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Medicaid Changes Will Affect People With COD

Recent changes in Medicaid rules could have positive effects on clients with substance use and/or other mental disorders. Beginning in January 2007, the Centers for Medicare & Medicaid Services (CMS) will be adding codes to its Level II Health Care Service Procedures Coding System for (1) drug and/or alcohol screening and (2) brief intervention and counseling. This change will enable Level II-eligible agencies to bill for a valid screening and brief interventions with a clinician or counselor. This change has potential to reduce the negative consequences of substance abuse in individuals who might not otherwise receive treatment.

Another development in Medicaid; however, is likely to have negative effects for clients with mental disorders. CMS has begun approving changes requested by States to make reforms to rein in spending. CMS has authorized changes to Medicaid in West Virginia and Kentucky that are in line with changes in the 2005 Deficit Reduction Act. In West Virginia, these changes create a two-tiered benefit system that offers enhanced services (including substance abuse treatment and mental health services) to participants who sign and adhere to a compliance agreement. After signing up, individuals who do not comply with treatment (e.g., taking medication as directed, keeping appointments) can lose their mental health benefits and some of their prescription coverage as well. Clients with serious mental illness may have significant problems following their treatment plans or may not understand the agreement they have signed.

In Kentucky, Medicaid is also offering a range of service plans but not using a compliance agreement. Still there is

some concern that new higher co-pays for mental health services will have a negative impact on those clients who may need the services the most.

For more information on the forthcoming changes to the Level II coding system see **Barclay, Laurie (2006, September 13). Medicaid will reimburse for alcohol, drug screening and brief intervention. *Medscape Medical News*. Online at <http://www.medscape.com/viewarticle/544548>**

For more information on the Medicaid changes in West Virginia and Kentucky see **Daly, Rich (2006, September 1). Medicaid innovations may make MH care less accessible. *Psychiatric News*, 41, 16. Online at <http://pn.psychiatryonline.org/cgi/content/full/41/17/16>**

For other relevant background information on coding and screening and brief assessments see **Ensuring Solutions to Alcohol Problems (2006, July 24). *Detailed information about coding for SBI reimbursement*. Washington DC: George Washington University Medical Center. Online at http://www.ensuringsolutions.org/usr_doc/SBIbackground.pdf**

& **National Association of State Alcohol and Drug Abuse Directors (2006, August). *Current research on screening and brief intervention and implications for state alcohol and other drug (AOD) systems* (State Issue Brief). Washington DC: Author. Online at http://www.nasdad.org/resource.php?base_id=788**

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COD Research

Epidemiology

Caton, C. L. M., Hasin, D. S., Shrout, P. E., Drake, R. E., Dominguez, B., Samet, S., & Schanzer, B. (2006). Predictors of psychosis remission in psychotic disorders that co-occur with substance use. *Schizophrenia Bulletin*, 32, 618–625.

The authors rediagnosed 319 patients (83 percent of original sample) who had psychosis and were substance users at one year after intake. Of those who had a primary diagnosis of a psychotic disorder, half were in remission at reassessment while 77 percent of those who had a diagnosis of substance-induced psychosis were in remission. For both groups having fewer positive and negative symptoms, better premorbid functioning, more insight into their psychosis, and a shorter duration of psychosis before getting treatment predicted remission at the 1-year reassessment.

Cunningham-Williams, R. M., Cottler, L. B., Compton, W. M., Spitznagel, E. L., & Ben-Abdallah, A. (2000). Problem gambling and comorbid psychiatric and substance use disorders among drug users recruited from drug treatment and community settings. *Journal of Gambling Studies*, 16, 347–376.

The authors investigated links between problem gambling and psychiatric disorders (including substance use disorders) among samples taken from substance abuse treatment settings ($n = 512$) and the community settings ($n = 478$). The overall prevalence (for both samples) of problem gambling was 22 percent and the prevalence of pathological gambling was 11 percent, with statistically significant differences in the prevalence between the two samples. Problem gambling was associated with Antisocial Personality Disorder (ASPD) but always occurred after the ASPD (on average 11.4 years after).

Dom, G., de Wilde, B., Hulstijn, W., van den Brink, W., & Sabbe, B. (2006). Decision-making deficits in alcohol-dependent patients with and without comorbid personality disorder. *Alcoholism: Clinical and Experimental Research*.

The authors compared the decisionmaking ability (as evaluated by the Iowa Gambling Task) of a control group who did not abuse substances ($n = 53$) to three different groups of currently abstinent people with alcohol use disorders (ones without any co-occurring personality disorder [$n = 38$], ones with a co-occurring cluster A or C personality disorder [$n = 19$], and ones with a cluster B personality disorder [$n = 23$]). All three subsamples with alcohol dependence had more impaired decisionmaking skill than the control group. Of the three, the group with cluster B personality disorders had the greatest impairment.

Foley, D. L., Goldston, D. B., Costello, E. J., & Angold, A. (2006). Proximal psychiatric risk factors for suicidality in youth: The Great Smoky Mountains Study. *Archives of General Psychiatry*, 63, 1017–1024.

The authors sought to determine the level of risk associated with anxiety, depression, disruptive behavior, and substance use disorders for suicide among children and adolescents. They followed 1,420 youth (ages 9 to 16) from 1993 to 2000 to evaluate wanting to die, suicidal ideation, suicide planning, or attempting suicide during the past 3 months. Among the conditions evaluated, the greatest suicide risk was associated with current depression plus anxiety (with an odds ratio of 468.53) followed by depression plus a disruptive disorder (with an odds ratio of 222.94). Severity of impairment related to symptoms and poverty (as defined by Federal guidelines) were both independent risk factors, irrespective of psychiatric diagnosis.

Harder, V. S., Morral, A. R., & Arkes, J. (2006). Marijuana use and depression among adults: testing for causal associations. *Addiction*, 101, 1463–1472. Available online at www.blackwell-synergy.com/doi/abs/10.1111/j.1360-0443.2006.01545.x

The authors used data from 8,759 adults (ages 29 to 37 years) to evaluate the effect of marijuana use on depression. They found that after adjusting for group differences in baseline risk factors past-year marijuana use did not significantly predict later depression.

Harned, M. S., Najavits, L. M., & Weiss, R. D. (2006). Self-harm and suicidal behavior in women with comorbid PTSD and substance dependence. *American Journal on Addictions, 15*, 392–395.

The authors evaluated 65 women who had posttraumatic stress disorder (PTSD) and substance dependence enrolled in an outpatient treatment program. Study participants had elevated rates of suicidal ideation, suicide attempts, and self-harm ideation and attempts. The authors saw both PTSD and substance dependence as contributing to these behaviors.

Henquet, C., Krabbendam, L., de Graaf, R., ten Have, M., & van Os, J. (2006). Cannabis use and expression of mania in the general population. *Journal of Affective Disorders, 95*, 103–110.

The authors sought to evaluate the effect cannabis use on manic symptoms. They looked at a general population sample of 4815 people (ages 18 to 64). After controlling for psychotic symptoms and adjusting for age, sex, educational level, ethnicity, single marital status, neuroticism, use of other drugs, use of alcohol, depressive symptoms, and manic symptoms at baseline, they found that the use of cannabis at baseline increased the risk of having manic symptoms at the follow-up assessment (with an adjusted odds ratio of 2.70). However, manic symptoms at baseline did not predict the onset of cannabis use prior to followup.

McKetin, R., McLaren, J., Lubman, D. I., & Hides, L. (2006). The prevalence of psychotic symptoms among methamphetamine users. *Addiction, 101*, 1473–1478. Available online at <http://www.blackwell-synergy.com/doi/abs/10.1111/j.1360-0443.2006.01496.x>

The authors investigated 309 Australians (ages 16 or older) who took methamphetamine at least monthly during the prior year to assess the prevalence of psychotic symptoms. They found 13 percent of participants screened positive for psychosis and 23 percent had a clinically significant psychotic symptom in the prior year (i.e., suspiciousness, unusual thought content, hallucinations). Methamphetamine users who were dependent on the drug were three times as likely to have psychotic symptoms as those who were not dependent.

Modesto-Lowe, V., Brooks, D., & Ghani, M. (2006). Alcohol dependence and suicidal behavior: From research to clinical challenges. *Harvard Review of Psychiatry, 14*, 241–248.

The authors review current knowledge on the links between alcohol dependence and suicidal behavior. Presenting the risk factors associated with suicide and current research on treatment strategies (e.g., the use of fluoxetine) to reduce risk in this population.

Mueser, K. T., Crocker, A. G., Frisman, L. B., Drake, R. E., Covell, N. H., & Essock, S. M. (2006). Conduct disorder and antisocial personality disorder in persons with severe psychiatric and substance use disorders. *Schizophrenia Bulletin, 32*, 626–636.

The authors compared demographic, substance abuse, clinical, housing, sexual risk, and criminal justice characteristics of 178 individuals with COD in two urban areas, separating them into four groups (ones with neither conduct disorder [CD] nor antisocial personality disorder [ASPD], with CD only, with adult ASPD only, and with full ASPD). Individuals in the adult ASPD only group had the most severe substance abuse, most extensive homelessness, and most lifetime sexual partners. They were followed in this regard by the full ASPD group, who also had the most criminal justice involvement. The authors conclude from their results that late-onset ASPD may develop in individuals who have a severe mental illness secondary to a substance use disorder and that much of the criminal behavior in individuals with COD may be attributable to ASPD and not just the individual's substance use disorders.

Office of Applied Studies. (2006). *Results from the 2005 National Survey on Drug Use and Health: National findings* (NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD: Substance Abuse and Mental Health Services Administration. Available online at <http://www.oas.samhsa.gov/nsduh/2k5nsduh/2k5Results.pdf>

This publication provides the latest data on prevalence and correlates of substance use, serious mental illness, related problems, and treatment in the United States.

Office of Applied Studies (2006). *Suicidal thoughts, suicide attempts, major depressive episode, and substance use among adults* (OAS Report, Issue 34). Rockville, MD: Substance Abuse and Mental Health Services Administration. Available online at <http://oas.samhsa.gov/2k6/suicide/suicide.pdf>

The risk of suicidal thoughts and suicide attempts among people who have experienced a major depressive episode (MDE) increases with the use of alcohol or drugs. Using data from the 2004 and 2005 National Survey on Drug Use and Health, researchers found that among adults who experienced an MDE during the past year, 40.3 percent thought about committing suicide, 14.5 percent made a suicide plan, and 10.4 percent made a suicide attempt. Adults with past-year MDE and past-month binge alcohol use were more likely to report suicidal thoughts (61.8 percent) and suicide attempts (13.7 percent) than their counterparts who did not binge drink (57.1 percent reported suicidal thoughts and 9.1 percent reported attempts). Similarly, of those with past-year MDE and past-month illicit drug use, more reported suicidal thoughts (67.0 percent) and attempts (19.0 percent) compared to those without past-month illicit drug use (56.9 percent for suicidal thoughts and 8.9 percent for attempts). Data on suicide-related emergency department visits from SAMHSA's Drug Abuse Warning Network (DAWN), a public health surveillance system that measures some of the health consequences of drug use by monitoring drug-related visits to hospital emergency departments, also support these findings.

Wade, D., Harrigan, S., Edwards, J., Burgess, P. M., Whelan, G., & McGorry, P. D. (2006). Substance misuse in first-episode psychosis: 15-month prospective follow-up study. *British Journal of Psychiatry, 189*, 229–234.

The authors examined the effects of substance misuse on inpatient admission and remission in cases of first-episode psychosis ($N = 103$). After controlling for confounding factors, they found an independent association between substance misuse and risk of inpatient admission, relapse of positive symptoms, and decreased time before relapse of positive symptoms.

Waldrop, A. E., Back, S. E., Verduin, M. L., & Brady, K. T. (2006). Triggers for cocaine and alcohol use in the presence and absence of posttraumatic stress disorder. *Addictive Behaviors*.

The authors investigated triggers for substance use in a group of 72 (34 men, 38 women) patients with substance dependence (on either alcohol or cocaine) some of whom had co-occurring PTSD. Those who had PTSD were more likely to use substances in response to negative events and feelings (e.g., unpleasant emotions, physical discomfort) than those without PTSD. Individuals with cocaine dependence and PTSD were more likely to use substances while feeling good or experiencing pleasant events than others in the study.

Services & Service Systems

Screening & Assessment

Hu, H. M., Kline, A., Huang, F. Y., & Ziedonis, D. M. (2006). Detection of co-occurring mental illness among adult patients in the New Jersey substance abuse treatment system. *American Journal of Public Health, 96*, 1785–1793.

The authors used four years (1994 to 1997) of administrative records from the State of New Jersey to evaluate referral rates to mental health treatment for patients in substance abuse treatment. They considered that a mental disorder had been detected if a diagnosis was given in substance abuse treatment and undetected if the individual was seen in both mental health and substance abuse treatment systems without a diagnosis in the latter and within the same year. They found that 21.9 percent of the cases of COD were detected and of those 57.9 percent received a referral for mental health treatment. Regarding types of substance abuse treatment, methadone maintenance clinics were the least likely to detect COD but had the highest referral rate for the cases they detected. Patients who were male, Hispanic, African American, used heroin, and/or were involved in the criminal justice system had a greater risk of having their disorder go undetected. Among individuals whose disorders were detected, those who were African American, used heroin, and/or were involved in the criminal justice system were less likely to get a referral to mental health treatment.

Kim, S.-W., Kim, S.-J., Yoon, B.-H., Kim, J.-M., Shin, I.-S., Hwang, M. Y., & Yoon, J.-S. (2006). Diagnostic validity of assessment scales for depression in patients with schizophrenia. *Psychiatry Research, 144*, 57–63.

The authors assessed the diagnostic validity of four instruments for detecting depression in a group of 84 people who were diagnosed with schizophrenia. They evaluated the Calgary Depression Scale for Schizophrenia (CDSS), the Beck Depression Inventory, the Hamilton Rating Scale for Depression, and the depression subscale of the PANSS and found that the CDSS appeared to work best at assessing depression in patients with schizophrenia.

Swartz, J. A., & Lurigio, A. J. (2006). Screening for serious mental illness in populations with co-occurring substance use disorders: Performance of the K6 scale. *Journal of Substance Abuse Treatment, 31*, 287–296.

The authors evaluated the ability of the K6 screening scale to screen for serious mental illness in people with co-occurring substance use disorders. They used data from the National Survey on Drug Use and Health and found that the K6 was able to accurately screen for severe psychological distress (a key element in serious mental illness) in this population.

Treatment Planning & Services

Bowen, S., Witkiewitz, K., Dillworth, T. M., Chawla, N., Simpson, T. L., Ostafin, B.D., Larimer, M. E., Blume, A. W., Parks, G. A., & Marlatt, G. A. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors, 20*, 343–347.

The authors evaluated the use of Vipassana meditation (VM), a Buddhist meditation technique, for improving psychiatric symptoms and decreasing substance use in a jail-based population. They found that individuals who took a course on VM (as compared to those who received the usual treatment) had significant reductions in alcohol, marijuana, and crack cocaine use. Subjects who were in the VM course also had fewer alcohol-related problems and fewer symptoms of psychiatric disorders and more positive psychosocial outcomes.

Druss, B. G., Bornemann, T., Fry-Johnson, Y. W., McCombs, H. G., Politzer, R. M., & Rust, G. (2006). Trends in mental health and substance abuse services at the nation's community health centers: 1998-2003. *American Journal of Public Health, 96*, 1779–1784.

According to data from the Health Resources and Services Administration, Bureau of Primary Care's Uniform Data System (as merged with country-level data), between 1998 and 2003 the number of people diagnosed with a substance use and/or other mental disorder in community health centers went from 210,000 to 800,000. This was accompanied by an increase in the number of patients seen by the average provider of mental health and/or substance abuse treatment services and a decrease in the mean number of patient visits for such services (from 7.3 visits per patient to 3.5 by 2003).

Feeney, G. F. X., Connor, J. P., Young, R. M., Tucker, J., & McPherson, A. (2006). Improvement in measures of psychological distress amongst amphetamine misusers treated with brief cognitive-behavioural therapy (CBT). *Addictive Behaviors, 31*, 1833–1843.

The authors evaluated a program to treat methamphetamine use with cognitive-behavioral therapy techniques (e.g., improving refusal skills, improving coping skills, improving problem solving skills, developing a relapse prevention plan) in an Australian, abstinence-based treatment program ($n = 507$). Individuals who completed the programs reported an improvement on all General Health Questionnaire-28 subscales (i.e., anxiety, social dysfunction, depression, somatic symptoms) and also reported better self-efficacy with amphetamine refusal.

Martino, S., Carroll, K. M., Nich, C., & Rounsaville, B. J. (2006). A randomized controlled pilot study of motivational interviewing for patients with psychotic and drug use disorders. *Addiction, 101*, 1479–1492. Available online at <http://www.blackwell-synergy.com/doi/abs/10.1111/j.1360-0443.2006.01554.x>

The authors compared a two-session motivational interview developed for clients with co-occurring psychotic ($n = 24$) and substance use disorders to a standard, two-session psychiatric interview ($n = 20$). Both groups improved in treatment outcomes after receiving the interview and there were no significant differences for the group as a whole. The authors did find, however, that when looked at separately users whose primary drug was cocaine had significantly better treatment outcomes with the motivational interview while users whose primary drug was marijuana had significantly better treatment outcomes with the standard psychiatric interview.

McHugo, G. J., Drake, R. E., Brunette, M. F., Xie, H., Essock, S. M., & Green, A. I. (2006). Enhancing validity in co-occurring disorders treatment research. *Schizophrenia Bulletin*, 32, 655–665.

The authors look at some of the major barriers in conducting research for people with COD in substance abuse treatment. Their primary recommendation is for researchers to move more rapidly from efficacy studies to effectiveness studies, which can better facilitate the adoption of evidence-based interventions in the field.

Morse, G. A., Calsyn, R. J., Klinkenberg, W., Helminiak, T. W., Wolff, N., Drake, R. E., Yonker, R. D., Lama, G., Lemming, M. R., & McCudden, S. (2006). Treating homeless clients with severe mental illness and substance use disorders: Costs and outcomes. *Community Mental Health Journal*, 42, 377–404.

The authors did a cost and outcome comparison of three different types of programs that treated individuals who were homeless and had COD ($N = 149$). The programs compared were Integrated Assertive Community Treatment (IACT), Assertive Community Treatment only (ACTO), and standard care control group. IACT and ACTO clients reported greater satisfaction with their treatment and more days in stable housing than those in the control group. There were no significant differences in psychiatric or substance abuse treatment outcomes among groups. Also, average costs were significantly less for IACT and standard treatment when compared to ACTO.

Nunes, E. V., & Levin, F. R. (2006). Treating depression in substance abusers. *Current Psychiatry Reports*, 8, 363–370.

The authors reviewed literature on diagnosing and treating depression in people with substance use disorders and make some recommendations based on that review. Their clinical recommendations are that clinicians need to treat substance dependence and encourage abstinence, take a complete psychiatric history and use DSM-IV criteria for primary or substance-induced depression, and if depression meets DSM-IV criteria and persists despite substance abuse treatment, treat the depression.

Office of Applied Studies. (2006). *Emergency department visits involving ADHD stimulant medications (The New Dawn Report, Issue 29)*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available online at <https://dawninfo.samhsa.gov/files/TNDR09ADHDmedsForHtml.pdf>

This report is based on SAMHSA's Drug Abuse Warning Network (DAWN). National data are presented on the characteristics of the patient and the visit to the DAWN emergency departments who present with nonmedical use of stimulant medications used for the treatment of attention deficit/hyperactivity disorder (AD/HD).

Petrakis, I. L., Poling, J., Levinson, C., Nich, C., Carroll, K., Ralevski, E., & Rounsaville, B. (2006). Naltrexone and disulfiram in patients with alcohol dependence and comorbid post-traumatic stress disorder. *Biological Psychiatry*, 60, 777–783.

The authors investigated the use of disulfiram and naltrexone for treating alcoholism in patients with co-occurring post-traumatic stress disorder (PTSD). Of the sample of 254 patients with co-occurring Axis I disorder and alcohol dependence, 93 met DSM-IV criteria for PTSD. Those individuals with PTSD had better alcohol-related outcomes when they received medication (either naltrexone, disulfiram, or the two in combination) than a placebo. Also, PTSD symptoms improved more for those who received the medication.

Petrakis, I. L., Nich, C., & Ralevski, E. (2006). Psychotic spectrum disorders and alcohol abuse: A review of pharmacotherapeutic strategies and a report on the effectiveness of naltrexone and disulfiram. *Schizophrenia Bulletin*, 32, 644–654.

The authors reviewed the literature on the use of disulfiram and naltrexone for alcoholism, particularly for individuals with COD. They also present results from a randomized clinical trial of disulfiram and naltrexone (both alone and in combination) for alcoholism in individuals with a co-occurring Axis I disorder. They note that patients who had a co-occurring psychotic disorder had better outcomes with medication than with a placebo, but that there was no significant difference between the medications (either individually or in combination).

Services Integration

Chandler, D., & Spicer, G. (2006). Integrated treatment for jail recidivists with co-occurring psychiatric and substance use disorders. *Community Mental Health Journal, 42*, 405–425.

The authors evaluated an Integrated Dual Disorders Treatment program for jail recidivists who had COD ($n = 103$), comparing it to a treatment as usual group ($n = 79$). Participants entered the program at the termination of their jail terms and were tracked an average of 18 months. Participants in the experimental group made less use (during the study period) of inpatient and crisis services and greater use of outpatient services than participants in the control group. There were no significant differences between the groups in regard to arrests, convictions, and days in jail during the study period.

Ducharme, L., Knudsen, H., & Roman, P. (2006). Availability of integrated care for co-occurring substance abuse and psychiatric conditions. *Community Mental Health Journal, 42*, 363–375.

The authors describe the current situation involving integrated treatment for people with COD in both public- and private-sector programs, including factors such as organizational attributes, patterns of services provided, etc.

McGovern, M. P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *Journal of Substance Abuse Treatment, 31*, 267–275.

The authors administered a self-report survey to a group of 452 substance abuse treatment professional (43 of whom were agency directors, 110 of whom were clinical supervisors, and 300 of whom were clinicians). Respondents estimated how commonly various psychiatric disorders were found in their substance abuse treatment populations: mood disorders (seen in 40–42 percent of clients), anxiety disorders (24–27 percent), posttraumatic stress disorder (24–27 percent), severe mental illnesses (16–21 percent), antisocial personality disorder (18–20 percent), and borderline personality disorder (17–18 percent). The respondents also noted common barriers to providing services to people with COD and described the most frequent treatment responses for this population.