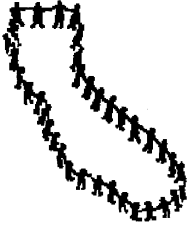


# **CALIFORNIA NETWORK OF MENTAL HEALTH CLIENTS**



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## **Treating Clients with Co-Occurring Disorders**

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The California Network for Mental Health Clients has an enormous stake in policy development that improves the lives of the range of mental health clients in the State of California. During a meeting on February 20, 2008, the Oversight and Accountability Commission, which oversees California’s Mental Health Services Act (MHSA), heard a detailed presentation on the extensiveness of co-occurring disorders (COD). This paper extends the hearing’s discussion by examining key policy issues and making recommendations for policy changes that will improve outcomes for COD clients.<sup>1</sup> Understanding the requirements of the Mental Health Services Act is essential to examining their particular application to clients with co-occurring disorders. Two key points of the MHSA follow, as cited in the OAC report:

- 1) Effective services for people with serious mental illnesses must include “whatever it takes” for recovery.
- 2) Those services must be integrated.

Besides examining effective, integrated services, this paper will look at the issues of COD in relation to criminal justice, trauma focus and awareness, and coercion of clients and reliance on a medical model of care.

The phrase “whatever it takes” refers to a wide array of clinical and support services that include and go beyond traditional conceptions of mental health care. These services may extend to such things as providing housing, supporting employment, and offering treatment for co-occurring conditions. The word “integrated” refers to services that are concurrently delivered by a team of providers, who often work at

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<sup>1</sup> This paper is largely based on the “Report on Co-Occurring Disorders,” developed from the February 20, 2008 meeting of the Oversight and Accountability Commission, Mental Health Services Act. See the following website for that report: <http://www.dmh.ca.gov/MHSOAC/docs/Co-OccurringDisorders.pdf>.

the same site. Among the most important services to be integrated with mental health is treatment for substance use.

About one half of those who have a mental health condition or a substance use disorder also have the alternate condition. Frequently referred to as “dual diagnosis” or “co-occurring disorders” (COD), the medical term for the condition of having both a mental health diagnosis and a substance use or primary care diagnosis is called “co-morbidity” and that term will sometimes be used to refer to the condition of dual diagnosis.

A number of studies suggest that integrated care is necessary for successful treatment of co-occurring disorders. Care models that are not integrated are less effective. At the same time, there is a dearth of publicly funded programs for integrated care. Only those programs provided under the law “AB34” are significant.<sup>2</sup> Other programs provide treatment for one diagnosis or the other, and most private insurance covers treatment for one condition or the other, but not both.

The California Network for Mental Health Clients is working toward dual diagnosis policy change in a number of ways. One involves integration of care. In order for integration to occur it must be supported by both policy and funding. Some of that policy and funding should be directed toward identifying those mental health clients who have COD. Notably, when standards are put in place to require the co-location of mental health and COD services, integration outcomes are likely to be improved. To this end, screening of all those who come into contact with either mental health or COD programs should be required as a central means of integrating and improving services.

In addition, the improvement of dual diagnosis services requires better preparation of care providers. All physicians, general practitioners and psychiatrists, should be required to have training in COD and mental health. This training will help ensure that clients are not shuffled from one practitioner to another who is deemed a more suitable match because of his or her specialty in one or the other of the diagnoses.

Increasingly important is the need for public and private insurance to provide services for individuals with COD, and to be held accountable when they allow these individuals to be ignored by the mental and behavioral health system. This need has long been recognized and has been incorporated into law, but insurers are still consistently failing COD clients. Part of the response to this failure of insurers to abide by the law is to require the housing of mental health and substance use services in the same location. By

making clear and sensible plans to reorganize systems that respond to the requirement of integration, mental health and substance abuse agencies can support the ability and likelihood that public and private insurers will cover the combined treatment needs of COD clients. Creative funding strategies must be embraced and employed by administrators in both areas. While sharing financial resources is seldom a popular policy option, it is required before integration can occur.

In general, all policy that addresses COD must be made more specific and enforceable. Emphasis should be placed on the inclusion of potential COD clients rather than the exclusion of those who might be unable to avoid rejection due to policy technicalities. In particular, these general policy changes should extend to the following issues: criminal justice and mental health, trauma focus and awareness, and coercion of clients and reliance on a medical model of care

The criminal justice system is currently the largest government facility for housing those with mental health disorders, substance use issues, and co-occurring disorders. To make significant changes in the ways mental health clients are treated, training reflecting policy changes must be provided to all those who serve COD clients in the criminal justice system. This training must reflect a major change from that provided by many criminal justice facilities. It must emphasize hope, recovery, and support for those with CODs, rather than the undeserved and irrational punishment of those who pose little threat to society and who will benefit both themselves and society by receiving appropriate, integrated treatment, supports, and services.

In addition to changes in criminal justice practices, programs for individuals with dual diagnoses should be overhauled so as to be more sensitive to the trauma experienced by a majority of clients with COD. Steps must be taken to reduce the repeated traumatizing of clients within mental health, substance abuse, and behavioral health systems. In particular, trauma-informed sexual abuse prevention and recovery services are needed. According to the National Trauma Consortium, “Trauma is often the central issue for people with mental health problems, substance abuse problems, or co-occurring disorders, and there are huge personal, social and economic costs to ignoring trauma.”<sup>3</sup>

Research has demonstrated that a close relationship exists between trauma, mental health, and substance use diagnoses. Ann Jennings, in “The Damaging Consequences of Violence and Trauma,” reports, “As many as 80% of men and women in psychiatric hospitals have experienced physical or sexual abuse, most

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<sup>2</sup> See the following website for analysis of California’s law “AB34”: [http://info.sen.ca.gov/pub/07-08/bill/asm/ab\\_0001-0050/ab\\_34\\_cfa\\_20070626\\_131817\\_sen\\_comm.html](http://info.sen.ca.gov/pub/07-08/bill/asm/ab_0001-0050/ab_34_cfa_20070626_131817_sen_comm.html).

<sup>3</sup> The National Trauma Consortium website is <http://www.nationaltraumaconsortium.org/>.

of them as children.” Studies indicate that the vast majority of adults diagnosed with borderline personality disorder and dissociative identity disorder, as well as a significant majority of those with substance abuse diagnoses report childhood abuse or neglect. In addition, most youth in inpatient and residential treatment programs have histories of trauma.<sup>4</sup>

Besides lacking sensitivity to trauma-related issues, mental and behavioral health care has been characterized by coercion and over-reliance on a traditional medical model. Policy changes must reflect an understanding that public mental and behavioral health systems have focused their efforts almost exclusively on managing socially “aberrant” behaviors. Instead, policy should support the fight against the social stigma associated with mental health and substance use diagnoses. It should work against discrimination: COD clients must be able to make choices about their treatment and their lives as a whole. The traditional medical model, in which doctors and other providers exclude clients from decision-making processes, must be replaced by a client-driven model. These are some of the policy changes required by the Mental Health Services Act.

In conclusion, when support for policy change is lacking or disorganized, mental health advocates lose the opportunity to promote a full continuum of care for clients with co-occurring disorders. Along with being integrated, mental health programs should be voluntary and client-driven, and should pay particular attention to issues in criminal justice, trauma-informed care, and coercive/medical model treatment. The California Network for Mental Health Clients strongly urges its affiliates and the public at large to become well informed about the enormous number of clients with co-occurring disorders and to support integrated care for those individuals in every setting, from private clinics to public agencies to criminal justice facilities.

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<sup>4</sup> All statistics cited can be found in *The Damaging Consequences of Violence and Trauma*, compiled by Ann Jennings, Ph.D. NTAC: 2004 and the NASMHPD Curriculum: *Six Core Strategies for the Reduction of Seclusion and Restraint*©, 2004.