **multiple co-occurring disorders and problems , which often lead to greater costs for public services**

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leading to increased public costs

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primary cause of relapse into mental illness is untreated substance abuse, and the primary cause of relapse into substance abuse is untreated mental illness

Á **The Connection Between Addictive and Mental Disorders**

THE NATIONAL PERSPECTIVE ON CO-OCCURRING DISORDERS

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National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders.

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Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders

Á **SAMHSA Position Statement on Use of Substance Abuse Prevention and Treatment Block Grants (SAPTBG) and Community Mental Health Services Block Grant (CMHSBG) Funds to Treat People with Co-Occurring Disorders**

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GUIDING PRINCIPLES OF EFFECTIVE SERVICES FOR CO-OCCURRING DISORDERS

Desirable Co-occurring Treatment System Characteristics

Philosophy

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Service Delivery System

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Funding

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Four Quadrant Model: Co-occurring Disorders by Severity (Figure 1)

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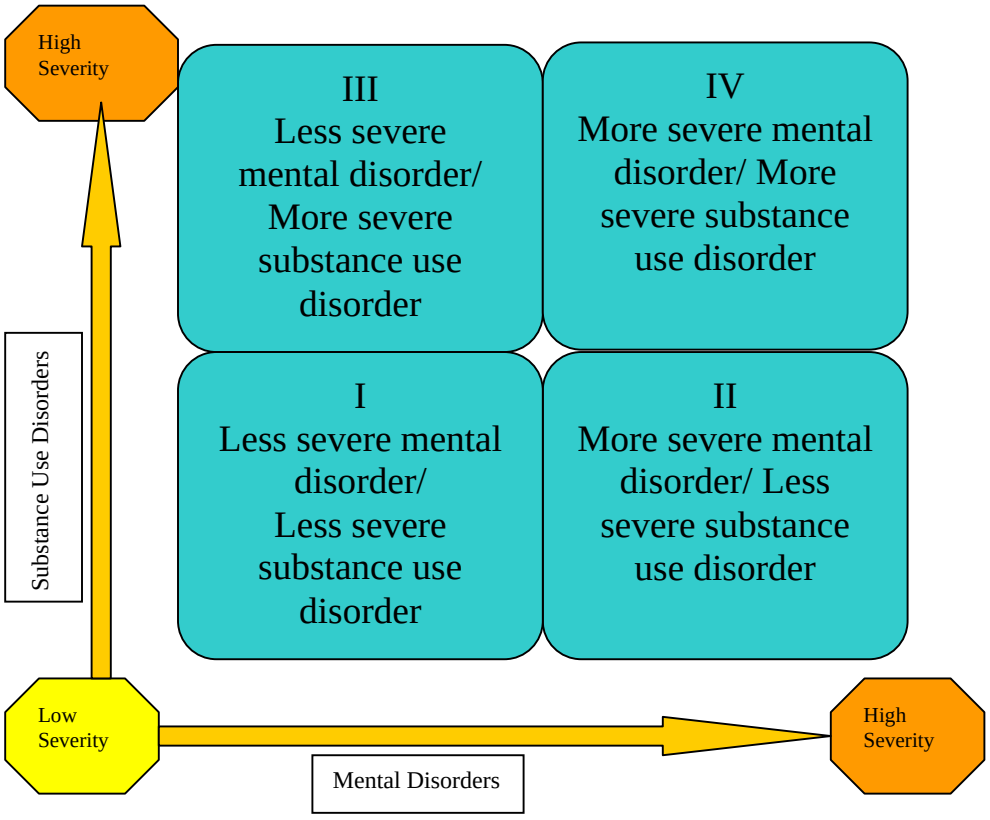
Figure 1

Co-occurring Disorders by Severity



Case Mix and Risk Adjustment, Including Adjustment of Performance Outcome Standards and Service Rates for Co-occurring Disorders

STRATEGIC IMPLEMENTATION PLAN

Action Step 1: Develop an Integrated System Planning Process and Structure

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Action Step 2: Continue to Implement Current Projects in Florida Related to Improving Services for Co-occurring Disorders

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Additional Action Steps- Minkoff's 12 Steps of Implementation of CCISC Model

Attachment A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE (CCISC) MODEL

Principles

1. Dual diagnosis is an expectation, not an exception.

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.

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

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.

5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual

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2. Formal Consensus on CCISC Model

3. Formal Consensus on Funding the CCISC Model

4. Identify Priority Populations and Focus of Responsibility for Each

5. Develop and Implement Program Standards

6. Structures for Intersystem and Inter-Program Care Coordination

10. **Develop Basic Dual Diagnosis Capable Competencies for all Clinicians**

11. **Implement a System Wide Training Plan**

d. Continuum of levels of care:

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

Attachment B

AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRY (AACP) POSITION STATEMENT ON PROGRAM COMPETENCIES IN A COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

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Introduction

DDC-CD:

1. **Mission and Philosophy**

2. **Screening for Co-morbidity**

4. **Diagnosis and Treatment Planning**

Ex. Problem:
Goal:
Objective

5. **Documentation**

6. **Programming**

DDE-CD:

1.
2.
3.
4.
5.

1. **Mission and Philosophy**

2. **Screening for Co-morbidity**

3. **Assessment**

4. **Treatment Planning**

5. **Substance Disorder Consultation**

6. **Continuity**

7. **Stage-Specific Treatment**

8. **Competencies**

9. **Collaboration with CD Clinicians**

10. **Discharge Planning**

DDE-MH:

1.

2.

3.

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring disorder) who need housing assistance due to

Attachment C

Different Treatment Models for Co-occurring Disorders

- **No Treatment**
- **Sequential Treatment**
- **Parallel Treatment**
- **Integrated Treatment**

Which Treatment Model Works Best?

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integrated, long-term, comprehensive treatment programs, which include assertive outreach and motivational interventions, are most likely to

- **Longitudinal Perspective**

- **Stable Living Situation**

- **Harm Reduction Strategies**

- **Stages of Treatment**

A. <u>Engagement</u>

B. <u>Persuasion</u>

C. <u>Active Treatment</u>

D. <u>Relapse Prevention</u>

- **Cultural Competency and Consumer Centeredness**

- **Optimism and Recovery**

References