

DC COSIG: Using Co-Occurring Disorder Screening & Assessment to Drive Systems Change

**State System Development Program (SSDP VIII) Conference
Partnering to Support Recovery-Oriented Systems of Care**

The Center of Substance Abuse Treatment of the
Substance Abuse and Mental Health Services Administration
Hyatt Regency Washington DC

William Reidy, MSW

Deputy Director DC-COSIG

District of Columbia Dept. of Mental Health

August 20, 2008

What is DC COSIG?

- A cross-agency systems change initiative
- Funded by a SAMHSA COSIG award
Sept 1, 2005 thru Aug 31, 2010
- \$ 1,057,565 / year for 3 years
- Year 4 & 5 funded only for Evaluation by
George Washington Univ.
- COSIG Partners DC Dept of MH, DC Dept
of Health/ Addiction Prevention & Recovery
Admin, and George Washington University

DC COSIG GOAL:

Create a sustainable interagency collaboration to Change the
DC Public Mental Health and Substance Use Treatment
System

to

support integrated service delivery

so that by August 31, 2010 there will be

NO WRONG DOOR

to effective treatment for individuals

with co-occurring mental and substance use disorders.

What is the basic need in DC?

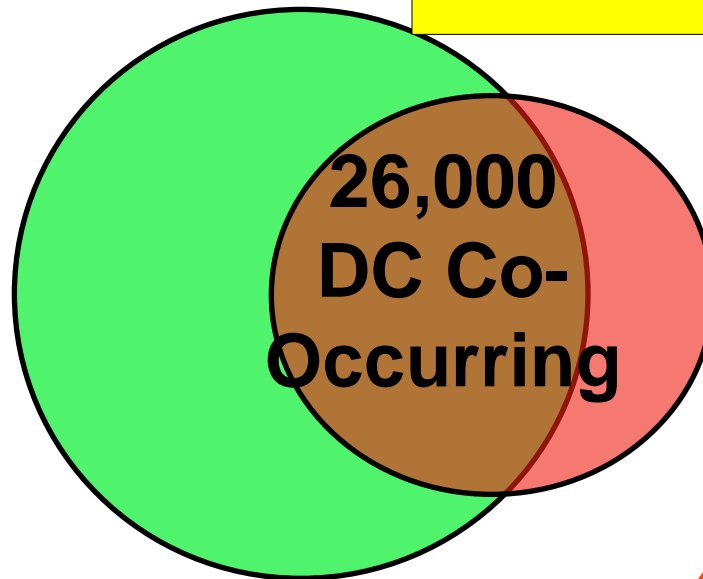
APRA's 2000 Household Survey
Population 572,059

Serious drug or Alcohol	11%	64,000
Serious Mental Illness	6.8%	40,000

Significant Overlap of Illnesses

40% of substance abusers have mental illnesses

66% of mentally ill also abuse substances



64,000 substance abusers in DC

40,000 mentally ill In DC

Risk of Co-Occurring Disorders

Epidemiologic Catchment Area Study Found:

Having a mental disorder **triples** the risk of having a co-occurring substance use disorder

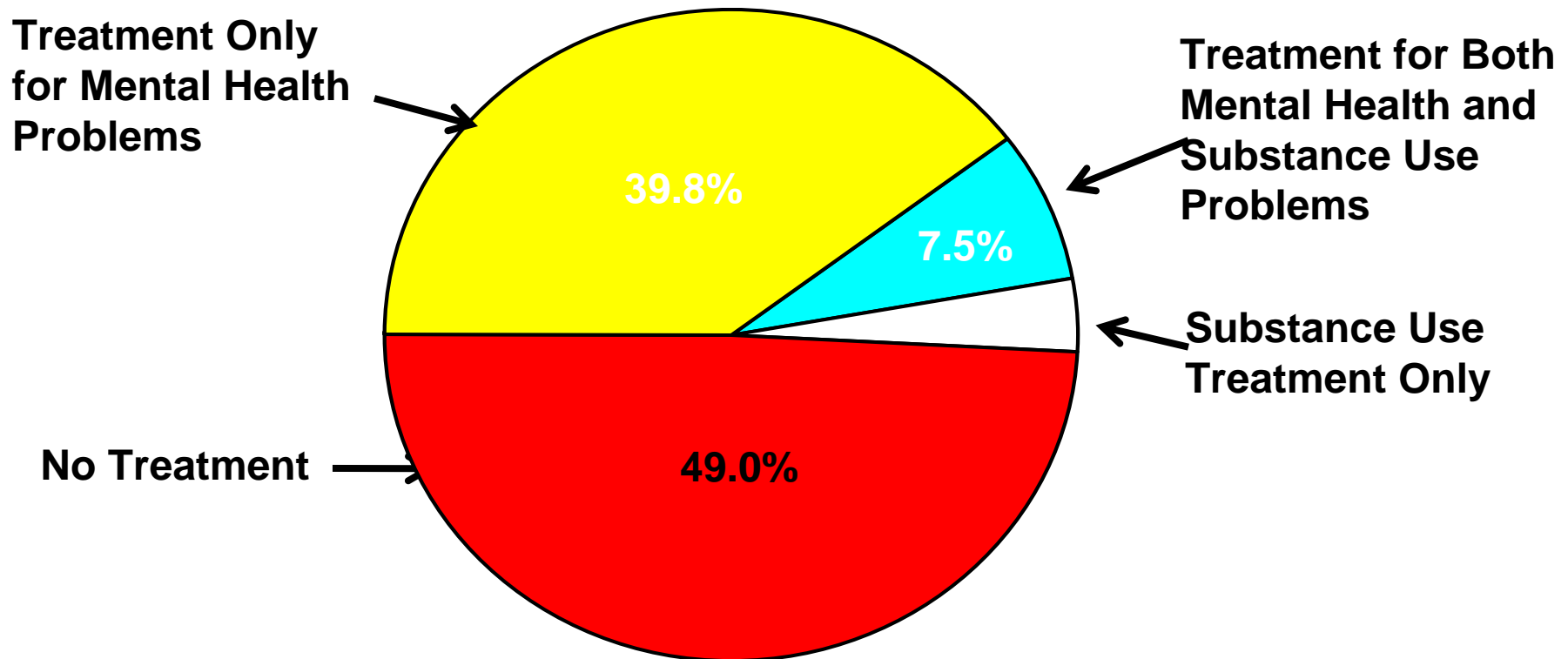
Having an addictive disorder **quadruples** the risk of having a co-occurring mental disorder

Co-Occurring Disorders are **the expectation** not the exception

Ken Minkoff MD

Do people with Co-Occurring get treatment?

Past Year Treatment among Adults Aged 18 or Older with Co-Occurring SMI and a Substance Use Disorder: 2003 (NSDUH)



4.2 Million Adults with Co-Occurring SMI and Substance Use Disorder

Why have integrated service delivery for Co-Occurring Disorders?

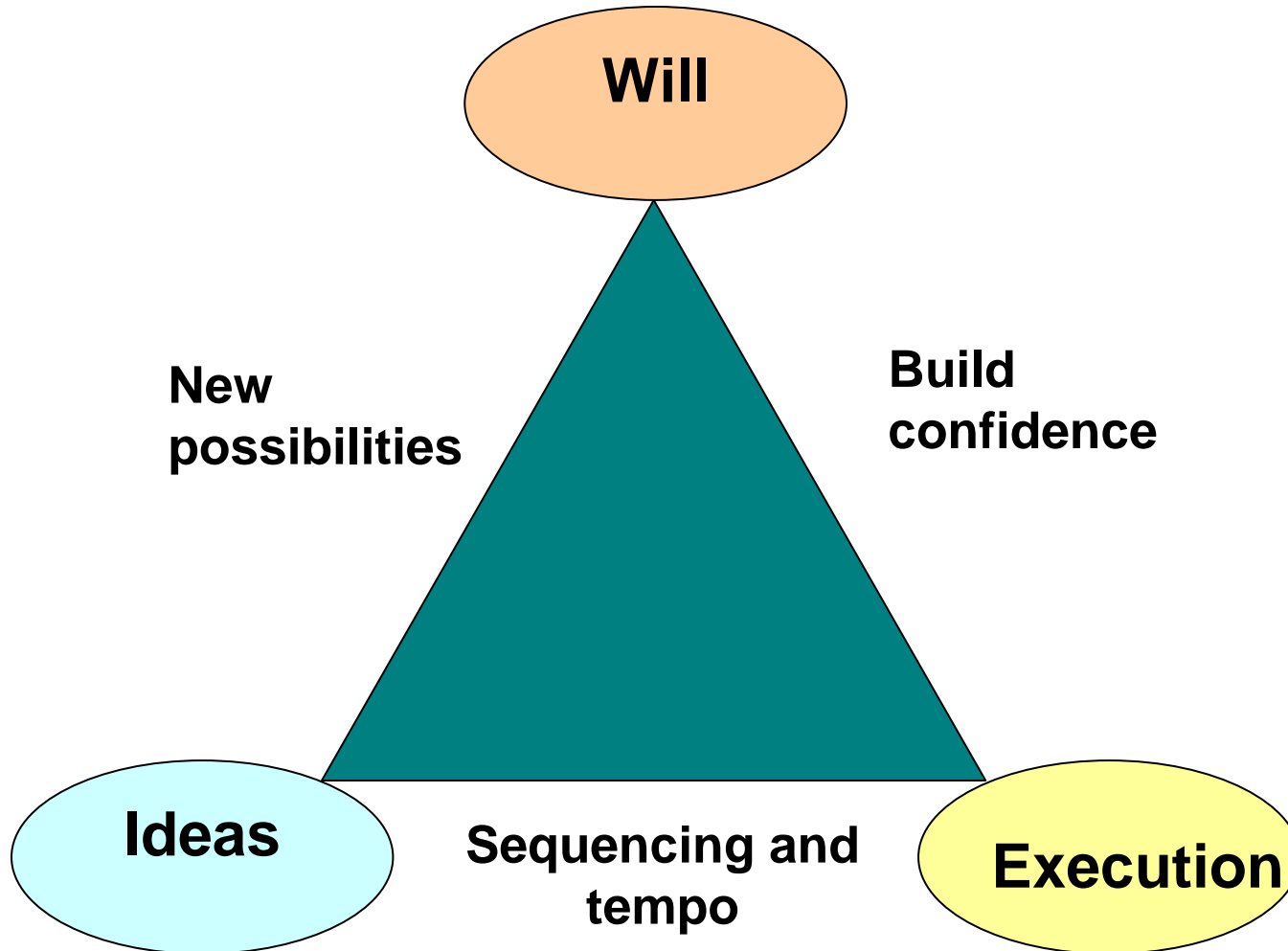
Failure to appropriately address each disorder when treating an individual with both mental illness and substance use disorders results in:

- Increased vulnerability to relapse and rehospitalization
- More psychotic symptoms
- Inability to manage finances
- Housing instability and homelessness
- Noncompliance with medications and treatment
- Increased vulnerability to HIV infection and hepatitis
- Lower satisfaction with familial relationships
- Increased family burden
- Violence
- Incarceration
- Increased depression and suicidality
- Higher service utilization and costs

Why does integrated service delivery require systems change?

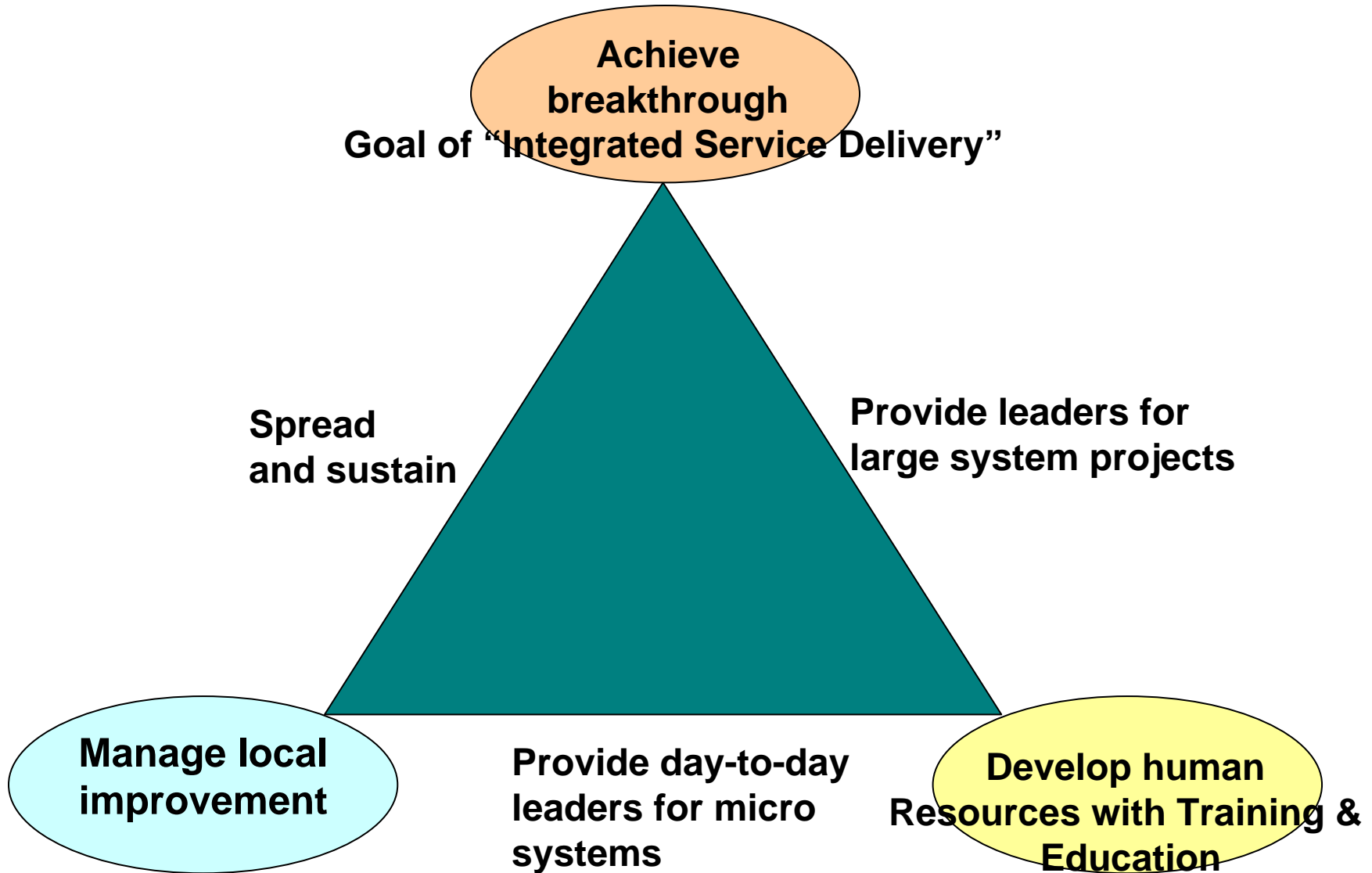
- Separate treatment systems focused on one problem, too often does not adequately recognize and address the other, resulting in failed treatment.
- Successful treatment of people with co-occurring disorders, requires that both problems are simultaneously addressed.
- Different Law & Regulations
- Different funding..audits etc
- Different personnel
- Different training
- Different certification
- Different sites
- Different Norms

Achieving System Level Results*



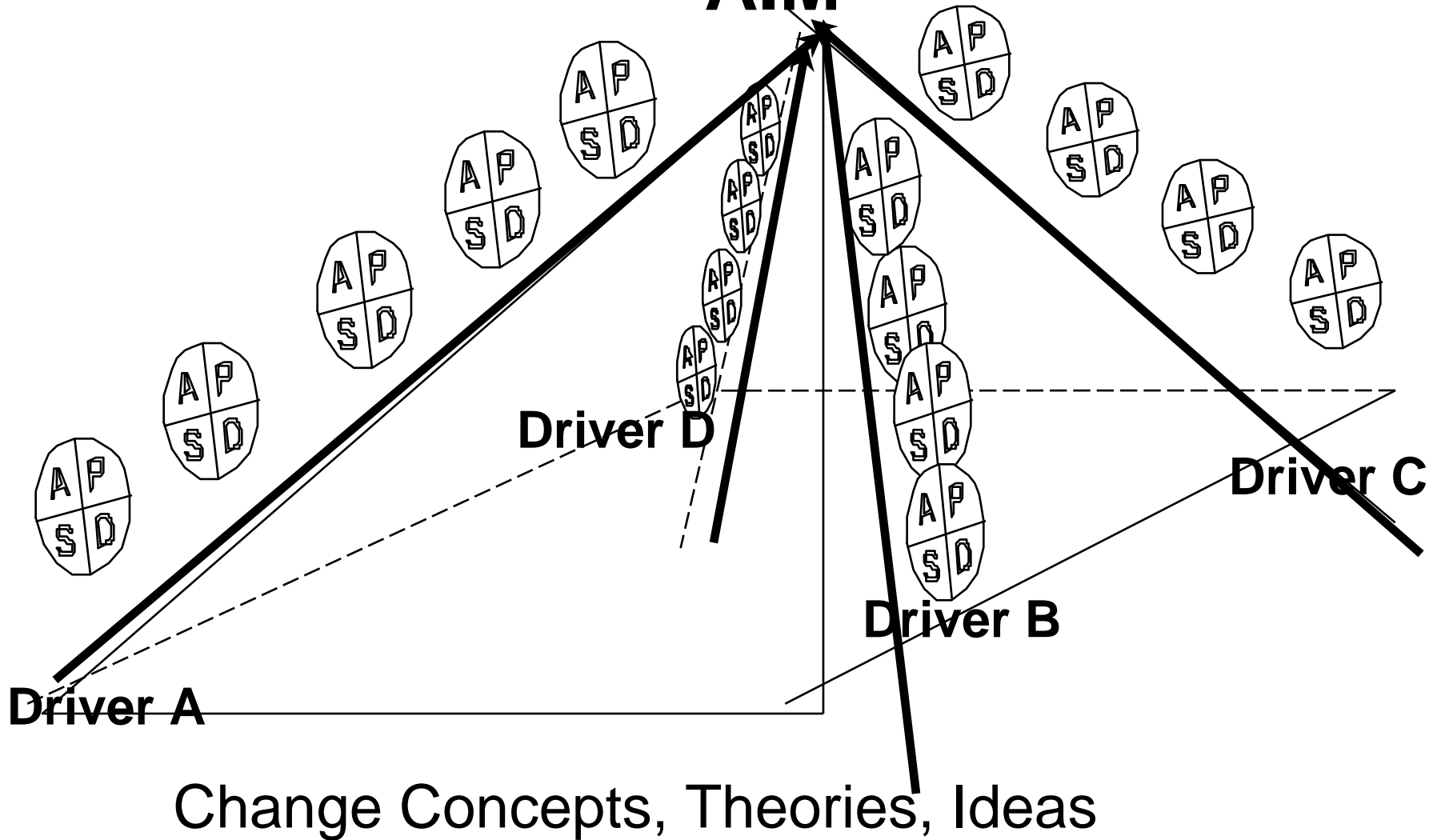
* IHI Executing Change

Execution



Multiple Changes Lead to One Aim:

AIM



System Wide Goal

“No wrong door to treatment”

Establish an **integrated approach to service delivery** so there is “no wrong door” to appropriate treatment for individuals with Co-Occurring mental illness & substance use disorders in the DMH and DOH/ APRA systems

Sponsors: Steve Baron, Director of DMH & Tori Fernandez Whitney, Senior Deputy Director of DOH/APRA

Primary Drivers

Objectives

1. Infrastructure Supporting Integrated Approach to COD Service Delivery

2. Universal Screening, Assessment, & Treatment Planning for COD

3. Continuous Quality Improvement Support & incentives to improve COD Consumer Outcomes

4. COD Workforce Competencies via Training & Education

Secondary Drivers / Interventions

- DMH and DOH /APRA Interagency Leadership Team for COD
- DMH & APRA system rules, values, standards, structures, financing, and processes

- Expect individuals with COD with all MH & APRA providers doing routine screening,
- Positive COD screens addressed with integrated assessment to determine consumer needs
- DMH & APRA Treatment plans address both disorders simultaneously with appropriate treatment matched to consumer needs.

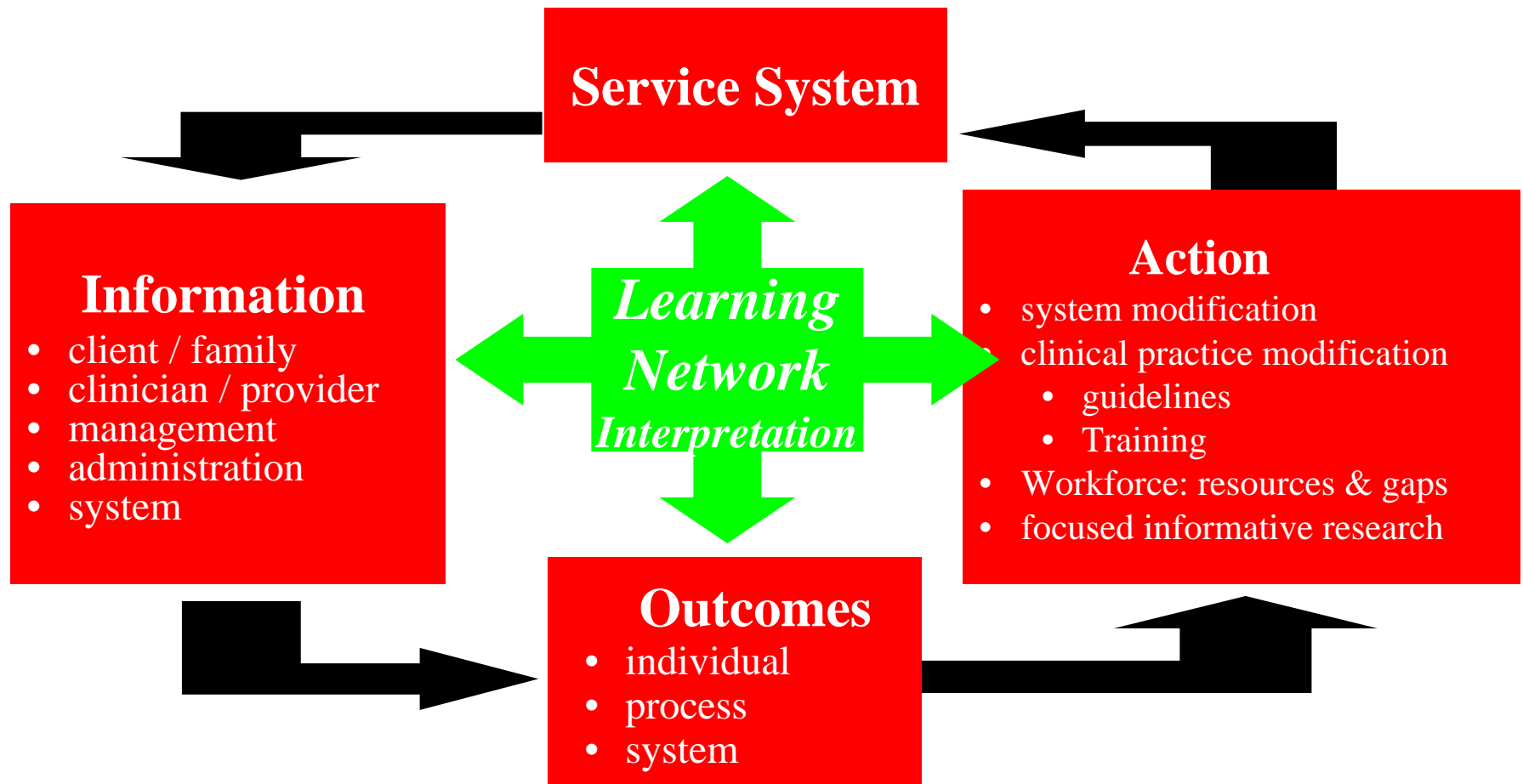
- Infrastructure to support continuous improvement & spread best practices
- Learning Community & format for Cross-Agency CQI to achieve system level change

- COD Training Curriculum
- Increase Clinical Competency in COD for MH and Increase Leadership competencies in COD
- Network of provider- based COD trainers to institutionalize COD training within DMH & APRA
- Expand provider competencies in consumer empowerment via 12 step “Double Trouble” programs for individuals wit COD

Systems Change

- Interagency Leadership Group
- APRA & DMH policy directives established Universal COD Screening, Assessment and Treatment Coordination
- Agency Competency Designation in Co-Occurring Disorder Competency
- Clinical Chart Reviews/ Scorecard
- Develop Practice-Based Evidence of Treatment Effectiveness
- Continuous Quality Improvement

Using Information for Continuous Quality Improvement



Using Performance Data to Support Systems Change

Universal COD Screening and Assessment Mandated by DMH and APRA

Agency performance on screening and assessment monitored by clinical chart audits

Continuous quality improvement approach to data sharing on performance, with provision of technical assistance, coaching and training as needed

Agency Designation of Competency in Co-Occurring Disorders

DC COSIG Data Collection: Overview

Data Collection Overview

Sample

- SAMHSA Sampling Frame
 - 2200 New Consumers/24 Mental Health and Substance Abuse Agencies

Materials

- Chart Review Data Collection Tool

Method

- Consumer Medical Record Audits
 - Medical Auditors
 - Onsite Data Collection

Reporting

- Analysis using SPSS
- Export Aggregate Data
 - Seventy percent collection rate
 - Exported 5 agencies reports

1	ID # or ECURA:			
2	Date of Birth: ____/____/19____			
3	Date of Admission: ____/____/____			
4	Gender: (1 = Male, 2 = Female)			4
5	Race:	White/Caucasian	1	5
		Black/African American	2	
		Hispanic/Spanish/Latino	3	
		Asian	4	
		Native American	5	
		Other	6	
6	Legal Status	Voluntary	1	6
		Involuntary	2	
		COMM	3	
		CMOP	4	
<i>SCREENING AND ASSESSMENT</i>				
7	Was person screened for:	Substance Use/Abuse Only	1	7
		Mental Health Only	2	
		Both Substance Use & Mental Health	3	
		Neither	4	
8	If screened for both mental health and substance use,			
	a.	Is the MIDAS/Gain used? (1 = yes, 2 = no, 3 = na)		8a

DC COSIG Data Collection: Sample Demographics

Consumer Demographics by Race and Ethnicity: 2008

Overall Sample (N= 1428)

Mean age: 39 years
Range: 6 – 74 years

APRA: n = 537

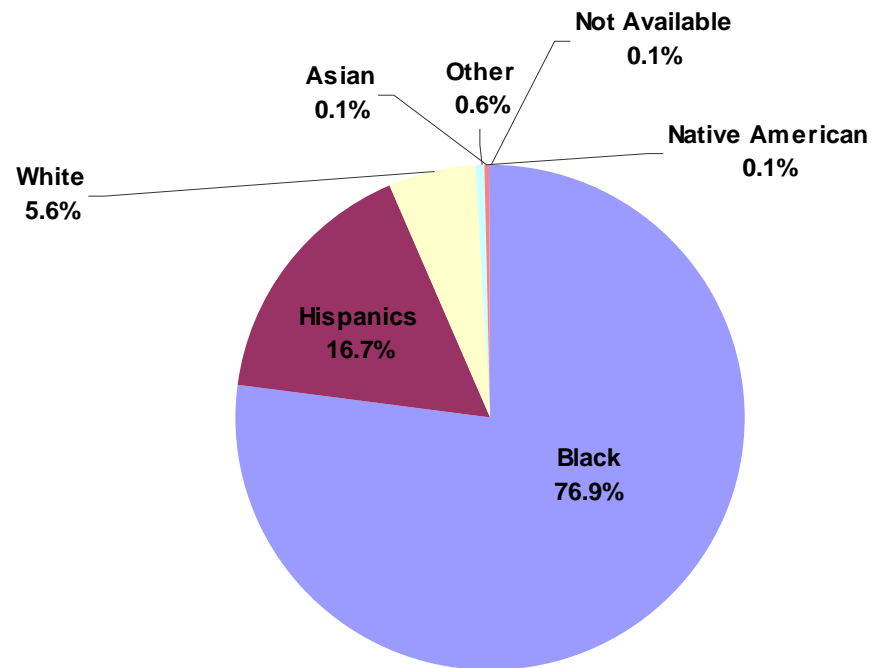
Mean age: 39.5
Range: 14 – 72

Female : 17%
Male: 83%

DMH: n = 886

Mean age: 38
Range: 6 – 74

Female: 55%
Male: 45%



Overall racial/ethnic distribution of consumers was 77 percent Black, 17 percent Hispanic, 6 percent White, and while Asians, Native Americans and consumers who classified themselves as “Other” comprised less than .1 percent of the sample.

DC COSIG Data Collection: Results

Co-Occurring Consumers

Of the overall co-occurring population, DMH (76 percent) had a greater percentage of consumers classified as having a co-occurring disorder than APRA (24%).

APRA

32 percent of consumers within APRA were classified as having a co-occurring disorder.

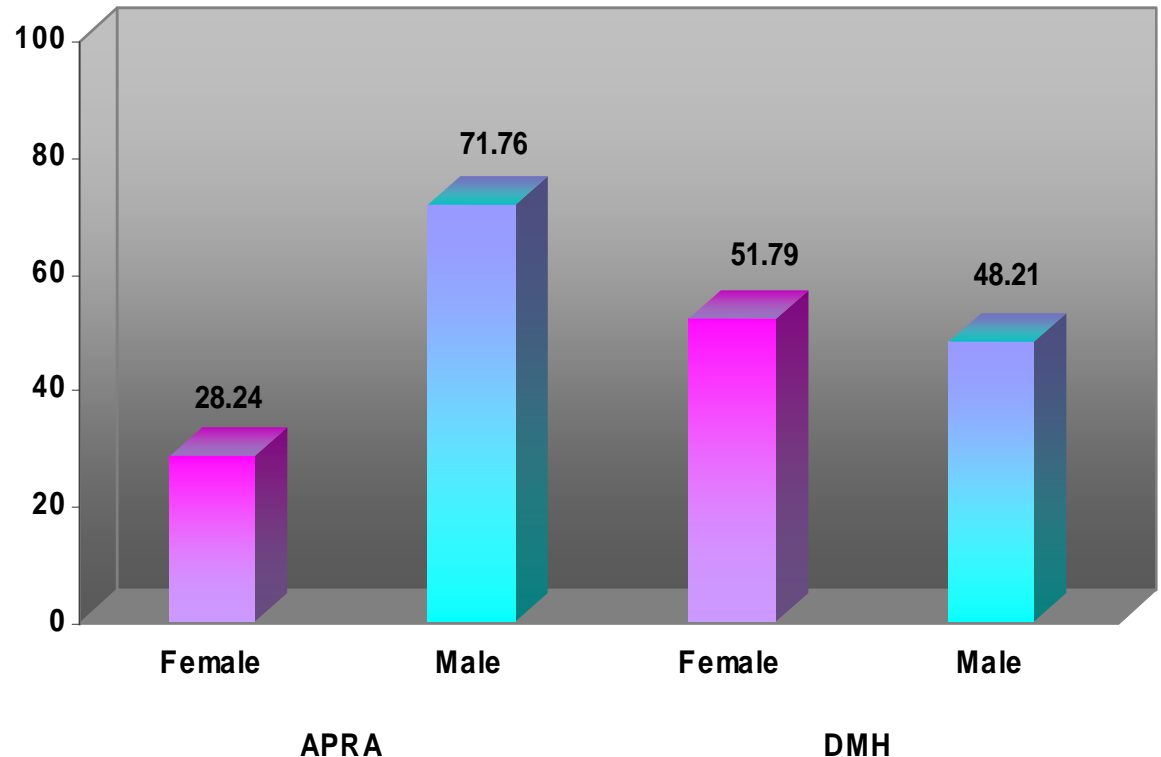
- Males were significantly more likely to be identified as co-occurring than females.

DMH

60 percent of consumers within DMH were classified as having a co-occurring disorder

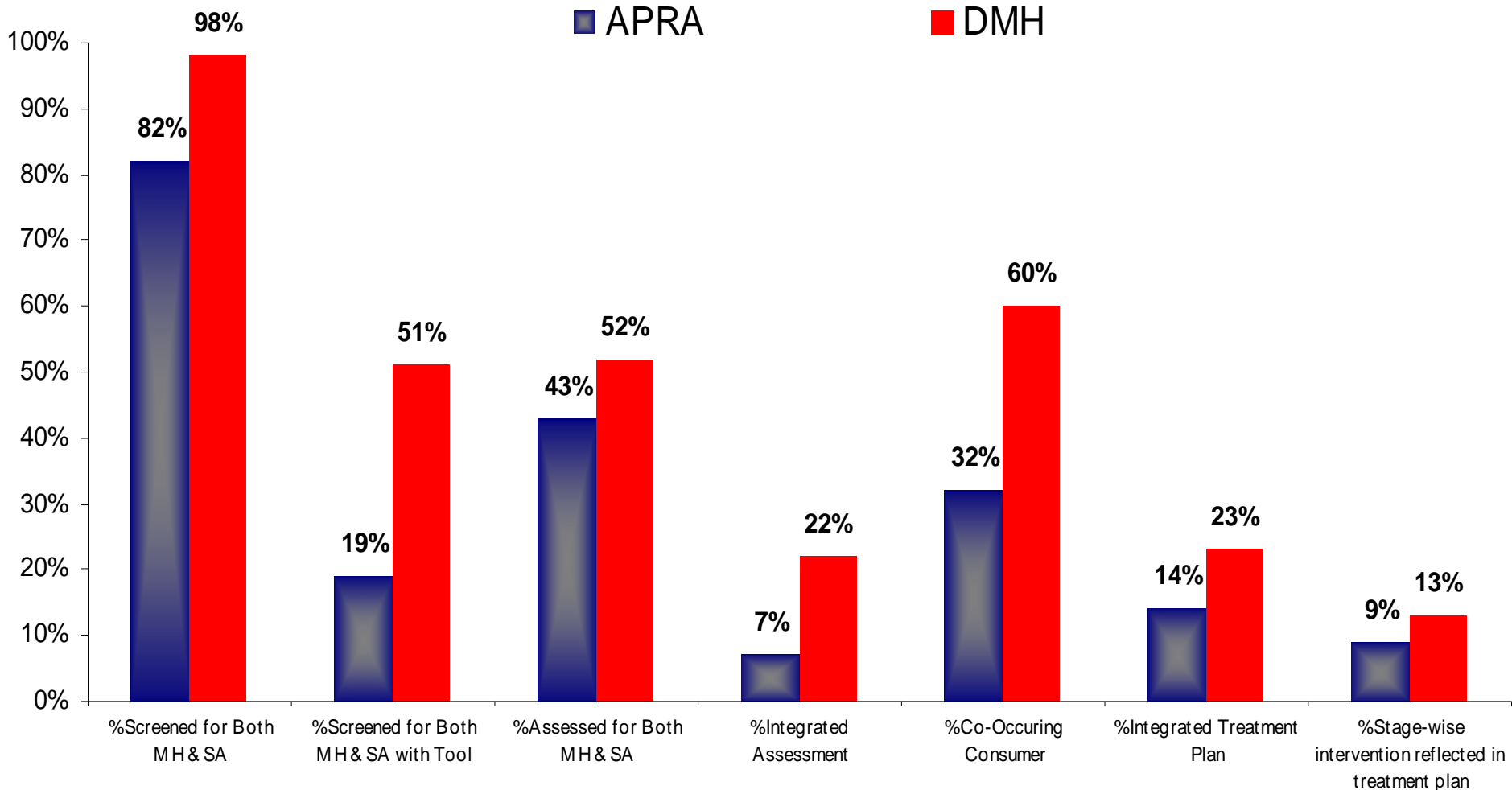
- Females were more likely to be identified as co-occurring than males.

Percent Co-occurring Consumers by Department and Gender: 2008



DC COSIG Data Collection: Results

Summary of Co-Occurring Practices



DC COSIG Data Collection: Results

Treatment Modalities and Coordination for COD Consumers

- **APRA**

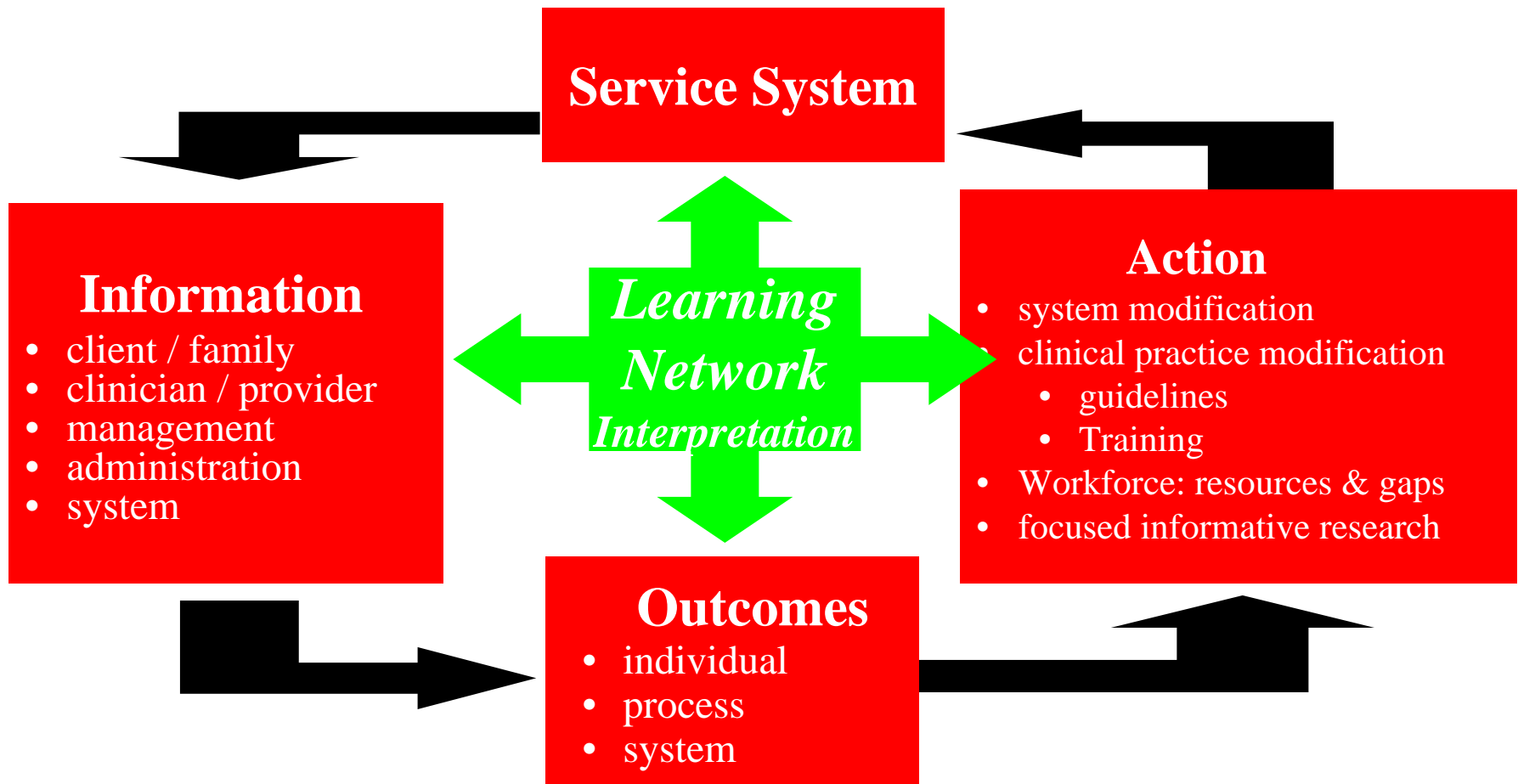
- 2% were treated for both their substance abuse and mental disorders within the same facility
- 76% were treated for their substance abuse at the SA facility and were treated elsewhere for their mental disorders
- 22% were treated for their substance abuse at the SA facility and were not treated elsewhere for their mental disorders

- **DMH**

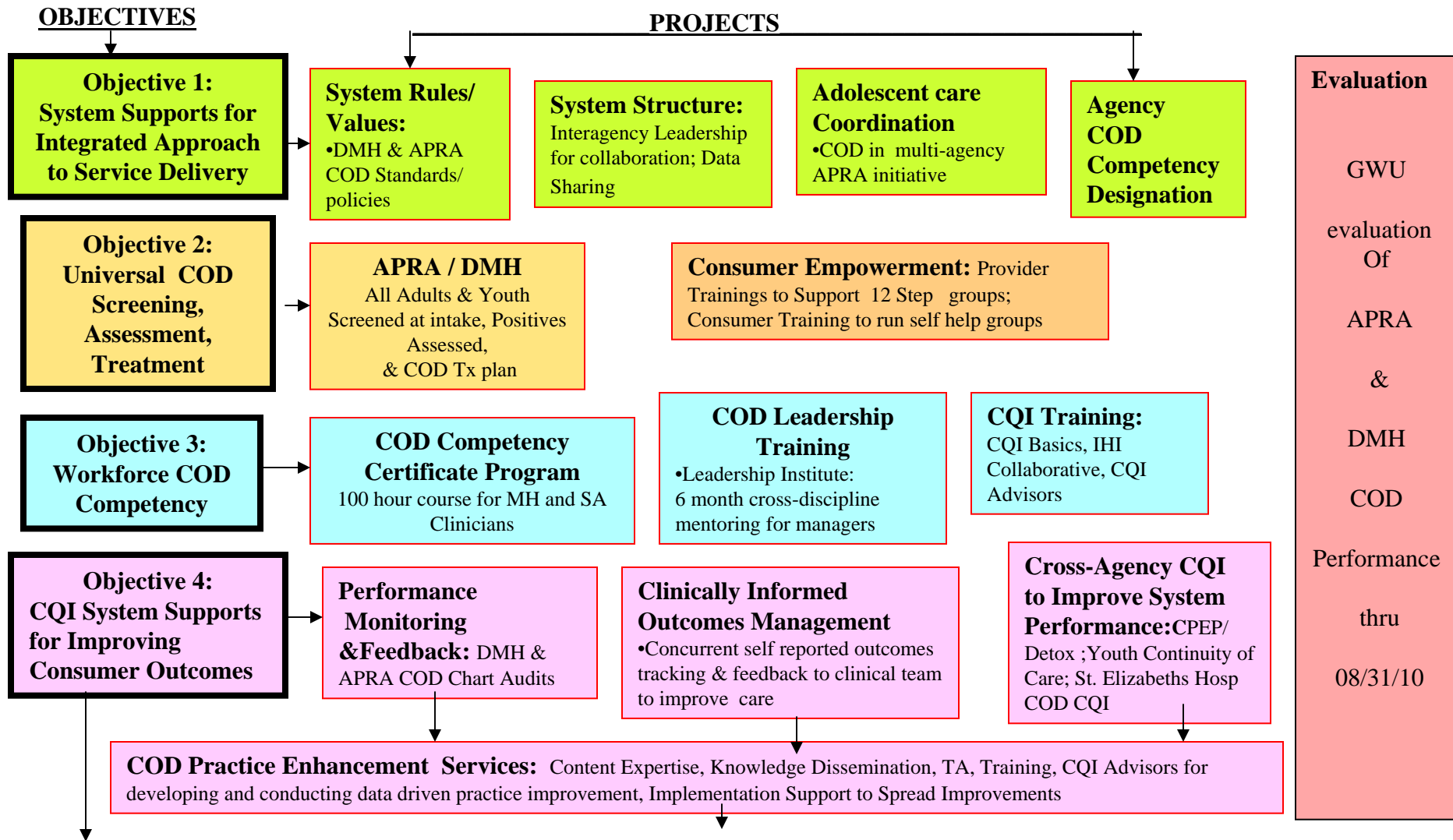
- 11 % were treated for both their substance abuse and mental disorders within the same facility
- 59% were treated for their mental disorders at the MH facility and were treated elsewhere for their substance abuse
- 30% were treated for their mental disorders at the MH facility and were not treated elsewhere for their substance abuse

Overall, the coordination of mental health and substance abuse services for COD consumers among providers was minimal.

Using Information for Continuous Quality Improvement



GOAL: "No wrong door" Integrated Service Delivery for Co-Occurring Disorders (COD) By 08/31/10



“Every system is perfectly designed to get the results it gets.”

If we persist in holding the **beliefs we have always held, and**

Insist on taking the **action we have always taken,**

We should expect to continue to get the same **results we have always gotten.**

Paul Batalden

Dartmouth Medical School

System Wide Goal

“No wrong door to treatment”

Establish an **integrated approach to service delivery** so there is “no wrong door” to appropriate treatment for individuals with Co-Occurring mental illness & substance use disorders in the DMH and DOH/ APRA systems

Sponsors: Steve Baron, Director of DMH & Tori Fernandez Whitney, Senior Deputy Director of DOH/APRA

Primary Drivers

Objectives

1. **Infrastructure Supporting Integrated Approach to COD Service Delivery**

2. **Universal Screening, Assessment, & Treatment Planning for COD**

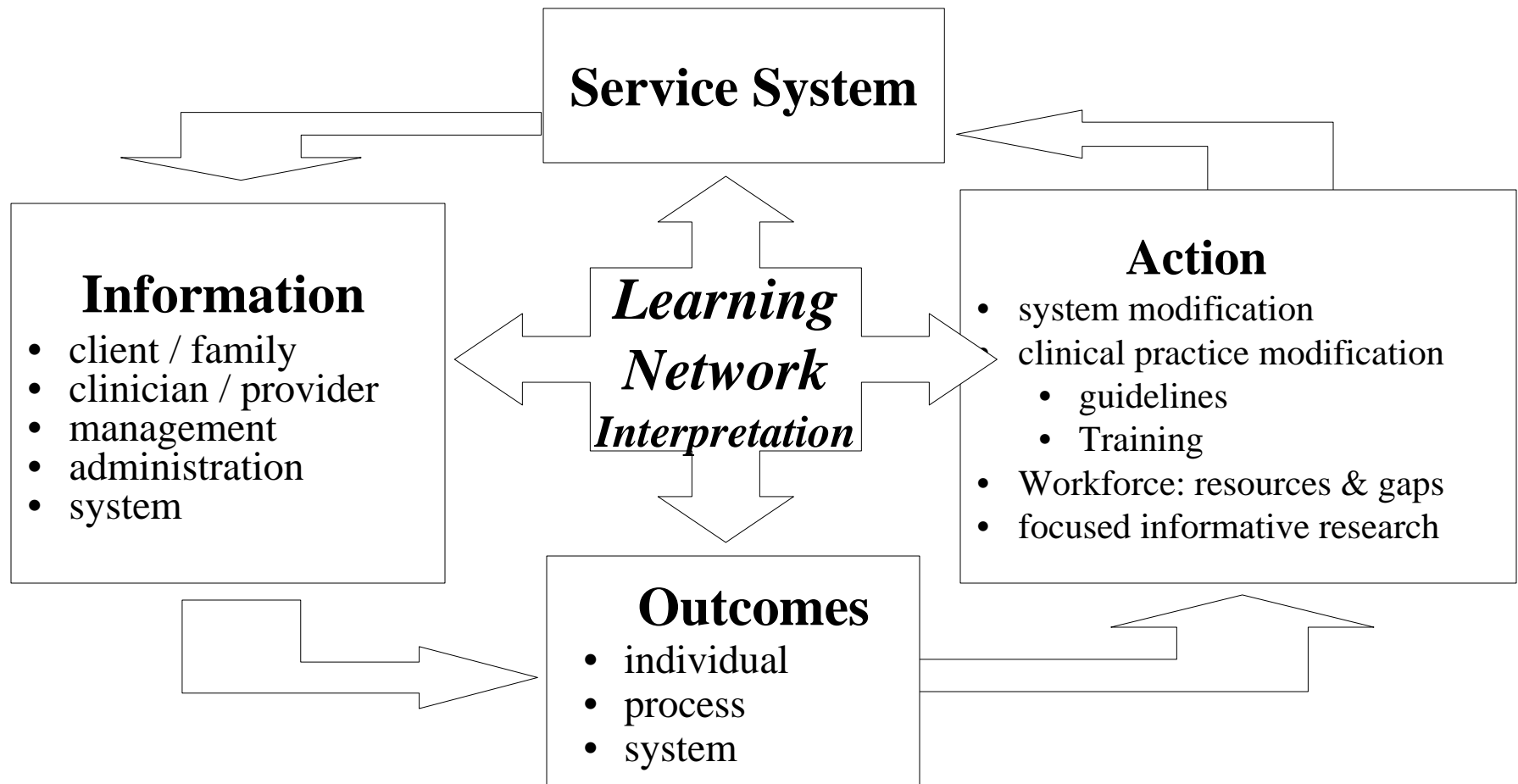
3. **Continuous Quality Improvement Support & incentives to improve COD Consumer Outcomes**

4. **COD Workforce Competencies via Training & Education**

Secondary Drivers / Interventions

- DMH and DOH /APRA Interagency Leadership Team for COD
- DMH & APRA system rules, values, standards, structures, financing, and processes
- Expect individuals with COD with all MH & APRA providers doing routine screening,
- Positive COD screens addressed with integrated assessment to determine consumer needs
- DMH & APRA Treatment plans address both disorders simultaneously with appropriate treatment matched to consumer needs.
- Infrastructure to support continuous improvement & spread best practices
- Learning Community & format for Cross-Agency CQI to achieve system level change
- COD Training Curriculum
- Increase Clinical Competency in COD for MH and Increase Leadership competencies in COD
- Network of provider- based COD trainers to institutionalize COD training within DMH & APRA
- Expand provider competencies in consumer empowerment via 12 step “Double Trouble” programs for individuals wit COD

Using Information for Continuous Quality Improvement



DC COSIG Data Collection: Overview

Data Collection Overview

Sample

- SAMHSA Sampling Frame
 - 2200 New Consumers/24 Mental Health and Substance Abuse Agencies

Materials

- Chart Review Data Collection Tool

Method

- Consumer Medical Record Audits
 - Medical Auditors
 - Onsite Data Collection

Reporting

- Analysis using SPSS
- Export Aggregate Data
 - Seventy percent collection rate
 - Exported 5 agencies reports

1	ID # or ECURA:			
2	Date of Birth: ____/____/19____			
3	Date of Admission: ____/____/____			
4	Gender: (1 = Male, 2 = Female)			4
5	Race:	White/Caucasian	1	5
		Black/African American	2	
		Hispanic/Spanish/Latino	3	
		Asian	4	
		Native American	5	
		Other	6	
6	Legal Status	Voluntary	1	6
		Involuntary	2	
		COMM	3	
		CMOP	4	
<i>SCREENING AND ASSESSMENT</i>				
7	Was person screened for:	Substance Use/Abuse Only	1	7
		Mental Health Only	2	
		Both Substance Use & Mental Health	3	
		Neither	4	
8	If screened for both mental health and substance use,			
	a.	Is the MIDAS/Gain used? (1 = yes, 2 = no, 3 = na)		8a

DC COSIG Data Collection: Sample Demographics

Consumer Demographics by Race and Ethnicity: 2008

Overall Sample (N= 1428)

Mean age: 39 years
Range: 6 – 74 years

APRA: n = 537

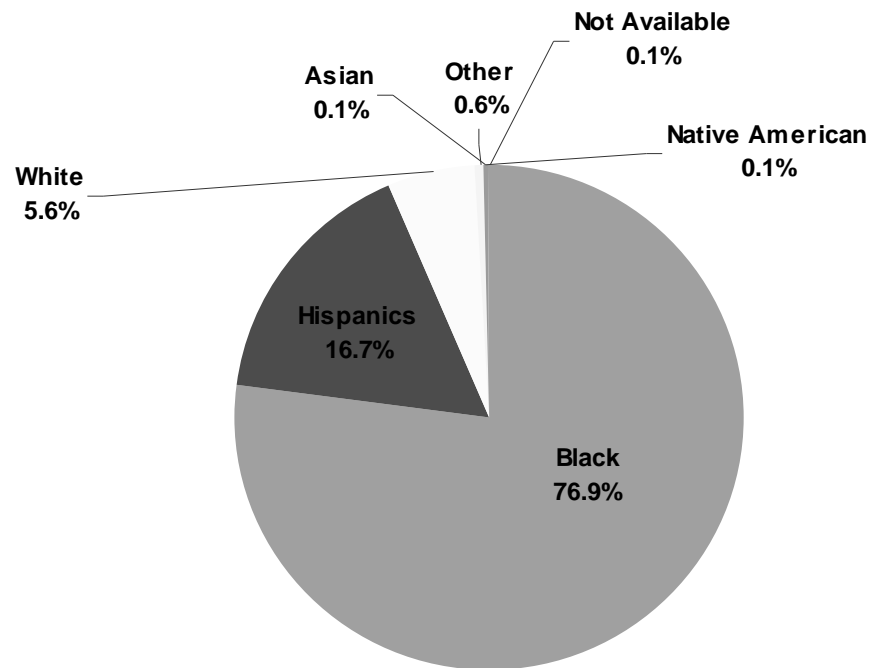
Mean age: 39.5
Range: 14 – 72

Female : 17%
Male: 83%

DMH: n = 886

Mean age: 38
Range: 6 – 74

Female: 55%
Male: 45%



Overall racial/ethnic distribution of consumers was 77 percent Black, 17 percent Hispanic, 6 percent White, and while Asians, Native Americans and consumers who classified themselves as “Other” comprised less than .1 percent of the sample.

DC COSIG Data Collection: Results

Co-Occurring Consumers

Of the overall co-occurring population, DMH (76 percent) had a greater percentage of consumers classified as having a co-occurring disorder than APRA (24%).

APRA

32 percent of consumers within APRA were classified as having a co-occurring disorder.

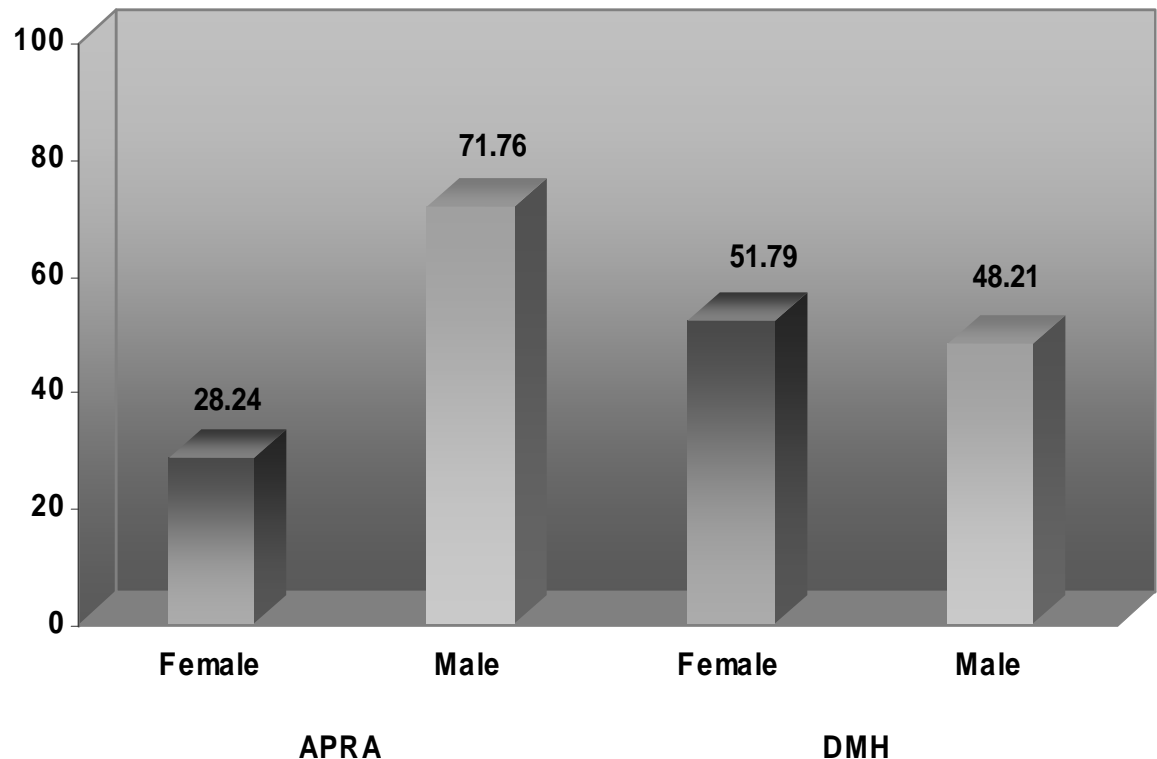
- Males were significantly more likely to be identified as co-occurring than females.

DMH

60 percent of consumers within DMH were classified as having a co-occurring disorder

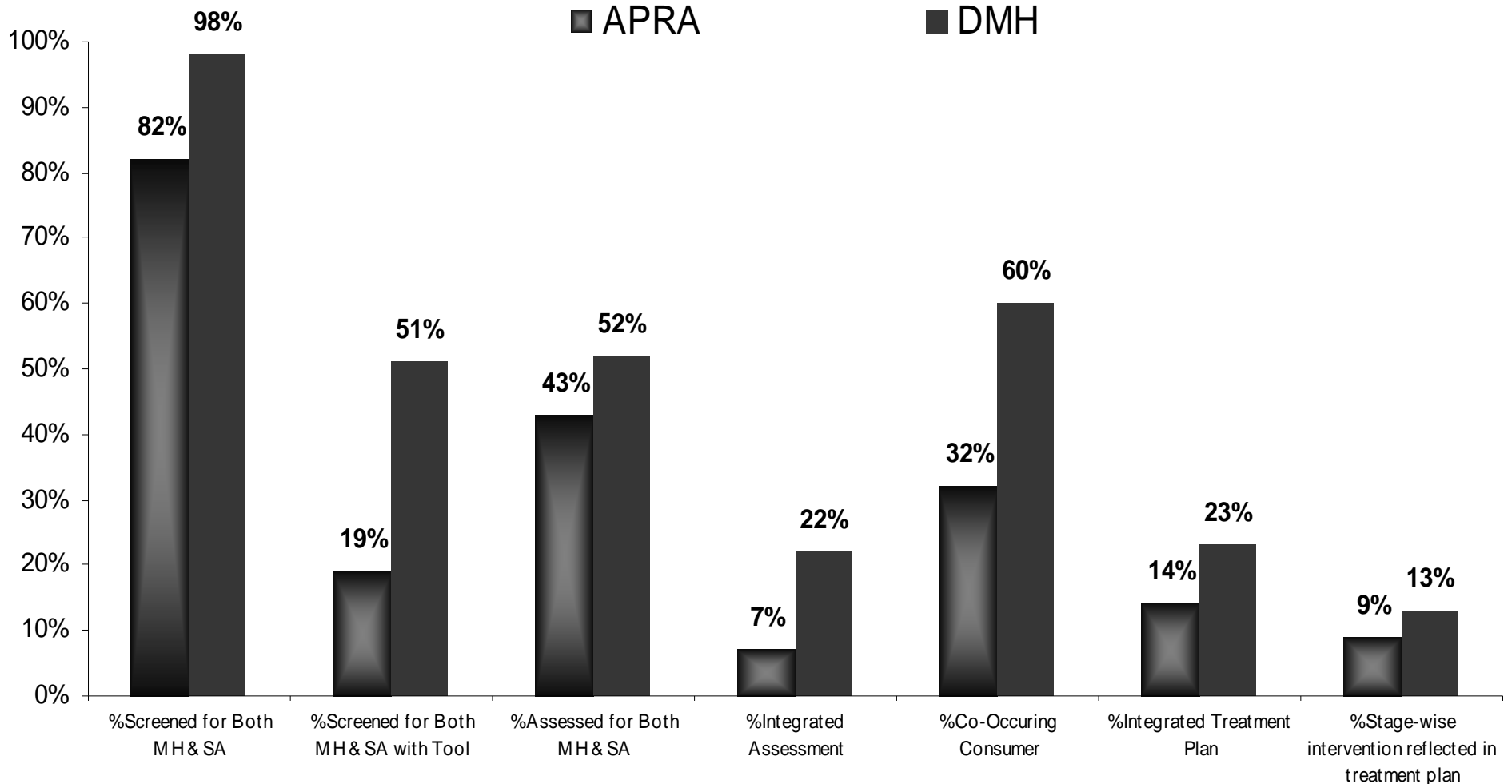
- Females were more likely to be identified as co-occurring than males.

Percent Co-occurring Consumers by Department and Gender: 2008



DC COSIG Data Collection: Results

Summary of Co-Occurring Practices



DC COSIG Data Collection: Results

Treatment Modalities and Coordination for COD Consumers

- **APRA**

- 2% were treated for both their substance abuse and mental disorders within the same facility
- 76% were treated for their substance abuse at the SA facility and were treated elsewhere for their mental disorders
- 22% were treated for their substance abuse at the SA facility and were not treated elsewhere for their mental disorders

- **DMH**

- 11 % were treated for both their substance abuse and mental disorders within the same facility
- 59% were treated for their mental disorders at the MH facility and were treated elsewhere for their substance abuse
- 30% were treated for their mental disorders at the MH facility and were not treated elsewhere for their substance abuse

Overall, the coordination of mental health and substance abuse services for COD consumers among providers was minimal.

GOAL: “No wrong door” Integrated Service Delivery for Co-Occurring Disorders (COD) By 08/31/10

