Public Meeting Notice

Please note this meeting is open to the public and is being recorded
Anything said during this meeting may be part of the public record

Co-Occurring Disorders

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

HMA
Health Management Associates

Learning Objectives

1. By the end of the session, attendees will be able to identify the prevalence of Co-Occurring Disorders (COD).
2. By the end of the session, attendees will be able to identify one evidence-based screening tool for COD.
3. By the end of the session, attendees will be able to identify one evidence-based practice for COD.
4. By the end of the session, attendees will be able to define COD as it relates to MH and SUD.

Defining Co-Occurring Disorders

For the purpose of this training, we will be using the following definitions:

Co-occurring disorders – A mental health condition along with a substance use disorder.

Co-occurring services – Treat MH and SUD in the same service line.

Integrated services - Integrated behavioral health and primary care services.
Integrated care is defined per the Agency for Healthcare Research and Quality as "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

In the people you treat, what is the percentage you think have a COD:

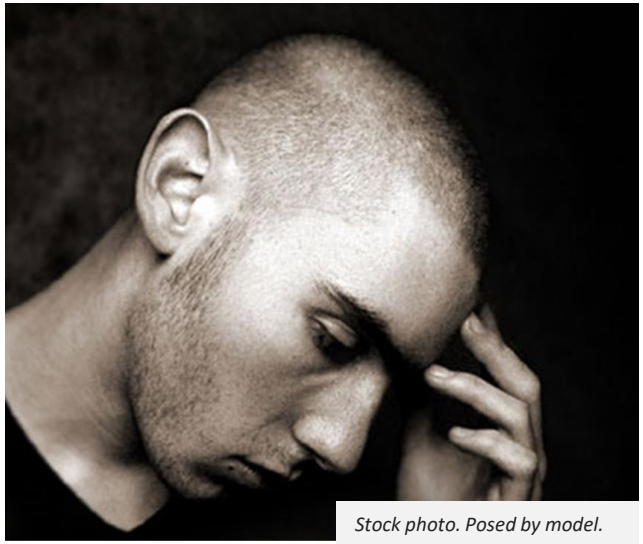
- Mental Health Disorder
- Substance Use Disorder
- Medical Condition

Co-Occurring Mental Health AND Substance Use Disorders

- 58 million US adults have a mental health (MH) condition
- Almost 49 million have a substance use disorder (SUD)
  - <10% receive SUD treatment (compared to 40-60% with MH dx)
- 19.4 million US adults have a MH condition and SUD
  - 6.5% receive treatment for both
- People with Serious Mental Illness (SMI) are
  - 4 times more likely to heavily use alcohol
  - 3.5 times more likely to regularly use cannabis
  - 4.6 times more likely to use other drugs
- 55% of people with schizophrenia have SUD
  - 43% alcohol
  - 35% cannabis
  - 27% illicit substances

High Rate of Co-Occurring Disorders (COD)

- Of 2 million US adults with opioid use disorder (OUD) (2015-17):
  - 77% had another substance use disorder (SUD) or nicotine dependence in past year
  - 64% had co-occurring MH condition in past year
  - 27% had Serious Mental Illness (SMI) in past year
- 90% of persons with COD do not receive treatment



Stock photo. Posed by model.

Why Do We Care About Co-Occurring Disorders in a Value Based Payment (VBP) Environment

- Those with COD have increased rates of:
  - Medical illnesses
  - Suicide
  - Early mortality
  - Hospitalization medical & mental health
  - Noncompliance with treatment
  - Reincarceration
- All of these outcomes cause people to use more expensive care

Caring for the Whole Person

We Want to Hear From You

When someone has SUD and a MH condition, providers should

A. Treat the SUD first
B. Treat the MH condition first
C. Treat both simultaneously for best results

We Want to Hear From You ANSWER

When someone has SUD and a MH condition, providers should

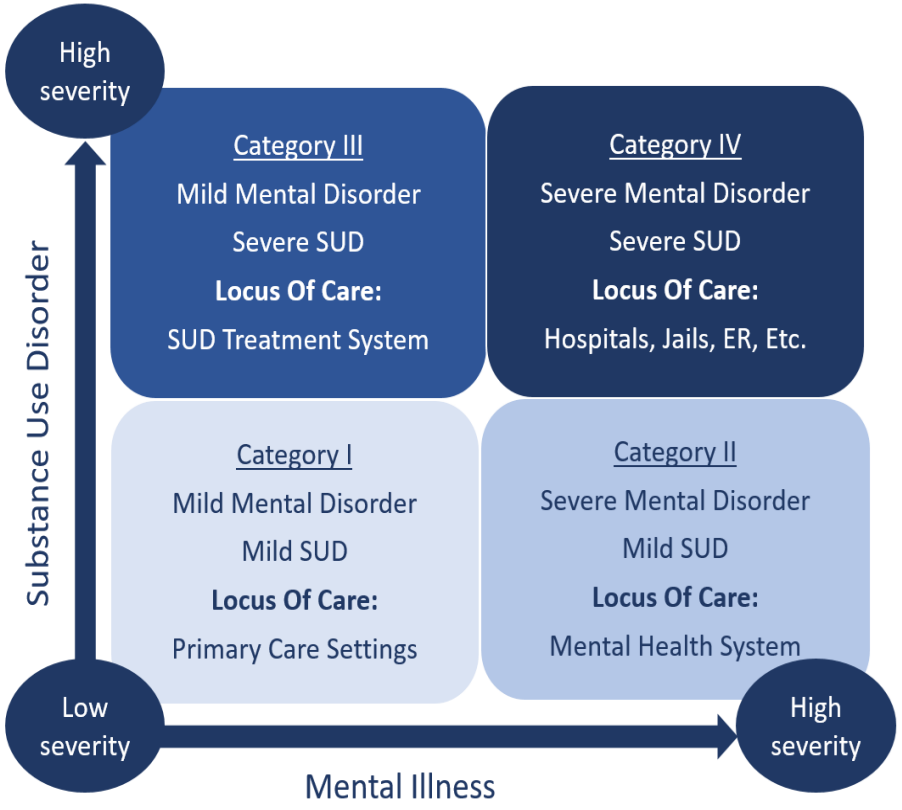
~~A. Treat the SUD first~~

~~B. Treat the MH condition first~~

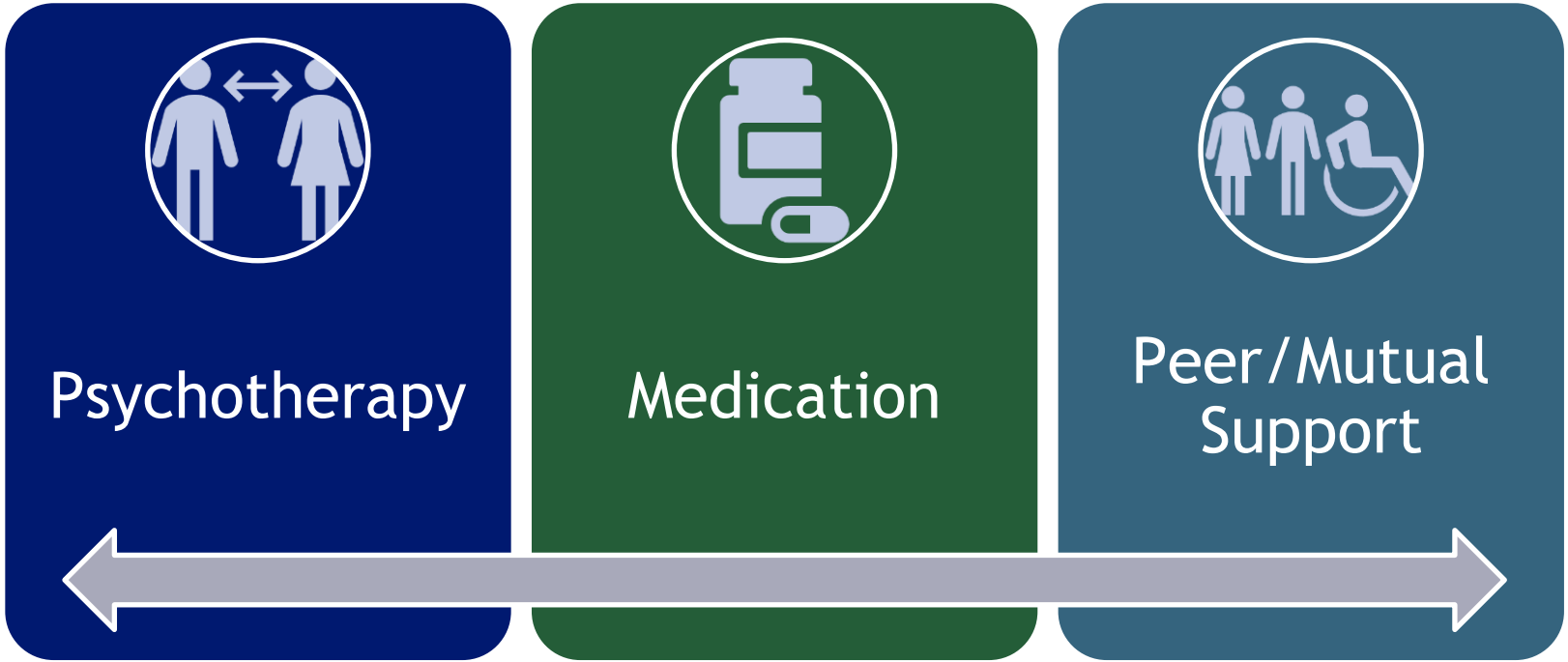
C. Treat both simultaneously for best results

Co-Occurring Disorder: Treatments

- Location of care
  - Primary Care
  - Mental Health SUD Treatment
  - Hospitals and Institutions



Variety of Treatment Options



Co-Occurring Disorder Treatment

Motivational Interviewing (MI)

Psychoeducation

Cognitive Behavioral Therapy (CBT)

- Distress tolerance skills
- Coping skills
- Behavioral activation
- Cognitive restructuring
- Relapse prevention

Co-Occurring Disorder Treatment - Medication Needs

- Some conditions require medication:
  - OUD
  - Psychosis

- Other conditions may require medication, or may improve from therapy:
  - Major Depressive Disorder
  - Anxiety disorders
  - PTSD

SAMHSA TIP 42 p 223

Co-Occurring Disorder Treatment - Peer Support

- Dual Recovery Anonymous
- Medication Assisted Recovery Anonymous
- Dual Diagnosis Anonymous

These Meetings:
- 12 Step Fellowships
- Don’t discourage medication use
- Fewer meetings than AA

Integrated Treatments for:

- Major Depressive Disorder
  - Improves depression & functioning
  - Decreases substance use
- PTSD (Only staff with adequate training should treat)
  - Decreases PTSD & SUD symptoms
- Anxiety Disorders
  - Decreases anxiety & SUD symptoms, most studies
  - Educate on dangers of self-medicating
- Bipolar
  - Increases abstinence & medication adherence
  - Decreases hospitalization & SUD symptoms
- Schizophrenia
  - Increases abstinence, quality of life and functioning
  - Decreases drinking days, relapse rates, positive toxicology, negative consequences of substance use, violence, costs, symptom severity

On-site prescribing works best to eliminate barriers to treatment

Co-Morbid Medical Conditions

There are many common co-occurring medical conditions in the SUD population:

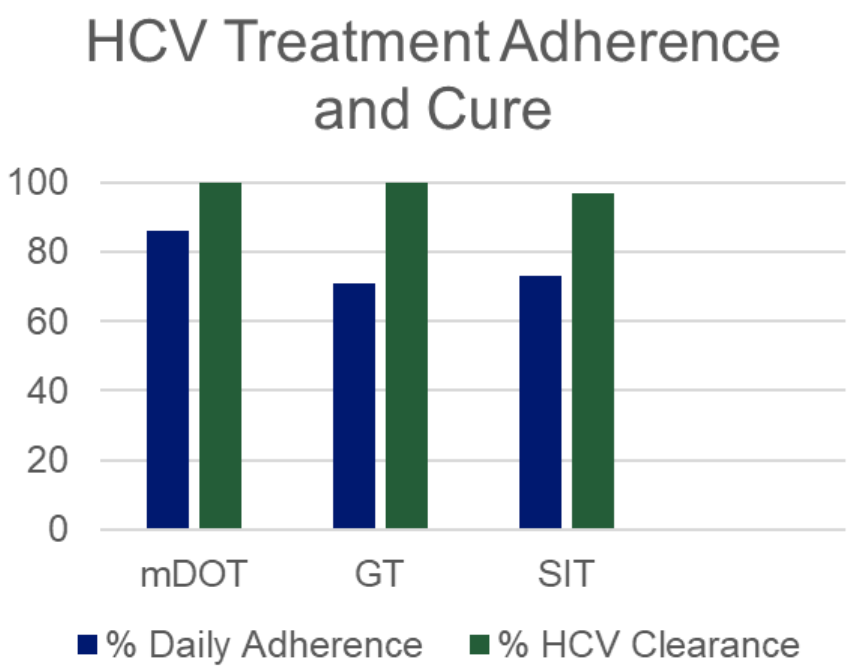
- HIV
- Hepatitis C Virus
- High Blood Pressure
- Heart disease
- Diabetes
- Metabolic conditions

Testing recommendations for behavioral health facilities include:

- Routine lab test
- Vitals
- Measurement of waist circumference
- Ability to get EKGs for some BH medications

Medical Co-Morbidities

- Consider the possible medical conditions that may be present along with the BH need
- Medical consequences of substance use:
  - Liver disease
  - Infection
  - HIV, HCV
  - Skin infection
  - Endocarditis
  - TB
  - Metabolic/nutrition



mDOT = modified directly observed therapy; GT= group therapy; SIT= self-administered individual treatment

Hepatitis C Virus (HCV) Treatment in People Who Use Drugs

- Injection drug use accounts for ~ 70% of new HCV infections
- Active or recent drug use is NOT a contraindication for HCV treatment
- Cure rates ~ 95% in persons reporting drug use at start of HCV treatment
- Opioid agonist treatment (methadone or buprenorphine) reduces rate of HCV acquisition by 50%

Screening

What is Screening?

- Screening helps identify who has, or is at risk of, a medical condition
- You can't treat what you do not know exists
  - Therefore, we screen
- Key is to screen all patients to determine who should have further assessment

Which screening tool should I use?

Some considerations when deciding on a tool:

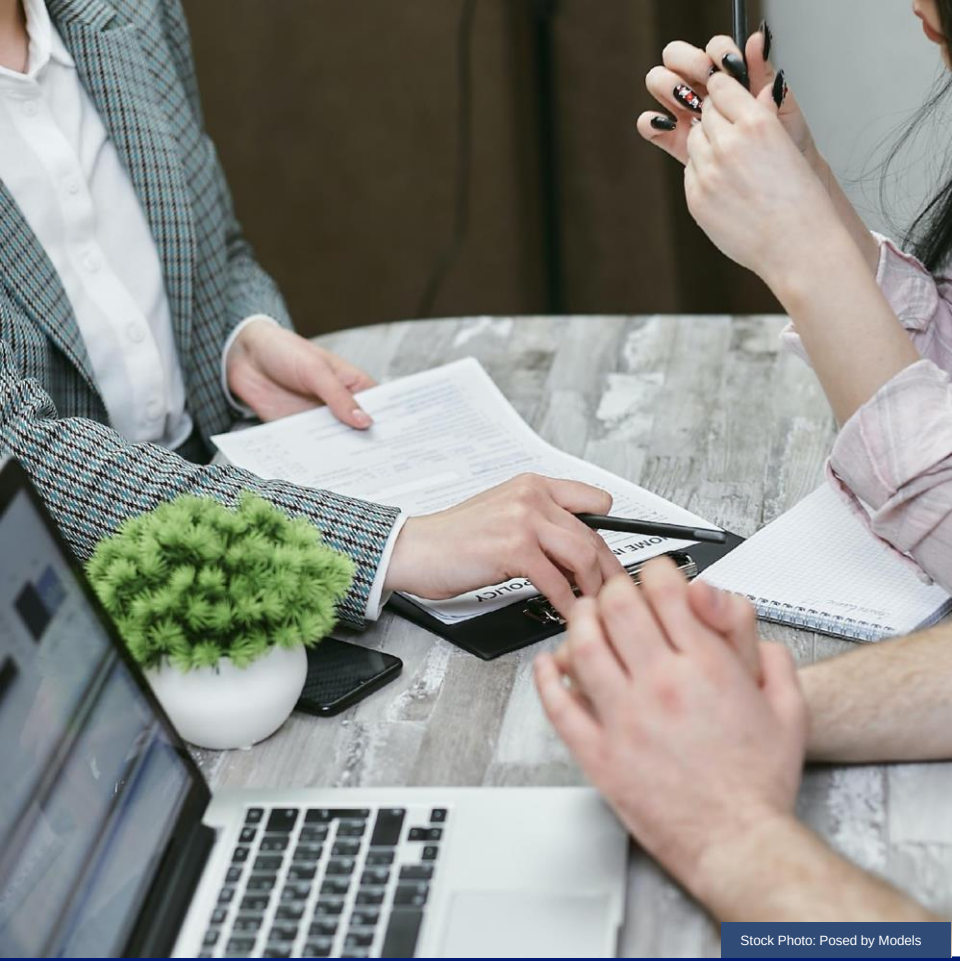
- "Homegrown" vs. standardized/validated?
- Time allotted for screening

"We have been doing it this way since…"

Use of results:

- Referral to Medical/BH
  - Treatment planning
  - Do we use a positive or negative screen for legal purposes?

NO!



Stock Photo: Posed by Models

What Do We Do With Screening Information?

- If a patient screens positive, assess if a MH/SUD is present
- If the disorder is present assess further to determine the severity

Note- Many tools we use for screening do offer value as assessments as well, depending on setting

Let's Hear From You

If you are a MH practice, what percentage of people do you screen for SUD?

If you are a MH practice what percentage of people do you screen for chronic medical conditions?

If you are a SUD practice, what percentage of people do you screen for MH Disorders?

If you are a SUD practice, what percentage of people do you screen for chronic medical conditions?

If you are a practice that treats MH/SUD in the same service line, what percentage of people do you screen for chronic medical conditions?

If you are a medical practice, what percentage of people do you screen for MH?

If you are a medical practice, what percentage of people do you screen for SUD?

Evidence-Based Screening for SUD

National Institute on Drug Abuse (NIDA)-Quick Screen and Modified ASSIST	Tobacco, Alcohol, Prescription (TAPs 1 and 2)	Texas Christian University (TCU)-5	Simple Screening Instruments (SSI)
• Great screener and first level assessment tool	• Screener plus mini-assessment (P 1 and P2) • Self-report or interview format • Based on NIDA products • Developed for primary care	• 13 items • Takes about 20 minutes to administer • Can be self-administered	• 10 items • CSAT Treatment Improvement Protocols in 1994 • Simple Screening Instruments for Outreach for Alcohol or Other Drugs (AOD), and Infectious Disease

Evidence-Based Screening for Mental Health

Patient Health Questionnaire (PHQ)- 2 and 9

- 2 Questions to screen for depression
- If screen positive move to PHQ-9

General Anxiety Disorder (GAD)-7

- 7 questions to screen for anxiety

Post Traumatic Stress Disorder Checklist (PCL) for Diagnostic & Statistical Manual of Mental Health (DSM)-5

- 20 item self- report measure that looks at the 20 DSM-5 symptoms of PTSD

Adverse Childhood Experiences (ACEs)

- Screens for risk of trauma by asking about adverse childhood experiences

Examples of Screening – SUD

No Wrong Door

No matter the condition we are treating, we should have a plan in place to screen and address (directly or through referral) for the common co-occurring disorders in our population:

- A person enters a BH program to address their MH concerns, the BH clinic screens the person for SUD and provides whole-person care. A person enters a BH program to address their MH concerns, the BH clinic screens the person for SUD and refers them to a partnering SUD program. A person arrives at their primary care provider for a work physical. The provider screens them for SUD and MH and arranges for their BH consultant to meet with the person and provide integrated services.

- A person arrives at their primary care provider for a work physical. The provider screens them for SUD and MH and refers to their partnering BH provider.

Examples of Screening – Mental Health

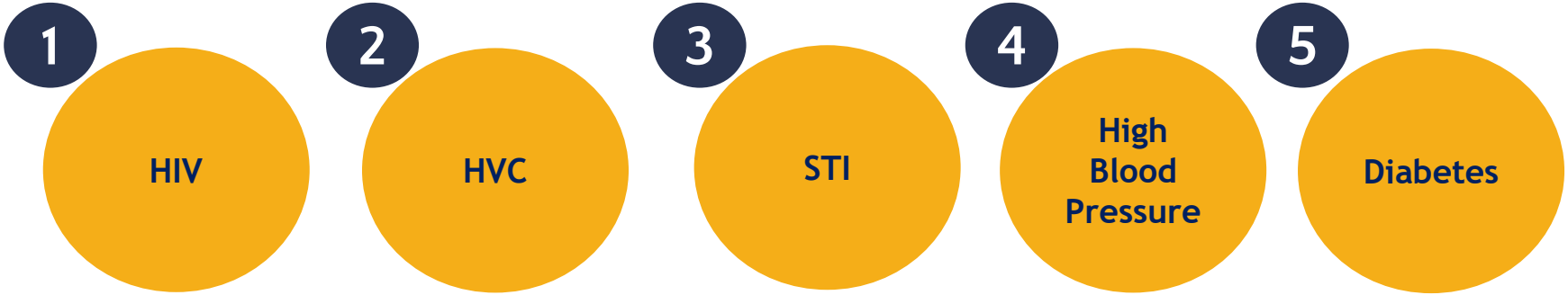
No matter the condition we are treating, we should have a plan in place to screen and address (directly or through referral) for the common co-occurring disorders in our population.

No Wrong Door

- A person enters a BH program to address their SUD concerns, the BH clinic screens the person for MH and provides whole-person care.
- A person enters a BH program to address their SUD concerns, the BH clinic screens the person for MH and refers them to a partnering MH program.
- A person arrives at their primary care provider for a work physical. The provider screens them for SUD and MH and arranges for their BH consultant to meet with the person and provide integrated services
- A person arrives at their primary care provider for a work physical. The provider screens them for SUD and MH and refers to their partnering BH provider.

Screening for Physical Health Conditions

Common Co-Morbid Chronic Medical Conditions



Examples of Screening- Medical Conditions

A person enters a BH program to address their MH and SUD concerns, the BH program screens for risk of diabetes, high blood pressure, HIV, and HCV and make referral with partnering FQHC for a same-day appointment to a PCP.

No Wrong Door

No matter the condition we are treating, we should have a plan in place to screen and address (directly or through referral) the common co-occurring disorders in our population.

A person enters a BH program to address their MH and SUD concerns, the BH program screens for risk of diabetes, high blood pressure, HIV and HCV and the program's NP meets with the person to perform a physical and develop a care plan.

Current Screening and Testing Rates

- 19% of 15-44yo in the US were tested for HIV in the past year.
- Only 35% of people in 10 outpatient HIV clinics reported talking to a primary care provider (PCP) about alcohol use.
- Less than 50% of providers in hospital-based HIV care programs conducted recommended screening and brief interventions for reducing alcohol.
- Only 29% of SUD programs offer onsite HIV testing.
- Only 49% of people with mental illness have had an HIV test.
- 21% of people with HIV-positive blood samples did not have documentation of infection during psychiatric hospitalization.

Who Should Be screened for Hepatitis C Virus (HCV)?

- Universal screening of all adults ≥ 18yo, at least once
- All pregnant women during each pregnancy

Periodic screening while risk factors persist:

- Persons who inject drugs and/or share needles, syringes or other drug preparation equipment
- Persons with selected medical conditions, including receipt of hemodialysis

HIV Testing Recommendations

- SAMHSA recommends universal HIV testing for:
  - Persons 15-65yo (and all pregnant persons)
  - Younger & older persons at increased risk, such as:
    - People who inject drugs
    - People who have condomless sex
    - People who participate in sex work
- U.S. Preventative Task Force Rating A Requires Medicare and Medicaid to pay for testing

All SUD Treatment programs should offer on-site same-day oral fluid testing.

Anyone at high risk should be tested yearly.

Let's Hear From You

What is one new screening practice you are taking away from today?

Integrated Care

Integrated Primary & Behavioral Health Care

Benefits of Integration

1. Increase the likelihood of follow-through on referrals
2. Improve physical health outcomes
3. Increased savings in healthcare cost
4. Reduce emergency room use

Ryan White HIV/ AIDS Treatment Extension Act 2009

Aligns with HHS guidelines. Mandates include:

1. Universal depression and SUD screening
    - MH screening rates currently are between 80%-100%
    - SUD screening rates currently are much lower
2. Establishment of follow-up plan

Coordinated

Key Element: Communication	
Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance
In separate facilities where they:	In separate facilities where they:
- Have separate systems - Communicate about cases only rarely and under compelling circumstances - Communicate, driven by provider need - May never meet in person - Have limited understanding of each other's roles	- Have separate systems - Communicated periodically about shared patients - Communicate, driven by specific patient issues - May meet as part of larger community - Appreciate each other's roles as resources

Co-Located

Key Element: Physical Proximity	
Level 3 Basic Collaboration Onsite	Level 4 Close Collaboration Onsite with Some System Integration
In same facility, not necessarily same office, where they	In same facility, not necessarily same office, where they
- Have separate systems - Communicate regularly about shared patients by phone or email - Collaborate driven by need for each other's services and more reliable referral - Meet occasionally to discuss cases due to close proximity - Feel part of a larger yet non-formal team	- Share some systems, like scheduling or medical records - communicate in person as needed - collaborate, driven by need for consultation and coordinated plans for difficult patients - Have regular face to face interactions about some patients - Have a basic understanding of roles and culture

Integrated

Key Element: Practice Change	
Level 5 Close Collaboration Approaching an Integrated Practice	Level 6 Full Collaboration in a Transformed/Merged Integrated Practice
In same space within the same facility (some shared space), where they	In same space within the same facility, sharing all practice space
- Actively seek system solutions together or develop work-arounds - Communicate frequently in person - Collaborate, driven by desire to be a member of the care team - Have regular team meetings to discuss overall patient care and specific patient issues - Have an in-depth understanding of roles and culture	- Have resolved most or all system issues, functioning as one integrated system - Communicate consistently at the system, team and individual levels - Collaborate, driven by shared concept of team care - Have formal and informal meetings to support integrated model of care - Have roles and cultures that blur or blend

Case Discussion: John

- Mr. John B. is a 58-year-old cisgender male who was referred by his husband after a recent recurrence of alcohol use.

- History includes 30 years of chronic heavy drinking with periods of sustained remission, the longest being 10 years. He returned to drinking 4 weeks ago in the setting of being laid off from his job at a tech company. He is currently drinking a pint of vodka daily with his last drink yesterday afternoon.

John's case

- John's medical history is significant for hypertension (high blood pressure), hyperlipidemia (high cholesterol) for which he takes medication daily and for osteoarthritis of the knees for which he takes ibuprofen and intermittent oxycodone.
- John was not adhering to his medication and has not been to the doctor in several years.
- He also has a history of major depression with suicidal ideation and hasn't taken his antidepressant for the last 3 weeks.
- His husband has threatened to kick him out if he did not enter treatment.
- John is now willing to accept treatment and to restart his antidepressant.
- On presentation to your office, he is sweaty, anxious, and irritable with notable tremors of his hands.

Screening and Integrated Care Considerations

Break Out

How can we support John in being successful?

Things to Consider:

- What would you address first?
- What environment of care might he need?
- What are other risk factors?
- What care providers might need to be involved?

To better inform our future trainings as well as request topics for office hours, please complete this short survey. Use the QR code or short URL to access it. Your feedback is important. Thank you!

https://bit.ly/bhprovidertrainingsurvey

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

HMA
Health Management Associates

Appendix A: Additional Resources

Office Hours

Last Friday of the month (March-June) @ 12pm MST, Register Here

Listserv

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

HCPF Safety Net Provider Website

Visit the website for details on upcoming training topics and announcements, training recordings and presentation decks, FAQs and more: https://hcpf.colorado.gov/safetynetproviders

TTA Request Form and E-Mail

Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

- Andriote. HIV and Clinical Depression APA Fact Sheet 2012, Arlington VA.
- Bhattacharya, D., Aronsohn, A., Price, J., Lo Re, V., III, & the American Association for the Study of Liver Diseases-Infectious Disease Society of America HCV Guidance Panel. (2023). Hepatitis C Guidance 2023 Update: American Association for the Study of Liver Diseases– Infectious Diseases Society of America Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection. Clinical Infectious Diseases. doi:10.1093/cid/ciad31
- CA Fatal Opioid OD & HIV or HCV Vulnerability Assessment (2020). Public Report. Retrieved from https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/VA_PublicReport.pdf
- Centers for Disease Control & Prevention. (n.d.). How does taking an HIV test help me? Retrieved February 2024 from https://www.cdc.gov/hiv/basics/hivtesting/gettingtested.html#:~:text=You%20should%20get%20tested%20at%20least%20once%20a%20year%20if%3A&text=You've%20shared%20needles%2C%20syringes,for%20another%20sexually%20transmitted%20disease.
- Centers for Disease Control & Prevention. (n.d.). People Coinfected with HIV and Viral Hepatitis. Retrieved February 2024 from https://www.cdc.gov/hepatitis/populations/hiv.htm.
- Hartz, et. al. (2014) Comorbidity of severe psychotic disorders with measures of substance use. *JAMA Psychiatry* 71(3), 248-254.
- HIV.gov. (2023, December). Fast Facts. New HIV Infections. Retrieved February 2024 from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.
- Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. Drug and Alcohol Dependence, 197, 78–82. https://doi.org/10.1016/j.drugalcdep.2018.12.030
- Kerner B. (2015) Comorbid substance use in schizophrenia: A latent class approach. *Psychiatry Research*, 225(3), 395-401.

Appendix B: References (pt. 2)

- Platt, L., Minozzi, S., Reed, J., Vickerman, P., Hagan, H., French, C., . . . Hickman, M. (2018). Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. Addiction, 113(3), 545-563. doi:10.1111/add.14012
- NIDA. 2022, September 27. Part 1: The Connection Between Substance Use Disorders and Mental Illness. Retrieved from https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness on 2024, February 27
- Norton, B. L., Akiyama, M. J., Arnsten, J. H., Agyemang, L., Heo, M., & Litwin, A. H. (2021). High HCV cure rates among people who inject drugs and have suboptimal adherence: A patient-centered approach to HCV models of care. *Int J Drug Policy*, 93, 103135. doi:10.1016/j.drugpo.2021.10313
- Rothbard AB, Blank MB, Staab JP, et al. Previously Undetected Metabolic Syndromes and Infectious Diseases Among Psychiatric Inpatients. *Psychiatric services*. 2009;60(4):534–537
- SAMHSA- HASA Center for Integrated Health Solutions. Table 1. Six Levels of Collaboration/Integration (Core Descriptions). Retrieved February, 2024 from https://www.careinnovations.org/wp- content/uploads/Behavioral-Health-Integration-Levels-Table-SAMHSA.pdf
- SAMHSA SUD Treatment for people with co-occurring disorders. (2020). TIP 42 SAMHSA Publication No. PEP20-02-01-004. Rockville, MS.
- SAMHSA: Substance Abuse and Mental Health Services Administration, & McCance-Katz, Elinore. (2019, November 21). Dear colleague letter from Dr. McCance-Katz on oral fluids HIV testing. https://www.samhsa.gov/sites/default/files/oral-fluids-dearcolleague-letter.pdf
- Strauss SM, Rindskopf DM. Screening patients in busy hospital-based HIV care centers for hazardous and harmful drinking patterns: the identification of an optimal screening tool. J Int Assoc Physicians AIDS Care (Chic). 2009 Nov-Dec;8(6):347-53. doi: 10.1177/1545109709350509. Epub 2009 Oct 22. PMID: 19850861

Appendix B: References (pt. 3)

- Substance Abuse and Mental Health Services Administration. (2021). Treating Substance Use Disorders Among People with HIV. Advisory. CDC. Retrieved February 2024 from https://www.cdc.gov/hiv/basics/hiv-testing/gettingtested.html#:~:text=You%20should%20get%20tested%20at%20least%20once%20a%20year%20if%3A&text=You've%20shared%20needles%2C%20syringes,for%20another%20sexually%20transmitted%20disease.
- Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
- Substance Abuse Mental Health Services Agency. 2020. Substance Use Disorder Treatment for People with Co-occurring Disorders Treatment Improvement Protocol Tip 42. SAMHS. Rockville, MD. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf