ASSESSMENT AND TREATMENT

OF PERSONS WITH PSYCHIATRIC COMORBIDITY IN

CONNECTICUT ADDICTION TREATMENT PROGRAMS

2002

Connecticut Department of Mental Health and Addiction Services

New Hampshire Dartmouth Psychiatric Research Center

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EXECUTIVE SUMMARY

BACKGROUND

Significant policy, research, training and treatment efforts have advanced the care of persons with co-occurring severe mental illness and substance use disorders in mental health settings. For persons with a dual diagnosis in addiction treatment settings, there are few established evidence-based practices to transfer to the community. Meanwhile at the national level, SAMHSA is encouraging integrated treatment for persons with co-occurring disorders, while trying to preserve the integrity of the mental health and addiction treatment delivery systems. It is therefore advisable for both systems to develop enhanced service capability to effectively treat persons with co-occurring disorders.

PURPOSE

The Department of Mental Health and Addiction Services of the State of Connecticut (DMHAS) seeks to improve the quality of care for persons with co-occurring disorders in both the mental health and addiction treatment delivery systems. Relative to other states, Connecticut has long been recognized as a leader in this mission.

The present project assessed the current practices with co-occurring disorders in Connecticut's addiction treatment programs. This assessment is intended to improve upon anecdotal and historical information, by producing an evidence-base for strategic planning and system enhancement.

This STAGE I study systematically assessed addiction treatment programs about their practices with persons who have co-occurring disorders. Prevalence estimates, routine assessment and treatment practices, attitudes towards persons with co-occurring disorders, perceptions about resources & barriers, perceived training needs, and program and workforce characteristics were gathered directly from service providers.

This information forms the basis for intelligent, evidence-based and consensus driven planning of STAGE II quality improvements for Connecticut's addiction treatment delivery system.

Specific recommendations for STAGE II are proposed in this report.

METHOD

Data collection instruments (provider surveys) were constructed to obtain the necessary information. Three versions were developed to assess three provider roles: agency director, clinical supervisor and clinician. Survey packets were mailed to 60 DMHAS funded, operated and representative General Assistance funded programs statewide. Agency directors (or a designate) distributed surveys within their respective agencies to clinical supervisory and clinical staff. Surveys were returned in sealed envelopes and mailed in larger packets to the project coordinator at the NH-Dartmouth Psychiatric Research Center for data coordination, entry and statistical analyses.

PARTICIPATION

Forty-eight (48) agencies participated in the study (80% response rate). A total of 456 providers composed the study sample (46 agency directors, 110 clinical supervisors, and 300 clinicians). Indicative of investment, a significant percentage of participants requested study results (54%) and many responded to optional open-ended questions. Only one complaint about the survey itself was recorded. We conclude that this procedure gathered representative data, and that it was well tolerated by participants.

FINDINGS

- **I. Prevalence Estimates.** Using the Quadrant model, providers estimate 50% of clients with co-occurring disorders are high substance use severity and low (mild/moderate) psychiatric severity (Quadrant III). Mood, anxiety and posttraumatic stress disorders are the most commonly observed comorbid psychiatric disorders.

- **II. Screening and assessment practices.** Providers estimate a reasonable capability to screen and assess for comorbid psychiatric disorders. Routine practices are counselor interview and DSM-IV diagnoses. The use of the CCPC, ASAM-PPC-2R, psychiatric interview, and the Addiction Severity Index are less common.

- **III. Treatment practices.** Providers estimate an overall reasonable capability to treat co-occurring disorders within their programs. Versus agency director reports, clinicians were more likely to report referral (versus acceptance for treatment) of persons with co-occurring disorders. Severe disorders (persons with severe mental illness or borderline personality disorder) in acute states were most likely to be referred, as were the more common mood, anxiety and posttraumatic stress disorders in acute states. These latter three categories may account for up to 37 per 100 clients presenting for treatment.

- **IV. Attitudes toward clients with co-occurring disorders.** Largely positive attitudes about both severe and mild to moderate types were found. Clients with co-occurring disorders were reported to require more time and clinical effort, and from the perspective of clinicians, are perceived as more violent, less motivated, and the source of more personal anxiety.

- **V. Resources/Barriers.** Psychiatric staffing, billing and reimbursement issues, and need for preferred practices are the most commonly cited barriers to programmatic and clinical capability to care for persons with co-occurring disorders. The three perspectives noted different barriers, with agency directors citing billing and reimbursement, supervisors citing adequate clinical supervision and number of trained staff, and clinicians noting a need for clinical supervision.

- **VI. Training.** Two tiers of targeted training were identified: a more basic training in screening, assessment and introduction to medications, and an advanced training in preferred practices and specific treatment approaches. The need for training in preferred practices was a “breakthrough” issue, as it was the most frequent write-in on the open-ended question.

- **VII. Workforce characteristics.** As a group, providers are highly educated, have significant clinical experience, and average 45 years of age. They are predominantly white, and clinicians are more likely to be female. The most common treatment approaches are eclectic and cognitive behavioral, with a singular 12-step model endorsed by only10% of providers.

- **VIII. Program characteristics.** Using the definitions featured in the ASAM-PPC-2R, providers identified their programs as *Addiction Only Services (AOS)*(12.8%), *Dual Diagnosis Capable (DDC)*(60.2%), or *Dual Diagnosis Enhanced (DDE)*(26.9%)(see brief definitions below, complete definitions in Appendix). This taxonomy was able to significantly distinguish providers on most other variables, including: Prevalence estimates, Screening and assessment practices, Treatment practices, Attitudes, Training needs, Barriers/Resources, and Workforce characteristics (staff education, experience level). Therefore, in knowing a provider's placement on this taxonomy, much is revealed about his or her practices and capability with co-occurring disorders.

ASAM-PPC-2R TAXONOMY OF DUAL DIAGNOSIS PROGRAM TYPES

ADDICTION-ONLY PROGRAM (A0S)

Programs that either by choice or for lack of resources, cannot accommodate clients who have psychiatric illnesses that require ongoing treatment, however stable the illness and however well-functioning the client.

DUAL DIAGNOSIS CAPABLE PROGRAM (DDC)

Programs that have a primary focus on the treatment of substance-related disorders, but are also capable of treating clients who have a relatively stable diagnostic or subdiagnostic co-occurring mental health problems related to an emotional, behavioral or cognitive disorder.

DUAL DIAGNOSIS ENHANCED PROGRAM (DDE)

Programs that are designed to treat clients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders.

STAGE II RECOMMENDATIONS

1. The ASAM-PPC-2R taxonomy of dual diagnosis program type proved to be a useful heuristic, and emerged as a promising organizing scheme. It is, however, limited in this study by the potential bias of self-report, and may not have external validity, (i.e. Does it reflect the actual routine practices of an addiction treatment program?). The Stage II task then is to more objectively determine the dual diagnosis capability of addiction treatment programs, and to use this information to guide a change process determined by DMHAS and the State of Connecticut's addiction treatment providers.

For example, once identified, DDE programs could serve as models for DDC programs seeking to expand their capabilities to treat all persons with co-occurring disorders. Upgrades in necessary resources, staffing, practices, and training would have to be considered. Once these factors are evaluated, a given program may elect to "move" up (or down) in dual diagnosis program capability.

DMHAS may seek to enhance the overall system by moving AOS programs in the direction of DDC programs and DDC programs in the direction of DDE capability. This movement may involve a redistribution of resources, or an increase in resources, since it appears that self-defined DDE programs have a more professional, well-trained and experienced staff.

Given resource constraints, DMHAS could also elect to shape the design of the addiction treatment system by region, or by level of care. This may involve each region (or other geographic section) having an array of services based upon dual diagnosis capability (AOS, DDC, DDE), and by level of care (outpatient, detoxification, residential, and hospital-based programs). *This would insure the regional availability of services to all, without asking specific providers to provide services to all.*

An objective measure of dual diagnosis program type is needed. Such a measure does not presently exist, and is not in development according to David Gastfriend (deputy editor of the ASAM-PPC-2R manual). Such a measure can be formatted as a fidelity scale. The New Hampshire Dartmouth Psychiatric Research Center is a national leader in the design, implementation and evaluation of fidelity scales. This technology and expertise could be brought to bear to develop fidelity scales for dual diagnosis program type: Addiction Only Services, Dual Diagnosis Capable and Dual Diagnosis Enhanced.

For the first phase, five to six months of site visits and interviews with representative programs in Connecticut would form the basis of the information necessary to develop the fidelity scales. Phase two would consist of the training of raters (DMHAS or project-specific staff) in using the pilot versions of scales, and making necessary revisions based on experience. The third and final phase would be the rating of voluntary or representative programs, or all of the addiction treatment programs statewide.

Preliminary contacts with private foundation (Robert Wood Johnson) and federal (National Institute on Drug Abuse) indicate that this Stage II project is of national interest and

importance. A grant proposal to either (or both) funding sources is recommended to support STAGE II phases two and three. Phase One could be accomplished by contract.

Once developed, a dual diagnosis program fidelity scale could be used for a number of purposes. It could be used collaboratively, to help an agency director determine where his or her program stands and needs to improve. It can be used by a single state agency to evaluate programs, as a basis for contracts and standards, or to incentivize system change by paying more for dual diagnosis capable programs. As stated previously, a fidelity measure could also assist in the rational design and allocation of a range of services by region. *The exact use of the fidelity scale therefore remains the purview of stakeholder leadership.*

2. Two tiers of training needs are indicated by the data obtained from the surveys: basic and advanced. Overall, training in co-occurring disorders is perceived as very much needed and likely beneficial. Closer inspection of training needs reveals that persons in AOS programs are seeking help with screening, diagnosis and assessment, whereas those in the DDE programs are interested in preferred treatment practices, and specialized individual and group approaches. This clearly reflects the clinical tasks within each program type. AOS tend to refer out persons with co-occurring disorders, so they want to know how to screen, assess and triage. DDE, and to a lesser extent DDC, are both involved in the active treatment of these clients and are looking for help with specialized therapies.

DMHAS invests a considerable sum in clinical training. Training in co-occurring disorders should remain a priority. However, a more prudent strategy would be to match training with the level of knowledge and the potential utility for each provider.

Basic level training in co-occurring disorders may include: review of etiology and prevalence (to increase empathic capacity and reduce anxiety), screening/assessment/diagnosis, psychotropic medications for psychiatric disorders and their use with addicted persons, and some basic intervention skills in individual and group modalities. Specific skills in assessing for suicide, violence, and familiarity with medications also would be very useful.

Advanced level training may include: specialized group and individual treatments, both as stand alone services for co-occurring disordered persons (as in outpatient settings), as well as a service within the context of a treatment program (as in intensive outpatient or residential settings). This may be a social phobia group, or an individual cognitive behavioral therapy for PTSD, either of which could be offered within routine addiction treatment.

These data suggest that our workforce is now saturated with training on motivational interviewing (although questions remain about post-training implementation in routine practice). The data also suggest that, based upon prevalence estimates of co-occurring disorders, the workforce no longer needs to be convinced psychiatric problems exist, are common, and are problematic.

DMHAS has an excellent training program within its own agency. This program can organize these curricula, and use its own faculty or outside consultants for specific areas. Advanced focus areas might be guided by the most commonly occurring psychiatric comorbidities and the available interventions for each: mood disorders, anxiety disorders, and PTSD.

3. Fifty percent (50%) of persons presenting for addiction treatment have mild to moderate psychiatric problems. In examining these data, the majority of these persons have mood (41%), anxiety (26%) or posttraumatic stress (25%) disorders.

Since persons with these disorders constitute everyday experience, algorithms or practice guidelines would be immediately useful. Such guidelines could help clinicians assess, offer the best treatment for most, and know when that treatment should be enhanced or abandoned in favor of other options.

The CSAT Tip #9 (1994) Assessment and treatment of patients with coexisting mental illness and alcohol and other drug use has been revised and is presently due for re-release. This Tip is organized along diagnostic lines, and may provide the basis for practice guidelines or for those types of algorithms used in pharmacotherapy decision-making.

DMHAS could wait for the release of the revised Tip from CSAT, convene a panel among its own administrative clinicians and key providers to develop practice guidelines. It would also be possible to convene a group of dual diagnosis experts from the region. Most of the field's leaders come from the states of Connecticut, Massachusetts, New York and New Hampshire.

Although funding opportunities have not been specifically explored as vehicles for this recommendation, both NIMH and CMH have funded similar approaches to practice guidelines for psychiatric disorders. The NIAAA or NIDA services branches, or CSAT may have an interest in these guidelines beyond Connecticut. No such guidelines presently exist and we are in dire need of practical strategies.

These recommendations form the basis of a proposal for STAGE II.

They are provided in order of priority and feasibility, and could be enacted alone or in any combination.

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OUTLINE OF THIS REPORT

This report describes the impetus, background, methodology and results of a survey of 456 addiction treatment providers in the State of Connecticut during the year 2002.

The data are presented in terms of participant responses to the survey items as a whole, and with specific sub-group comparisons based upon both a priori hypotheses about potential differences, and findings from exploratory statistical analyses. A substantial number of independent variable group comparisons are possible with this data set. We limited our focus in this report to the following: 1) the responses of the sample as a whole; 2) group differences by data source: agency director, clinical supervisor, and clinician; and 3) dual diagnosis program capability: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), and Dual Diagnosis Enhanced (DDE).

Many other group comparisons (for example, gender of respondent) were analyzed, with generally less than robust statistically significant differences. One group comparison was made, methadone programs versus non-methadone programs, which formed the basis of a paper proposed to the American Association for the Treatment of Opioid Dependence, by Sam R. Segal and Mark P. McGovern entitled "Opioid agonist providers and co-occurring disorders: Perceptions and practices." Other group analyses are possible by arrangement.

This report is organized to provide the reader with a practical understanding of the conduct and findings of the study. A comprehensive literature review of the broad field of co-occurring disorders is therefore not provided. Instead we offer a Reference section which lists seminal articles on this subject. A brief introduction describes the background discussion that generated the project. A method section outlines the procedure of survey administration and collection.

The results of the survey are presented by section, ten sections in all. Sections I through IX each begin with a discussion of the total group responses, and then, if significant, a specific itemization of source and program differences. Section X is a thematic analysis of providers' responses to the open-ended questions. These data, although less systematic, offer a potentially rich source of important perceptions that respondents took both extra time and measure to convey.

The implications of these findings are not belabored beyond what is recommended in the Executive Summary section at the front of this report.

A more complete set and detailed analyses of these data, and copies of the surveys are available upon request from the principal investigator or from Sam R. Segal (DMHAS).

ACKNOWLEDGEMENTS

This project was accomplished, from planning through execution phases, by an excellent collaboration between leaders and staff of the Department of Mental Health and Addiction Services of the State of Connecticut and the New Hampshire Dartmouth Psychiatric Research Center. We are indebted to the guidance and leadership of Drs. Thomas A. Kirk, Jr., Arthur Evans, Kenneth M. Marcus and Paul J. DiLeo. Other key DMHAS contributors were Lauren Siembab, Richard Fisher and Gerald Croog. The treatment providers association was also most supportive and instrumental in this project, most notably Edward Dempsey, Kenneth Talge, Cinda Cash and Paul McLaughlin. The DMHAS Co-occurring Disorders Standing Committee also provided useful guidance in the planning phases, including content-specific suggestions by Michael Freeman. Most noteworthy is the insight, dedication, good humor, and collegiality of Sam R. Segal, Senior Clinical Officer and Addiction Services Policy Director, without whom this endeavor would not have been possible.

INTRODUCTION

Needs assessments of addiction treatment programs and counselors consistently find that psychiatric problems, other than substance abuse, pose the greatest challenge to everyday clinical practice. These findings have been reported in Connecticut, in New England, and in needs assessment studies from across the nation.

The addiction treatment delivery system and its workforce have varying degrees of capability, interest, and resources to assess and treat clients suffering dual diagnoses.

With respect to capability, many programs and counselors have a specific mission to treat substance use disorders, and hire staff with addiction education and training, not with mental health education and training. There may be licensure and regulatory standards limiting what services can be offered to clients with comorbid psychiatric disorders. Additional training may be sought out by programs and counselors, but it is unclear how much this training can really influence frontline practice.

Interest in assessing and treating co-occurring psychiatric disorders is also variable. Some programs and staff may feel too broad a focus on clients' psychiatric problems diminishes what can be accomplished with the addictive disease. Some programs and staff may hold the view that most psychological problems dissipate with recovery, and offering treatment, especially with medications, can cause confusion and splitting. Programs and staff may have attitudinal or emotional disinterest, such as stereotypes or fear, about treating such clients.

Interest or motivation may vary by the type of psychiatric disorder being considered. For example, mood disorders such as depression, anxiety disorders including post traumatic stress disorder, and personality disorders may be seen as commonplace in most addiction treatment settings. More severe disorders may be less common, and require a different level of motivation (and expertise) to treat. Such clients may suffer an addiction plus schizophrenia, bipolar disorder, schizoaffective disorder, or a cognitive disability or impairment. Whether a client is in a stable or acute phase of a psychiatric problem may also influence the program's capability and the clinician's anxiety level.

Limited resources may be the most real barrier to assessing and treating comorbid psychiatric disorders in addiction treatment programs. Funding and reimbursement disincentives, no new dollars to budget for new programming, workforce training limitations, and workforce turnover are major barriers that have been reported. Psychiatrist and psychologist coverage may be difficult to fund directly, so referrals are made to local mental health centers. Actual linkage may vary considerably. Many addiction treatment programs have existing waiting lists for minimal slots, and extending the periods of in-house assessment and treatment would lengthen delays.

Nonetheless, as a field, we know that psychiatric comorbidity is prevalent in persons seeking treatment for substance use disorders. Other than broad recommendations that these problems be assessed and treated, our field has surprisingly few evidence-based practices available. We have "best practices" which advise the concurrent treatment of both disorders, rather than treating one then the other sequentially. Clearly, the addiction field has much work to do in this area.

The purpose of this project is to work toward a better and real world understanding of dual diagnosis in the addiction treatment system of Connecticut. We sought to learn about existing assessment and treatment practices, capability, motivation, and resources. In doing so, we may develop a more thoughtful, enlightened, and realistic plan to address this clinical challenge.

The method was a direct survey of agency directors, clinical directors/supervisors, and clinicians/counselors about their practices, perceptions, and recommendations for assessing and treating clients with dual disorders. A systematic review of the literature found no such survey measures existed. There were measures that assessed attitudes (Arndt et al, 2001), organizational readiness for change (Lehman et al, 2002), and characteristics of the provider workforce (Foreman et al, 2001). Therefore, for this study we were required to construct surveys specific to this task. The surveys were based upon what is known in the field, and from suggestions made by DMHAS leadership, agency directors, clinical supervisors, counselors, and clinical researchers.

The surveys were distributed to programs across the state, and with confidentially protected they were collected, and then analyzed for group trends.

PROCEDURE

The project consultant and DMHAS leadership met with Health Care Operations (HCO) regional system managers to explain the project and their role in the distribution and collection of survey packets. HCO staff were provided with necessary materials and information with which to field questions or concerns. HCO staff developed a checklist of agencies the surveys were distributed to, the name of the agency director, the date on which the surveys were received by the Agency, and the date on which the surveys were received back from the agency. HCO staff mailed packages of surveys to the agency directors. The surveys were introduced by a cover letter from DMHAS leadership and instructions (See Appendix). These packages will included: Agency Director version of survey; Clinical Supervisor version of survey; Clinician version of survey; and Instructions.

Agency Directors were instructed to: complete the Agency Director version and place in envelope provided; Copy as necessary (if more than one Clinical Supervisor is identified) and distribute the Clinical Supervisor version to the person(s) "who are clinical leader(s) in their agency and who know most about the agency's clinical practices", and, include one copy of the Clinician Version of the survey in the packet to the Clinical Supervisor.

Clinical Supervisors were instructed to: complete the Clinical Supervisor version of the survey and place it in the envelope provided by the Agency Director; copy as necessary and distribute the Clinician version of the survey to no more than five (5) Clinicians who work directly with clients in their programs, providing each Clinician with an envelope for return; and collect surveys from Clinicians, and along with the Clinical Supervisor Version return to Agency Director or his/her designate.

Clinicians were instructed to complete the Clinician Version of the survey and return it to their Clinical Supervisor in the envelope that has been provided by their Clinical Supervisor.

The sealed package was returned by US mail to DMHAS (Attention: Sam Segal) and addressed to the New Hampshire Dartmouth Psychiatric Research Center, Connecticut Co-occurring Disorders Project.

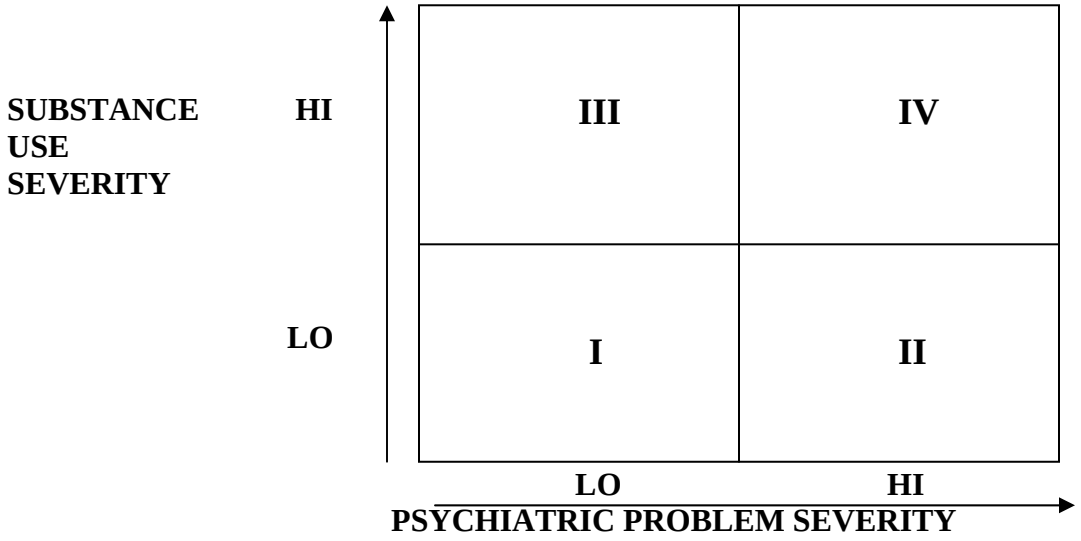
TOTAL NUMBER OF PROGRAMS SURVEYED	**=**	**60**	**(100%)**
TOTAL NUMBER OF PROGRAMS RESPONDING	**=**	**48**	**(80%)**
TOTAL NUMBER OF INDIVIDUAL PROVIDERS	**=**	**456**	**(100%)**
Total number of agency directors	**=**	**46**	**(10%)**
Total number of clinical supervisors	**=**	**110**	**(24%)**
Total number of clinicians	**=**	**300**	**(66%)**

RESULTS

I. PREVALENCE

Historically, the addiction treatment community had been divided on whether psychiatric disorders were present in addicted persons, or were simply sequelae of chronic substance use. For the past twenty years, there have been many studies and efforts discerning prevalence rates of psychiatric disorders among addicted persons, from epidemiological to clinical. Consistent with recommendations by Cacciola et al (2001) in understanding that persons with co-occurring disorders were a heterogeneous group, we used the quadrant model originally developed by Rosenthal (1993). In the table below, it is clear that providers view persons with co-occurring disorders as common, with the most prevalent those with Hi Substance Use Severity and Lo Psychiatric Problem Severity, i.e. Quadrant III. Quadrant II would likely represent those clients who are more likely found in the mental health system, and who could benefit from the Drake et al (1998) integrated treatment model.

Using the quadrant model of co-occurring disorders (see below), please <u>estimate</u> the percentage of clients who present for services and who may be placed in each of the quadrants:



	Mean	(SD)
Quadrant I:	**15.16%**	**(19.84)**
Quadrant II:	**15.87%**	**(18.23)**
Quadrant III:	**50.08%**	**(28.72)**
Quadrant IV:	**24.59%**	**(22.99)**

There were no group differences by source (agency directors vs. clinical supervisors vs. clinicians), however, dual diagnosis program type yield several significant findings. AOS programs reported significantly lower rates of clients in Quadrant II (7.4%), with DDC in the mid-range (13.9%), and DDE reporting the highest rate (19.6)($p < .001$). This same trend was true for Quadrant IV (AOS=17.7%; DDC=21.0%; DDE=32.9%)($p < .001$). The reverse was true for Quadrant III with AOS reporting the highest rates (60.6%), followed by DDC (55.4%), and lastly by DDE (37.1%)($p < .001$). These findings suggest as might be expected, that AOS programs see a less psychiatrically severe client, and DDE find the group with co-occurring disorders to be most common.

The Table below depicts the next Prevalence item, which asks about the presentation of specific diagnostic groups. Mood, anxiety and PTSD are the most common psychiatric disorders, together accounting for nearly 90% of clients presenting for addiction treatment. There were no source differences (agency directors, clinical supervisors, clinicians) in these estimates. We again found dual diagnosis program type differences, with AOS programs noting significantly lower rates of Antisocial ($p < .01$) and Borderline personality ($p < .001$) disordered patients. DDE programs reported higher rates of clients with severe mental illness than the other two program types ($p < .001$), and both DDE and DDC tended to higher estimates of PTSD versus AOS programs ($p < .05$). These findings suggest that co-occurring disorders are seen as typical. In DDC and DDE programs this is routine practice, and clients have considerable severity, particularly those in the DDE.

Please <u>estimate</u> the percentage of clients who present for addiction treatment services who also suffer from the following psychiatric disorders:

Mean (SD)	
40.56% (23.89)	Mood disorders (dysthymia, moderately severe depression)
26.46% (20.86)	Anxiety disorders (generalized, phobia, panic)
25.08% (23.56)	Post-traumatic stress disorders (PTSD)
17.36% (20.17)	Serious mental illness (schizophrenia, bipolar, schizoaffective, major severe and recurrent depression)
5.84% (7.38)	Eating disorders
18.33% (22.08)	Axis II. Antisocial personality disorders
17.40% (18.09)	Axis II. Borderline personality disorders
10.01% (16.12)	Any other Axis II disorder

II. SCREENING AND ASSESSMENT

Screening and assessment for comorbid psychiatric disorders, as a first step in a clinical process, is often cited as problematic for addiction treatment providers. In the table below, we asked for a global rating of perceived capability to screen and assess clients with co-occurring disorders. The group overall rated their capability to be "Reasonable" on average. There were no source differences (agency directors, clinical supervisors, clinicians). Although there were dual diagnosis program differences, counter to hypotheses, DDE (M=3.95) programs rated themselves as significantly higher than DDC (M=3.27)($p < .001$), with AOS providers in the middle.

How would you rate your overall ability to screen and assess clients with co-occurring disorders? Please circle the number that best reflects your answer.

5 = Great 4 = Between great and reasonable 3 = Reasonable
2 = Between reasonable and lacking 1 = Lacking

Mean = 3.51 (SD = 1.58)

We next inquired about specific practices used for screening and assessment, and asked about the percentage of the time these practices were used for clinical work with co-occurring disorders. (See table on next page). Overall, clinical interview by a counselor and use of the DSM-IV framework were the most common practices. Source differences were discovered here, with agency directors reporting higher frequency of psychologist or social worker interview, use of ASAM-PPC-2R and Connecticut Client Placement Criteria ($p < .01$). Significant dual diagnosis program type differences were found, with DDE programs relying significantly more of both psychologist or social worker and psychiatrist interview for screening and assessment purposes, and with a more common reliance on the DSM-IV. AOS services reported greater use of the Addiction Severity Index and the DDC programs relied more so on the CCPC than the other two program types.

These findings support the hypothesis that DDE programs may have more highly trained clinical staff to screen and assess clients with co-occurring disorders. The difference in reported practices by data sources is first significant divergence. This may either be a positive response bias on the part of agency directors (inflating to desirability) or a true difference in perceptions about what takes place in actual practice. In general, the convergence of viewpoints is suggestive of survey validity, as determined by inter-rater agreement.

What are your typical practices for screening for and/or assessing clients with psychiatric disorders? And, what percentage of the time does this practice occur?

Practice	**% of the time Mean (SD)**
A. Clinical interview by counselor.	**74.08% (39.91)**
B. Clinical interview by psychologist or social worker.	**35.85% (42.48)**
C. Clinical interview by psychiatrist.	**43.98% (41.91)**
D. Use of client self-report measures. (e.g. Beck Depression Inventory, SCL-90, MMPI)	**24.01% (37.65)**
E. Use of the Addiction Severity Index.	**19.21% (37.86)**
F. Use of the DSM-IV.	**78.99% (37.67)**
G. Use of the American Society of Addiction Medicine - Patient Placement Criteria (ASAM-PPC).	**32.36% (45.13)**
H. Use of the Connecticut Client Placement Criteria (CCPC).	**42.48% (48.79)**

III. TREATMENT

In this next section, we asked providers about usual treatment practices. In this pursuit, we focused on disposition (i.e. treatment acceptance, referral, or parallel treatment) as a proxy for treatment capability. As seen in the table below, the most common overall practice is to accept the client who has a co-occurring disorder for treatment: for monitoring and evaluation (A)(47%), integrated treatment (C)(47%), or parallel treatment (F)(39%). However, the combined overall rates of referral out (D, E, G) are 44%.

Overall, of the clients who your agency can identify at initial presentation to have a psychiatric disorder, please indicate from the following outcomes, in what percentage of cases does each disposition usually take place?

Disposition/Outcome	**% of cases Mean (SD)**
A. We accept the client for monitoring and continued evaluation.	**46.89% (42.03)**
B. We accept the client for treatment---most psychiatric symptoms resolve with abstinence and addiction treatment.	**32.60% (33.64)**
C. We accept the client for treatment, and provide services for the psychiatric disorder within our program.	**47.41% (39.90)**
D. We do not accept the client for treatment and refer to a licensed mental health agency (LMHA).	**11.90% (21.46)**
E. We refer the client to a LMHA but will accept back once psychiatrically stabilized.	**19.35% (31.83)**
F. We will accept the client for treatment for his/her addiction problems and will refer to and work concurrently with a LMHA who will treat the psychiatric problems.	**38.90% (40.48)**
G. We refer to another addiction treatment agency that has better capacity and skill for co-occurring disorders.	**13.04% (23.03)**

On E, F and G options, source differences were found, with clinicians reporting higher rates than agency directors on all three items, and versus clinical supervisors on E and G. These responses suggest that clinicians report less acceptance of dual diagnosis clients in their treatment program.

Dual diagnosis program type group differences are robust on this variable. DDE programs provide integrated treatment (C)(71.6%) more so than DDC (44.4%) and AOS (15.2%)($p < .001$). On this item, DDC and AOS are also significantly different ($p < .001$). The reverse trend is true for all the remaining items (D, E, F, G) with AOS services significantly more likely to refer to an LMHA, to provide sequential or concurrent treatment with an LMHA, or to refer to an agency more capable of integrated treatment. These differences are all highly significant ($p < .001$).

In the table on the next page, we addressed specific treatment (disposition) practices with specific psychiatric disorders. In addition, we examined the acuity or stability dimension, by examining diagnostic differences based on this covariate. Finally, in addiction treatment programs, specific symptoms of suicidality, homicidality or the use of psychiatric medications are major areas of concern. We queried providers on these presentations also. Option "0" and "1" are indicative of a treatment rejection or referral out, option "2" of a parallel treatment, and option "3" a conditional acceptance for treatment, and "4" providing both addiction and psychiatric services. For data analytic purposes, we converted this forced choice item into a scale, with lower scores associated with referral and higher scores with acceptance.

In examining the respective diagnostic group categories, most likely to be referred are persons with serious mental illness. The issue of acuity/stability is very predictive of disposition across all diagnostic and clinical (suicidal, homicidal) categories. Clients who are stable are more likely to be accepted for treatment. Not depicted on the table, we summed those responses indicative of referral out and found the following rates: severe mental illness @ 65%, borderline personality disorder @ 38%, mood disorders @ 35%, PTSD @ 30%, and anxiety disorders @ 27%.

By combining these estimates with the estimated prevalence rates, some important base rates of clients who are not accepted for treatment can be calculated. Per 100 clients who present, 16 with mood disorders, 16 with severe mental illness, 9 with anxiety, 9 with PTSD, 8 with borderline personality disorder, and 3 with antisocial personality disorder will not be treated on site. The common disorders of mood, anxiety and PTSD account for 37 of these 100 clients not accepted for treatment.

With respect to source differences (agency director, clinical supervisor, clinician) no differences were found on diagnostic or acuity status. Clinicians were however, more likely to refer clients with evidence for past aggressive or suicidal behavior versus their supervisors and agency directors ($p < .05$).

Dual diagnosis program type was again highly predictive of dispositional activities. For all disorders, DDE programs were more likely to provide treatment than DDC and AOS programs, both for acute and stabile states. For stable states, DDC was more able to provide services, but for acute states these programs were equivalent. DDE programs were likewise more capable of providing services to persons with either current or past suicidality or homicidality. AOS programs were significantly lower on these dimensions and on the use of psychotropic medications.

Choosing from the options listed below, please indicate your agency's typical practice with each co-occurring disorder type:

---

4 - We accept the client for treatment and provide both addiction and mental health services.
3 - We accept the client for monitoring and continued assessment.
2 - We accept the client for treatment of addiction problems and refer to a LMHA for concurrent treatment of the psychiatric problem.
1 - We refer the client to a LMHA and will accept the client back in our agency once psychiatrically stabilized.
0 - We refer the client to a LMHA.

	Client with a substance use disorder and:	**Mean (SD)**
A)	Mood disorder - acute and symptomatic	**2.46 (1.50**)
	Mood disorder - stabilized	**3.20 (1.03)**
B)	Anxiety disorder - acute and symptomatic	**2.64 (1.48)**
	Anxiety disorder - stabilized	**3.19 (1.07)**
C)	Post-traumatic stress disorder - acute and symptomatic	**2.52 (1.46)**
	Post-traumatic stress disorder - stabilized	**3.21 (1.04)**
D)	Serious mental illness - acute and symptomatic	**1.48 (1.51)**
	Serious mental illness - stabilized	**2.43 (1.55)**
E)	Axis II. Antisocial personality disorder	**2.90 (1.36)**
F)	Axis II. Borderline personality disorder - acute and symptomatic	**2.30 (1.53**)
	Axis II. Borderline personality disorder - stabilized	**3.03 (1.23)**
G)	On a psychotropic medication - now	**3.15 (1.10)**
	On a psychotropic medication - in the past	**3.25 (0.97)**
H)	Violent and aggressive impulses - now	**1.31 (1.39)**
	Violent and aggressive impulses - in the past	**3.00 (1.14)**
I)	Suicidal impulses - now	**1.25 (1.36)**
	Suicidal impulses - in the past	**3.16 (1.03)**

The final item pertaining to treatment practices assessed providers' global rating of capability to treat persons with co-occurring disorders. As can be observed in the table below, the overall average falls in the "Reasonable" range.

Group differences were not found by source. They were however quite significant by ASAM-PPC-2R program type. As might be expected, DDE programs rated themselves significantly more capable (M=3.92) versus DDC (M=3.22) versus AOS (M=2.61) programs. The overall test of significance is robust ($p < .001$) as are all three between group comparisons ($p < .001$).

How would you rate your overall ability to treat clients with co-occurring disorders? Please circle the number that best reflects your answer.

---

5 = Great 4 = Between great and reasonable 3 = Reasonable
2 = Between reasonable and lacking 1 = Lacking

Mean = 3.33 (SD = 0.95)

IV. ATTITUDES

The table below depicts provider attitudes towards persons with co-occurring psychiatric disorders of a severe and persistent type. For all respondents the two most distinctive difficulties are that persons in this category require more time and effort, and for some, may be the source of personal anxiety.

We expected an analysis of group differences would clarify these distinctions. With respect to source, clinical supervisors were significantly less inclined to see this client as more violent ($p < .001$), and less inclined to see as unmotivated, versus clinicians ($p < .01$). The total attitude score is marginally significant between the clinical supervisors and clinicians ($p < .05$).

With respect to dual diagnosis program type, DDE programs view these clients as significantly less disruptive, and causing less personal anxiety. Interestingly, DDE programs also significantly more so endorsed that segregated or specialized groups should be available (C).

Using the scale provided below, please rate the following statements according to your own perceptions:

1 - Strongly Agree 2 - Somewhat Agree 3 - Neutral
4 - Somewhat Disagree 5 - Strongly Disagree

SEVERE AND PERSISTENT PSYCHIATRIC PROBLEMS

		Mean (SD)
A)	Clients with co-occurring disorders require more time.	**1.46 (0.74)**
B)	Clients with co-occurring disorders require more effort.	**1.60 (0.82)**
C)	Clients with co-occurring disorders should be in their own groups.	**2.70 (1.18)**
D)	Clients with co-occurring disorders are more disruptive.	**2.91 (1.11)**
E)	Clients with co-occurring disorders are more difficult.	**2.54 (1.10)**
F)	Clients with co-occurring disorders are more violent.	**3.56 (1.06)**
G)	Clients with co-occurring disorders are less motivated.	**3.70 (1.08)**
H)	Clients with co-occurring disorders can affiliate with 12-step recovery groups.	**4.12 (1.04)**
I)	My anxiety level is higher with clients with co-occurring disorders.	**3.64 (1.21)**
	TOTAL SCORE	**26.12 (5.43)**

The next table pertains to attitudes towards clients with co-occurring disorders of a mild to moderately severe type. This category is reflective of the more common Quadrant III. Overall, similar items emerged as distinctive: more time, more effort, more personal anxiety. One may have hypothesized some differences between client categories (SMI versus mild/moderate) but the responses are fairly consistent. Source differences are again helpful to our understanding, with clinicians seeing clients as significantly more violent, less motivated, and a cause of personal anxiety. In addition, the overall score for this group is significantly different for clinicians versus the other two source groups (supervisors, directors)($p < .001$).

Program type revealed fewer differences than may have been expected. DDE continue to rate higher for specialized groups, but AOS see clients as significantly more violent and causing personal anxiety.

Using the scale provided below, please rate the following statements according to your own perceptions:

1 - Strongly Agree 2 - Somewhat Agree 3 - Neutral
4 - Somewhat Disagree 5 - Strongly Disagree

MILD TO MODERATELY SEVERE PSYCHIATRIC PROBLEMS

		Mean (SD)
A)	Clients with co-occurring disorders require more time.	**1.97 (0.99)**
B)	Clients with co-occurring disorders require more effort.	**2.06 (0.98)**
C)	Clients with co-occurring disorders should be in their own groups.	**3.20 (1.19)**
D)	Clients with co-occurring disorders are more disruptive.	**3.34 (1.06)**
E)	Clients with co-occurring disorders are more difficult.	**2.97 (1.13)**
F)	Clients with co-occurring disorders are more violent.	**3.80(0.97)**
G)	Clients with co-occurring disorders are less motivated.	**3.82 (1.04)**
H)	Clients with co-occurring disorders can affiliate with 12-step recovery groups.	**4.23 (0.99)**
I)	My anxiety level is higher with clients with co-occurring disorders.	**3.85 (1.16)**
	TOTAL SCORE	**29.15 (5.98)**

V. RESOURCES/BARRIERS

This section pertains to perceptions of resources or barriers to treat co-occurring disorders. The table is on the next page. Overall, the major barriers appear to be psychiatrist staffing, billing and reimbursement, and the need for preferred practices.

With respect to source, agency directors were significantly more inclined to report billing and reimbursement issues as a barrier ($p < .001$), whereas clinicians and clinical supervisors cited adequacy of clinical supervision ($p < .05$). Clinical supervisors also noted the barrier of the number of staff who can provide services (E)($p < .01$). The total score did not differentiate the three groups.

Program type differences are dramatic. AOS report significantly more barriers in all categories, with the greatest barriers being psychiatrist staffing (A), capable staff (B), and licensing and regulatory standards (G). DDE programs rate significantly more resources on all variables (vs. AOS) and for most compared to DDC. DDC has more similarity with AOS on items such as: psychiatrist staffing, LMHA relationship, LMHA linkage, and management support. The total Resource/Barrier score is significant (AOS: M=27.4; DDC: M=33.1; DDE: M=40.1)($p < .001$) and all post hoc tests @ $p < .001$. Note that higher scores indicate more resources and/or fewer barriers.

Using the scale below, please rate the following resources that you perceive your agency to have regarding co-occurring disorder capability:

---

1 - Lacking 2 - Between Lacking and Reasonable 3 - Neutral
4 - Between Reasonable and Great 5 - Great

	Mean (SD)
A) Psychiatrist staffing at our agency.	**2.57 (1.31)**
B) Staff at our agency who can provide mental health services to clients.	**2.94 (1.29)**
C) An excellent relationship with a LMHA who can provide mental Health services for clients with co-occurring disorders.	**3.10 (1.25**)
D) Mechanisms to insure and follow-up linkage for clients we refer to the LMHA.	**3.00 (1.21)**
E) The number of staff to provide services in our agency to clients with co-occurring disorders.	**2.86 (1.25)**
F) Physical resources (space, room size, beds) to provide services in our agency to clients with co-occurring disorders.	**2.80 (1.32)**
G) Licensing and regulatory standards that exist to provide services to clients with co-occurring disorders in our agency.	**3.04 (1.28)**
H) Billing and re-imbursement issues that exist in providing services to clients with co-occurring disorders in our agency.	**2.83 (1.11)**
I) A good screening or assessment tool to identify clients with co-occurring disorders.	**2.95 (1.21)**
J) Evidence-based or preferred practices for clients with co-occurring disorders.	**2.84 (1.11)**
K) Educational/training experience of staff in the assessment and treatment of co-occurring disorders.	**2.88 (1.16**
L) Adequacy of clinical supervision for staff in their work with co-occurring disorders.	**3.13 (1.22)**
TOTAL	**34.28 (9.96)**

VI. TRAINING

Perceptions about training was the next section of inquiry. As depicted in the table below, overall training in this area remains a need and of considerable benefit. There were no differences in either the source or program type group comparisons. All groups seek training in co-occurring disorders.

The staff at my agency would benefit from continuing education workshops on co-occurring disorders. Please circle the number which best reflects your response.

1 - Strongly agree 2 - Agree 3 - Neutral
4 - Disagree Strongly disagree

Mean = 1.72 (SD = 1.01)

The table on the next page addresses specific areas of training identified. It is here that we find group differences.

Agency directors rank preferred practices #1, medications #2, and assessment & diagnosis #3. Clinical supervisors rank preferred practices #1, assessment & diagnosis #2, and specialized group treatments #3. Clinicians also rank preferred practices #1, specialized groups #2, and assessment & diagnosis #3.

Program type differences are even more revealing. AOS providers seek training in assessment & diagnosis, screening instruments, and groups. DDC providers seek preferred practices, assessment & diagnosis, and individual therapies. Finally, DDE providers identify preferred practices, and scored significantly lower on most other areas including, assessment & diagnosis ($p < .001$).

This suggests two levels of training curricula, basic and advanced, to address knowledge requirements for assessment and treatment of co-occurring disorders.

Training in co-occurring disorders would be most helpful to staff at this agency if it focused on (check all that apply):

Specific Training Needs	Number (%)
Diagnosis/assessment via interview	**360 (78.9%)**
Using standardized screening instruments	**331 (72.6%)**
Etiology and prevalence of co-occurring disorders	**285 (62.5%)**
Preferred treatment practices	**379 (83.1%)**
Motivational Interviewing (MI)	**322 (70.6%)**
Specialized group treatments	**355 (77.9%)**
Medication issues	**340 (74.6%)**
Assertive case management approaches	**286 (62.7%)**
Specialized 12-step facilitation approaches	**281 (61.6%)**
Individual/group psychotherapies	**349 (76.5%)**

VII. WORKFORCE CHARACTERISTICS

Overall, the study sample is primarily female, middle 40s in age, white, and with significant professional experience in the field of addiction.

The agency directors (M = 51.8) are significantly older than the clinical supervisors (45.7) and clinicians (43.6) ($p < .01$). Clinicians are more likely to be non-white ($p < .01$). With respect to gender, agency directors are more likely to be male (67.4%), and clinicians female (62%), with clinical supervisors balanced. Agency directors have significantly more administrative experience, professional experience in the field, duration at the present agency, and higher educational level vis-a-vis clinicians ($p < .001$). Clinical supervisors tend to fall directly between these two groups, however, more have certification or licensure than both agency directors and clinicians ($p < .001$).

What is your age?	**Mean = 44.95 (SD = 10.31)**

What is your gender?	**Male: n = 180 (41.5%)**	**Female: n = 254 (58.8%)**

What is your race?:		
	White	**308 (73.0%)**
	Black	**58 (13.7%)**
	Hispanic	**43 (10.2%)**
	Asian	**4 (0.9%)**
	Other	**11 (2.1%)**

AOS providers are significantly younger, more racially balanced (DDE and DDC are predominantly white), more male, and more likely to have an associates or high school degree. DDE providers are more likely to have a RN, MD, or Ph.D. degree. In terms of experience, DDE providers have significantly more clinical experience (vs. AOS), administrative experience (vs. AOS, DDC), years in the field (vs. AOS), and duration at the present agency (vs. AOS, DDC).

Agency directors and clinical supervisors were also asked to estimate the mental health and training background of staff at their agency. DDE was highest, DDC was in the mid-range and AOS was lowest on these estimates ($p < .001$ overall).

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How many months of clinical experience do you have?	**M = 135.91 (SD = 101.01)**
How many months of administrative or supervisory experience in the addiction or mental health field do you have?	**M = 66.72 (SD = 81.75)**
How many total months have you worked in the addiction field?	**M = 116.67 (SD = 88.61)**
How many months have you worked with your present agency?	**M = 72.70 (SD = 73.67)**

Given the widespread assumption that the majority of addiction treatment providers espouse the twelve-step model of recovery, we assessed clinical supervisors and clinicians using an open-ended question, and then classified their responses according to the categories in the table below. The construction of these categories was based upon the responses provided, with common descriptors and clusters of descriptors used to form each option.

Although endorsed the twelve-step facilitation (TSF) model is clearly integrated with other approaches. The recognition of eclectic and cognitive behavioral (CBT) approaches is observed. Agency directors were not asked this question, but clinical supervisors (6.6%) and clinicians (11.7%) differed slightly in twelve-step affiliation. However, the frequency distribution overall found both clinicians and their supervisors similar: eclectic-unspecified #1, CBT #2, and eclectic: CBT/TSF #3.

With respect to program type, AOS programs rated eclectic as #1, as did the DDC and DDE programs. AOS did rate twelve-step second and CBT third, whereas the other groups rated CBT second, and the eclectic mix of CBT/TSF third. Nonetheless, we can largely conclude that the groups are similar in theoretical approach. Assumptions about obstacles for implementation of new practices because of rigid adherence to the twelve-step model are unfounded.

What is your approach to the treatment of addiction?

Approach	**Number (%)**
Twelve-step facilitation (TSF)	**39 (10.3%)**
Cognitive Behavioral Therapy (CBT)	**77 (20.3%)**
Biopsychosocial	**27 (7.1%)**
Eclectic - unspecified	**108 (28.4%)**
Eclectic - TSF/MI	**10 (2.6%)**
Eclectic - TSF/CBT	**59 (15.5%)**
Eclectic - CBT/MI	**16 (4.2%)**
Motivational Interviewing (MI)	**8 (2.1%)**
Other Approach	**13 (3.4%)**
CB/BIO	**15 (3.9%)**
CB/BIO/TSF	**8 (2.1%)**

VIII. PROGRAM CHARACTERISTICS

Depending on their role, providers were asked to check in what type of program they worked, or in what types of programs they supervised, or administered. These categories were structured according the ASAM-PPC-2R levels of care. As can be seen in the table below, a broad range of programs were represented.

AOS programs were more likely to be in Level III. Residential: Long term care, Intermediate long term, and Intensive - clinically managed.

DDE programs were more likely to be Level I. Outpatient (Drug Free), Level II. Intensive Outpatient (IOP, Partial Hospitalization), and Level IV. Residential/Hospital (Medically managed intensive inpatient services).

What type of substance abuse treatment programs or services does your agency provide?

	Level of care	Number (%)
I.	**Outpatient**	
	Drug Free	**179 (39.3%)**
	Methadone detox	**38 (8.3%)**
	Methadone maintenance	**85 (18.6%)**
	Ambulatory detox	**21 (4.6%)**
	Other	**78 (17.1%)**
II.	**Intensive Outpatient**	
	IOP	**115 (25.2%)**
	Methadone	**30 (6.6%)**
	Ambulatory detox	**13 (2.9%)**
	Partial hospitalization	**69 (15.1%)**
	Other	**38 (8.3%)**
III.	**Residential**	
	Trans/HWH	**32 (7.0%)**
	Social detox	**1 (0.2%)**
	Long-term care	**22 (4.8%)**
	Intermediate long-term	**95 (20.8%)**
	Intensive - clinically managed	**55 (12.1%)**
	Medically monitored inpatient detox	**35 (7.7%)**
	Medically managed inpatient	**25 (5.5%)**
	Other	**32 (7.0%)**
IV.	**Residential/hospital**	
	Medically managed inpatient detox	**30 (6.6%)**
	Medically managed intensive inpatient detox	**12 (2.6%)**
	Other	**21 (4.6%)**

The table below presents the frequency of endorsement of the ASAM-PPC-2R dual diagnosis program types. The definitions were provided directly on the survey, in order to help respondents make the appropriate selection. In some cases, respondents indicated more than one program type, and on these occasions we coded the response in the more dual diagnosis "capable" direction.

Based upon the new ASAM-PPC-2R definitions, please check the following category that best describes your program?:

Program Type	**Number (%)**
Addiction-only programs (AOS)	**97 (21.3%)**
Dual-diagnosis capable (DDC)	**316 (69.3%)**
Dual-diagnosis enhanced (DDE)	**113 (24.8%)**

The table below indicates the reports on populations served. There were no source differences, however, programs that served adolescents tended to be DDE and DDC, and services for men only AOS. Programs for pregnant women and correctional/mandated special populations were either AOS or DDC.

What populations are served by your program(s)?:

Target population	**Number (%)**
Adults	**415 (91.0%)**
Adolescents	**111 (24.3%)**
Special Populations	**243 (53.3%)**
Women	**95 (20.8%)**
Men	**90 (19.7%)**
Pregnant women	**84 (18.4%)**
Correctional/mandated	**147 (32.2%)**
Other	**77 (16.9%)**

IX. INVESTMENT IN SURVEY AND QUALITATIVE DATA

A significant number of respondents desired a summary of the findings from this survey (53.5%). Agency directors were significantly more likely (92%) that clinical supervisors and clinicians (50%) to request a summary ($p < .01$). With respect to program type, no differences were noted.

Do you have any additional comments or suggestions regarding the assessment and treatment of co-occurring disorders in your agency or with respect to the addiction treatment delivery system?

	Number (%)
Comments or suggestions	**84 (18.4%)**

Would you like to receive a summary of findings?

Requested summary	**244 (53.5%)**

The next section (X) will explore in greater detail the respondents approach to the open-ended question in the table above.

X. THEMATIC ANALYSIS OF OPEN-ENDED RESPONSES

The table below depicts an abstraction of the open-ended responses. These responses were analyzed for content and then grouped into categories based on the narrative. A list of ten composite categories was constructed. The frequency of mention by individual respondents for each composite category (and for those with multiple mentions) was then recorded.

An inspection of this table reveals that issues with training prevail. Notable was training in treatment approaches, screening/assessment practices, and in culture-based specialized services (e.g. for Latino clients).

The need for more resources was also often indicated. Shortage of generic services was mentioned, but more specifically was the need for residential programs that would accept persons with psychiatric disorders and on psychotropic medications. One might connect this with the need for safe (sober) housing alternatives as well. As noted above, AOS programs are more often found at the residential level of care.

CATEGORIES OF NARRATIVE	FREQUENCY OF MENTION
1.Training	**37**
Training needed (unspecified type)	18
Screening/assessment	6
Cultural/Latino specific	5
Supervision	3
Medications	2
Other	3
2.Resources/Services	**32**
Resources services (unspecified)	10
Residential for co-occurring	6
Housing	5
Case management	3
Other	8
3.Increasing prevalence	**9**
4.Structural obstacles	**8**
Financing, insurance, Policy	
Title 19, DPH licensure	
5.Positive report of treatment	**7**
6.Workforce issues	**7**
Number or money	5
Other	2
7.Communication/Linkage	**6**
8.Negative report of treatment	**4**
9.Complaints about DHMAS	**2**
10.Complaints about survey	**1**

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APPENDIX

TO: DMHAS FUNDED OR OPERATED SUBSTANCE ABUSE PROGRAMS

FROM: THOMAS A. KIRK, JR., Ph.D., COMMISSIONER
KENNETH M. MARCUS, M.D., MEDICAL DIRECTOR
PAUL J. DILEO, DIRECTOR OF COMMUNITY SERVICES AND HOSPITALS

DATE: APRIL 1, 2002

RE: CO-OCCURRING DISORDERS IN SUBSTANCE ABUSE TREATMENT INITIATIVE

As you are well aware, the topic of clients with co-occurring disorders is of considerable interest to both addiction and mental health providers. These clients provide us with clinical and administrative challenges, and seem to find the crevices and nerves of our service delivery system.

Outside of Connecticut and nationally, providers are likewise wrestling with developing the best or preferred practices to serve clients with dual-disorders. On the mental health side, several evidence-based practices have emerged, particularly targeted to clients with severe mental illness and a co-occurring substance abuse problem. Unfortunately, less technology is available for clients with co-occurring disorders within the addiction treatment delivery system.

This is where this project begins. It is our intent to obtain an estimate of the current practices, perceptions, motivations, capabilities, and barriers for the assessment and treatment of co-occurring disorders in the addiction treatment system in the state of Connecticut. We are asking for your help in doing this.

To obtain this estimate, surveys have been developed to assess key issues of co-occurring disorders. These surveys are designed to be completed by Agency Directors, Clinical Supervisors, and Clinicians within all DMHAS funded or operated and representative General Assistance funded programs across the state. This should provide us with a wide range of programs, geographic settings, and a broad and multidisciplinary perspective on this important issue.

We believe that this information will form the basis of a starting point and to plan for statewide administrative, clinical, training, and research responses to co-occurring disorders.

No survey of this scope has ever been conducted, and this effort promises to place us on the cutting edge of programmatic efforts in this area.
We require your help to conduct this project.

You will receive a packet of surveys: Agency Director, Clinical Supervisor, and Clinician versions. Please see that these surveys are distributed within your agency to all Clinical Supervisors, and that these Clinical Supervisors are instructed to distribute Clinician surveys to no more than five (5) clinicians under their direct supervision. Envelopes will be provided so that each person can complete the survey with the assurance that their responses will be confidential, not known to anyone within the agency, and analyzed by our research consultant team only.

Each agency is expected to collect the survey envelopes, and return them to DMHAS for processing.

It is our intent to analyze these data for group trends only, not for individual or specific agency responses.

The plan is to examine the data in aggregate and to use this evidence to begin a thoughtful and reality-based planning process with all of you.

We thank you, in advance, for your participation and support.

CO-OCCURRING DISORDER

SURVEY QUESTIONNAIRES

AGENCY INSTRUCTIONS

Your agency has been provided with a packet of surveys and envelopes by DMHAS Health Care Operations regional system managers .

These packets include three (3) versions of surveys: Agency Director, Clinical Supervisor, and Clinician. Unless you are a smaller agency, you have been provided with 1 Agency Director survey, 2 Clinical Supervisor surveys, and 10 Clinician surveys, along with corresponding envelopes.

Each Agency Director should complete his/her version of the survey.

All Clinical Supervisors within an agency should complete his/her version of the survey. If more copies are needed for additional Clinical Supervisors within an agency, they can be made by the agency.

Clinical Supervisors should distribute surveys (and envelopes) to no more than five (5) Clinicians each who they directly supervise. Again, if more copies of the surveys are needed, the agency can make the necessary number required.

Clinicians should complete the surveys, place them in the envelopes provided, and return them to their Clinical Supervisor. Clinical Supervisors should collect these envelopes, complete their own version of the survey and place it in the envelope provided, and return all envelops to the Agency Director or his/her designate.

The entire packet of completed surveys are to be returned WITHIN THIRTY (30) DAYS OF RECEIPT in the large manila envelope addressed to:

Sam R. Segal
Connecticut DMHAS
P.O. Box 341431
Hartford, CT 06134

Attn: Dr. McGovern

Dr. McGovern and the research staff at the New Hampshire Dartmouth Psychiatric Research Center in Concord NH will process the surveys, enter the responses into a database file, and analyze the data for group trends only.

If desired, specific agency data can be requested by that agency. This request must be in writing and forwarded via Sam Segal.

Otherwise, all data will be summarized in aggregate, in statewide format.

No individual survey response data will ever be identified or released.

The results of the survey will be available for presentation in June 2002.

Thank you for your participation.

ASAM-PPC-2R CO-OCCURRING DISORDER PROGRAM TYPOLOGY

ADDICTION-ONLY SERVICE (AOS)

Services directed solely at the treatment of addictive disorders. Such services are not directed at co-occurring mental disorders: for example, an AOS program typically would not accept an individual who needs psychotropic medications, and mental health issues generally would not be addressed in treatment planning or content. (p.359*).

Programs that either by choice or for lack of resources, cannot accommodate clients who have psychiatric illnesses that require ongoing treatment, however stable the illness and however well-functioning the client. (From Co-Occurring Disorders Survey Questionnaire).

DUAL DIAGNOSIS CAPABLE (DDC)

Treatment programs that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning. Such programs have arrangements in place for coordination and collaboration with mental health services. They also can provide psychopharmacologic monitoring and psychological assessment and consultation, either on site or through coordinated consultation with off site providers. Program staff are able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change-as well as relapse and recovery environment issues-through individual and group program content. Nevertheless, the primary focus of DDC programs is the treatment of substance-related disorders. (p.362*).

Programs that have a primary focus on the treatment of substance-related disorders, but are also capable of treating clients who have relatively stable diagnostic or subdiagnostic co-occurring mental health problems related to an emotional, behavioral or cognitive disorder. (From COD Survey Questionnaire).

DUAL DIAGNOSIS ENHANCED (DDE)

Treatment programs that incorporate policies, procedures, assessments, treatment and discharge planning processes that accommodate patients who have co-occurring mental and substance-related disorders. Mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies specifically designed for those with co-occurring mental and substance-related disorders are more likely to be available (particularly in outpatient settings) and, ideally, there is close collaboration or integration with a mental health program that provides crisis back-up services and access to mental health case management and continuing care. In contrast to DDC services, DDE services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services an program content. (p.362).

Programs that are designed to treat clients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders. (From COD Survey Questionnaire).

* American Society of Addiction Medicine. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders. Second Edition-Revised. Chevy Chase MD: American Society of Addiction Medicine.