Co-Occurring Disorders in Montana Youth

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This report was produced and authored by Daphne Herling for Montana KIDS COUNT at the University of Montana Bureau of Business and Economic Research (BBER). Any errors and omissions are, of course, our own.

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INTRODUCTION

Most of us remember what it was like to be a teenager, that difficult time in our lives when we tried to navigate life despite peer pressure, massive physical and emotional change, and decision-making skills compromised by a brain still under construction. It is also a time that experimentation is appropriate, but fraught with confusing and potentially dangerous choices in terms of drug and alcohol use. Now imagine when, on top of all these issues, a teenager has to deal with any degree of mental illness. The layers of complexity imposed by a mental illness exponentially increase the difficulties inherent in teenage brain development.

This Montana KIDS COUNT paper will seek to shed some light on the issue of co-occurring disorders, the intersection of mental illness and substance use disorders. However, it is a relatively ill-understood issue; research on it began only recently and much is still to be learned. In addition, focusing on youth is challenging, as most research on co-occurring disorders has been done on the adult population. Because of this relative lack of research on co-occurring disorders in youth, this report places much of the background about the disorder within the population as a whole before delving into its occurrence in youth.

WHAT IS A CO-OCCURRING DISORDER?

First we will start with an explanation of what is meant by co-occurring disorders (CODs), so that the data, treatment approaches, programs, and policies can be better understood.

Simply put, COD is when one person has two or more disorders at the same time, a mental illness and a substance use disorder.¹ Thus COD covers this wide array of diagnoses but its defining factor is the fact that both, in whatever form, are present.

It is not necessary for both psychiatric and substance issues to emerge at the same time; one can occur as the result of the other. For instance, someone experiencing symptoms of a mental illness might turn to substances to alleviate their pain and then become addicted to one or more of these substances. Likewise, the use of a substance can lead to a mental illness because of the effect of the drug on a person’s behavior, mood or brain chemistry. For instance, depression is a common after effect of using certain drugs such as alcohol or crystal meth.²

The great difficulty in writing a paper on COD is not the lack of information on mental illness or on substance use disorders; it is that much information is put into one silo or the other. This will especially be seen in the section on data. However, there is much information on COD in the area of treatment approaches. COD used to be known, and is still often referred to, as dual diagnosis.

¹https://www.psychologytoday.com/conditions/co-occurring-disorders
²https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Dual-Diagnosis
HISTORY

The history of COD is short and much work still needs to be done to truly understand the issue so that treatment systems can be better prepared. It only emerged as a concept about twenty years ago after clinicians had been unsuccessfully treating people with both a mental illness and a substance use disorder using a parallel approach, often under the care of two or more clinicians who may or may not be consulting with one another about the patient’s case.³

The history of an evolving integrated treatment approach to COD began in 1984 in a New York State outpatient psychiatric facility. The New York State Commission on Quality of Care released the findings of eighteen months of research, and the report resulted in a high profile story covered in TIME Magazine. This brought COD to the attention of the general public. The findings based on this new, integrated approach showed promising results, and training programs were developed for clinicians and service providers. The training model is still used in New York and around the nation.⁴ Originally integrated treatment was developed to meet the needs of severely mentally ill chemical abusers, but it has since been used to develop programs for all levels of severity and types of COD.

Researchers first investigated the national prevalence of co-occurring disorders in 1990 in the Epidemiologic Catchment Area Study which involved 20,000 adults age 18 and over. Their results suggested that co-occurring disorders were common.⁵

In Montana, CODs have been a focus for approximately ten years and were first noted, as one might expect, by agencies dealing with treatment of people with mental illness or substance use disorders.

An integrative treatment approach has been a focus of the Substance Abuse and Mental Health Services Administration (SAMHSA) the leading federal agency that conducts research and awards grants on mental health and substance use. SAMHSA has developed an entire website dedicated to the issue of COD. Likewise, leading non-profit organizations have disseminated much information about COD and best practices in treatment.

Before the 1970/1980’s there is very little historical information about mental illness and substance use disorders being considered as a dual problem in one person. Instead, patient reports from the past show how one or the other problem is viewed, approached and labeled. In all likelihood, in the distant past, people with COD have been treated the same as people with mental illnesses with a similar degree of vilification or deification, religious interpretations, blame and rejection, cruel punishments, incarceration and social stigmatization. These views can still be found in societies and cultures today.

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⁵ Reedy, A. R.: Adolescent Co-Occurring Disorders: Factors Related To Mental Health Problems among Substance Using Adolescents. An abstract of a thesis submitted in partial fulfillment of the requirements for the doctor of philosophy degree in social work in the graduate college of the University of Iowa, May 2010.
ISSUES WITH DIAGNOSING COD

To begin to understand COD, it is necessary to have some understanding of the two parts that make up the whole: mental illness and substance use disorder.

Mental Illness

In 2014, the National Institute of Mental Health estimated there are 43.6 million adults aged 18 or older with some type of mental illness. This number represented 18.1% of all U.S. adults.

Mental illnesses are health conditions involving changes in thinking, emotion or behavior (or a combination of these). Mental illnesses are associated with distress and may affect people’s ability to function in society on a day to day basis or to interact with others. The broad category is called mental illness, but is the same thing as mental disorders; for the purposes of this paper, mental illness is used throughout for consistency of understanding.

A defining characteristic of mental illness is its idiosyncratic nature. It is experienced differently by each individual, even in individuals with the same diagnosis. The jury is out as to whether all mental illnesses are biological disorders involving some form of breakdown in brain circuitry or whether there can be a psychological disorder without biological malfunction. This is an important point in terms of youth being diagnosed with COD and will be discussed later in this paper.

When a mental illness is classified as a Serious Mental Illness (SMI) it refers to the illness’s duration and intensity or the degree of disability produced. SMIs include such diseases as schizophrenia and schizoaffective disorder, and severe forms of other disorders, such as bipolar disorders. They are associated with psychosis and extremes of behavior produced by distortions of perception, delusions, or hallucinations. People do not recover from bipolar disorder, schizophrenia, or schizoaffective disorder. These are usually irreversible lifelong illnesses based in actual physical changes in the brain.

WHAT IS MENTAL HEALTH?

Mental Health involves effective functioning in daily activities resulting in:

- Productive activities (work, school, care giving).
- Healthy relationships.
- Ability to adapt to change and cope with adversity.
- Mental illness refers collectively to all diagnosable mental disorders health conditions involving.
- Significant changes in thinking, emotion and/or behavior.
- Distress and/or problems functioning in social, work or family activities.

American Psychiatric Association

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7 American Psychiatric Association (www.psychiatry.org) What is Mental Illness?
8 National Alliance on Mental Illness (www.nami.org) Mental Health Conditions.
Substance Use Disorders

It is estimated by the National Institute on Alcohol Abuse and Alcoholism that, in 2013, 16.6 million adults in the United States ages 18 and older abused alcohol. In 2013, according to the National Institute on Drug Abuse, an estimated 24.6 million Americans aged 12 or older—9.4 percent of the population—had used an illicit drug in the past month.

The terminology for substance abuse and substance dependence has been updated in the latest Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). All problems related to substances are now called Substance Use Disorders (SUD) and are measured on a continuum of mild to severe. Throughout this paper, substance use disorder is used to reflect this change in the field. However when quoting or directly referring to another source that uses ‘substance abuse’ as its nomenclature, the text keeps that language.

Physicians have long recognized that different types of drugs affect people differently. Seven major drug categories have been recognized for some time: central nervous system (CNS) depressants, CNS stimulants, hallucinogens, dissociative anesthetics, narcotic analgesics, inhalants, and cannabis. But within each category there are a myriad of drugs each of which might have its own effect. Then there are the interactions that can occur if a person uses two drugs at the same time. Layer the substance abuse on top of an existing mental illness and you can imagine the complicated puzzle facing the clinician who must reach a diagnosis and develop an effective treatment plan.
MENTAL ILLNESS AND SUBSTANCE USE DISORDER ASSOCIATIONS

According to the National Alliance on Mental Illness, about a third of all people experiencing mental illnesses and about half of people living with severe mental illnesses also experience substance abuse. These statistics are mirrored in the substance abuse community, where about a third of all alcohol abusers and more than half of all drug abusers report experiencing a mental illness.\(^\text{10}\)

Research has shown a broad range of mental health disorders found in people with substance use disorders. These tend to fall in the mood (major depression, dysthymia) and anxiety (post-traumatic stress disorder, panic disorder, social anxiety, generalized anxiety disorder, obsessive-compulsive disorder) disorders and, to an even higher percent, people with SMI (schizophrenia and schizoaffective disorder).

This list has been narrowed further to show the mental illness most commonly associated with addiction problems:\(^\text{11}\)
- Depression
- Bipolar disorder
- Obsessive compulsive disorder (OCD)
- Anxiety
- Post-traumatic stress disorder (PTSD)
- Eating disorders

The types of mental illnesses most commonly found in youth with COD are some form of behavioral or mood disorder, or an attention-deficit hyperactivity disorder.\(^\text{12}\)

Testing for COD is hard and often it is founded on disentangling the symptoms, as one disease can often contribute to or cause the other, an example being that alcohol use can intensify the symptoms of depression. Likewise use of hallucinogenic drugs or marijuana may initiate symptoms of psychosis or schizophrenia in susceptible individuals. Often health care practitioners have to determine which illness came first to accurately diagnose COD. This can be done but requires the patient to detoxify to see what symptoms remain.

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\(^\text{10}\) National Alliance on Mental Illness (www.nami.org) Dual Diagnosis.

\(^\text{11}\) Addiction Center (www.addictioncenter.com) What is Dual Diagnosis?

\(^\text{12}\) Hills, Holly A. Ph.D. Florida Certification Board/Southern Coast Addiction Technology Transfer Center, Treating Adolescents with Co-Occurring Disorders, August 2007.
THEORIES ON CO-OCCURRING DISORDERS

Why do so many people suffer from COD? There are several theories about this but the Dartmouth Psychiatric Research Center has put forth these four primary theories.\(^{13}\)

**Early Onset**

Some younger adults or adolescents can be vulnerable to early onset of mental illness through abusing certain types of drugs such as methamphetamine, cocaine, or alcohol. In this theory there is an underlying neurobiological condition that causes a sensitivity to a substance which increases each time an individual uses that substance. This underlying neurobiological tendency to sensitization may lead to both drug dependence and mood disorders.\(^{14}\)

**Genetic and Environmental**

There is a genetic factor to both substance use and some mental illnesses, but this alone cannot explain the prevalence of COD. In some cases stress interacts with a biological vulnerability to bring on a mental illness; this is known as the stress-vulnerability model. Biological vulnerability connotes a tendency to develop a condition when a person has had stressful experiences early in life. This will be explored in the section on Adverse Childhood Experiences (ACES).

**Susceptibility versus Causality**

Some people with mental illness may be unusually susceptible to the harmful effects of drugs or alcohol. The causality theory suggests that certain types of substance use may causally lead to mental illness. This would seem like a chicken and egg argument, however, which comes first is less relevant than the concept that some type of brain reaction happens when people with mental illness use alcohol or other substances or when people with substance use disorders develop mental illness.

**Self-medication**

In some cases people with mental illness use substances in an attempt to alleviate their symptoms and cope with their disease. This is sometimes called self-medication and is one way a person can develop a co-occurring disorder. However, scholarly articles on the self-medication hypothesis tend to point to its oversimplification and prefer to widen their search for COD causation to include more in-depth analysis of patient self-reporting.

**COD Across the lifespan**

Figure 1, from the 2014 National Survey on Drug Use and Health (NSDUH), shows substance use disorders and any mental illness in adults 18 and older and the intersection between the two. It indicates that approximately 7.9 million Americans in this age group suffer from COD. This is a significant increase from the NSDUH report analyzing 2006 data which showed 5.6 million people in the United States having co-occurring substance use and mental health disorders.

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COD affects people at different ages and stages of life and occurs across the lifespan. The chemical effects of substance use in youth, adulthood, and older adulthood are all different from one another. Youthful brains are still developing during early adulthood up to the early 20’s, creating the possibility of long-term negative effects of substance use. Likewise, the physiological changes resulting from the natural aging process increase the use of medications, drug and alcohol sensitivity, and the likelihood of co-occurring conditions.\textsuperscript{15}

\textbf{Figure 1.} Past Year Substance Use Disorders and Mental Illness among Adults 18 or Older: 2014. Source: Behavioral Health Trends in the United States; 2014 National Survey on Drug Use and Health.

### Table 1. Substance Use Patterns and Associated Mental and Physical Health Conditions by Life Stage.

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Physical/ Medical Conditions</th>
<th>Mental Health/Psychiatric Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adolescence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Accidental Injury</td>
<td>Suicidal Ideation/Behaviors</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Automobile Accidents</td>
<td>Internalizing disorders</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Physical/Sexual Violence</td>
<td>• Depression</td>
</tr>
<tr>
<td>Inhalants</td>
<td>Poisoning/Overdose</td>
<td>• Anxiety</td>
</tr>
<tr>
<td>Psychotherapeutic Drugs</td>
<td>Sexually Transmitted Diseases</td>
<td>• Externalizing Disorders</td>
</tr>
<tr>
<td>• Amphetamines</td>
<td>Respiratory Problems</td>
<td>• Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>• Opioids/Pain Relievers</td>
<td>(Asthma)</td>
<td>• Attention Deficit/</td>
</tr>
<tr>
<td></td>
<td>Pain-Related Diagnoses</td>
<td>• Hyperactivity Disorder</td>
</tr>
<tr>
<td><strong>Adulthood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Poisoning/Overdose</td>
<td>Suicidal Ideation/Behaviors</td>
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<tr>
<td>Marijuana</td>
<td>Sexually Transmitted Diseases</td>
<td>Mood Disorders</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Cancers</td>
<td>• Depression</td>
</tr>
<tr>
<td>Psychotherapeutic Drugs</td>
<td>Heart Disease/</td>
<td>• Bipolar I &amp; II</td>
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<tr>
<td>• Opioids/Pain Relievers</td>
<td>Hypertension/Stroke</td>
<td>Anxiety Disorders</td>
</tr>
<tr>
<td>• Tranquilizers</td>
<td>Reproductive Morbidity/</td>
<td>• Panic Disorders</td>
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<tr>
<td>• Benzodiazepines</td>
<td>Fetal Damage</td>
<td>• Post-Traumatic Stress Disorder</td>
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<tr>
<td>Cocaine/Crack</td>
<td>Diabetes</td>
<td>• Social and Specific Phobias</td>
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<tr>
<td>Heroin</td>
<td>Respiratory Problems</td>
<td>• Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Asthma</td>
<td>• Antisocial Personality Disorder</td>
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<tr>
<td></td>
<td>Infection</td>
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<td></td>
<td>Liver Damage/Disease</td>
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<tr>
<td><strong>Older Adulthood</strong></td>
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</tr>
<tr>
<td>Alcohol</td>
<td>Accidental Injury</td>
<td>Suicidal Ideation/Behaviors</td>
</tr>
<tr>
<td>Psychotherapeutic Drugs</td>
<td>Cirrhosis</td>
<td>Depression/Bereavement</td>
</tr>
<tr>
<td>• Opioids/Pain Relievers</td>
<td>Heart Attack/Stroke</td>
<td>Anxiety Disorders</td>
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<tr>
<td>• Sedatives</td>
<td>Insomnia</td>
<td>• Social and Specific Phobias</td>
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<tr>
<td>• Benzodiazepines</td>
<td>Cancers</td>
<td>• Generalized Anxiety Disorder</td>
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<tr>
<td>• Amphetamines</td>
<td>Diabetes</td>
<td>Dementia/Wernicke-Korsakoff Syndrome</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Tobacco</td>
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</table>
COD manifests differently in men versus women, whether one is looking at the substance used, or the mental illness present, in terms of receptivity to treatment and likelihood of recovery. According to the National Alliance on Mental Illness (NAMI), men are more likely to develop a co-occurring disorder than women.\textsuperscript{16} Although men are less likely to be diagnosed with a serious mental illness than women, there are more men than women in substance use treatment with co-occurring mental disorders.\textsuperscript{17} There is much in the literature pertaining to different approaches to treating men and women with COD, but less can be found about environmental factors that have created differences in how COD manifests itself by gender. Women with COD are less likely to be employed than women with just substance use disorders; conversely, they are more likely to have received treatment for a substance use disorder within the past year than their male counterparts.\textsuperscript{18} Although both men and women with COD are less likely to have a high school diploma, and men diagnosed with COD are more likely than women to have dropped out of high school. Additionally, more men than women tend to use more than one illicit substance.\textsuperscript{19}

Women with COD often have a personal history of victimization, homelessness, and domestic violence. They often have less education, have fewer job skills, are more likely to receive public assistance, report more relatives with alcohol and drug problems, and care for more dependents than men with COD. These are environmental factors that are frequently associated with depression, anxiety, eating disorders, and low self-esteem.\textsuperscript{20} Societally imposed masculine gender norms and expectations may account for the fact that men avoid seeking treatment for mental illnesses.\textsuperscript{21} There is shame involved with men admitting to the perceived “weakness” of a mental illness. Even men already in substance use treatment may be reluctant to seek assistance for their co-occurring mental illness.

62\% of male and 83\% of female adolescents who seek treatment for substance use also have a mental illness.\textsuperscript{22} Adolescents with COD also show some gender difference in the type of mental illness or substance use disorders manifested. Rates of depression are higher in girls than boys, although anxiety symptoms are high in both girls and boys with a diagnosed substance use problem.\textsuperscript{23} Additionally, more girls with high incidents of COD are found in the juvenile justice system than boys.\textsuperscript{24}

\textsuperscript{16}National Alliance on Mental Illness (www.nami.org) Dual Diagnosis.  
\textsuperscript{18}Borgelt, Laura Marie. Women’s Health Across the Lifespan: A Pharmacotherapeutic Approach. Chapter 36, Page 577. 2010 American Society of Health system Pharmacists, Bethesda MD.  
\textsuperscript{20}National Abandoned Infants Assistance Resource Center, University of California, Berkeley CA http://aia.berkeley.edu Women with Co-Occurring Mental Illness and Substance Abuse, May 2005.  
\textsuperscript{22}Hazelden Publishing. (www.hazeldon.org) Adolescent Co-Occurring Disorder Series.  
COD IN VULNERABLE POPULATIONS

As with so many substance use and/or mental illness disorders, vulnerable populations are disproportionately represented. This holds true for people with COD. Vulnerable populations include, but are not limited to, such groups as low-income children, the economically disadvantaged, racial and ethnic minorities, the uninsured, the elderly, the homeless, and those with other chronic health conditions, including severe mental illness.

The SAMHSA website dedicated to COD and COD treatment has several pages focused on four such vulnerable populations overly represented in data on COD: Criminal Justice Settings, Homelessness, Primary Care and in the Military. Information from those pages is summarized below.

Criminal Justice Settings

Every year over 10 million adults enter our jails; almost a million of those have a diagnosed COD.

More than two million youth under the age of 18 are arrested each year, half of whom will have contact with the juvenile justice system. A high percentage of youth in the juvenile justice system have both serious mental illness and substance use problems. Youth in the juvenile justice system will be revisited in the policy and practice sections later in this paper.

Studies show that almost three-quarters of jail inmates with mental illness have a co-occurring substance use disorder. Justice-involved individuals with co-occurring disorders often have complex social and behavioral health needs. Much is known about what works for providing effective services for individuals with co-occurring disorders in criminal justice settings, but the resources to provide them are often lacking.

Homelessness

People who are homeless have a lifetime COD prevalence rate of almost 25%, an alarming percentage given that overall approximately 2.5% of the American population is suffering from COD. Often practitioners initially do not know if the homelessness preceded the COD or vice versa. Although there are treatment options for a person with COD who is homeless, their unstable conditions severely compromise efforts to recover from illnesses and/or addictions. In fact some researchers feel it is unrealistic to expect to provide adequate support and treatment that will make a difference. That said, programs that work with people experiencing homelessness can and should recognize the urgent need to support and treat these individuals. The challenges of finding, treating and supporting this population are extremely complex and homelessness is a society-wide problem that America has yet to politically address.

Primary Care

Primary care is a broad term that includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses. Primary care services are administered in a variety of settings and primary care practitioners are expected to act as a consultant or referral service, as advocates for their patients, and as overall coordinators of health care services. Primary care physicians are specifically trained for and skilled in comprehensive first contact and continuing care for

25 Substance Abuse and Mental Health Services (http://media.samhsa.gov/co-occurring/) Co-Occurring Disorders in Criminal Justice Settings.

26 SAMHSA and United States Census Bureau 2014 data.

27 Winarski, James T. M.S.W. Implementing Interventions for Homeless Individuals with Co-Occurring Disorders. Prepared for: The Projects for Assistance in Transition from Homelessness Program; Center for Mental Health Services, Substance Abuse and Mental Health Services, March 1998.
persons with any undiagnosed sign, symptom, or health concern. Thus people who utilize primary care systems come with a wide swath of medical problems that are often exacerbated by the presence of COD. Research has shown that people with COD tend to be in poorer overall health and that primary care settings are uniquely positioned to provide comprehensive screening and appropriate referrals for people with COD.\(^{28}\) However, lack of health insurance, inadequate access to services (primary or otherwise), and complex public health program requirements challenge people in their quest for treatment.

**Military and Military Justice**

Military veterans have received much attention over the past years, especially since of the 2.5 million returning veterans from the Iraq and Afghanistan wars approximately one in five has been diagnosed with either Post Traumatic Stress Disorder (PTSD) or major depression. The number of veterans from these wars with COD has not been establish, however a telling number is that approximately three of every four Vietnam combat veterans with lifetime PTSD had co-occurring substance use disorders.\(^{29}\) There are estimated to be 23.4 million veterans and 2.2 million military service members (including National Guard and Reserve forces) in the USA, creating a huge challenge to health care systems and also creating political battles that have yet to be resolved to the benefit of veterans and their families. The fact that veterans themselves often do not seek treatment exacerbates the treatment challenges.

Women veterans are particularly susceptible to COD. Often they return from combat with PTSD and then are further exposed to domestic violence, increasing their risk of substance use disorders, and interaction with the criminal justice system.\(^{30}\) Eventually these female veterans can spiral into unemployment and/or homelessness.\(^{31}\)

Veterans are over-represented in homeless, unemployed and other vulnerable populations. Their suicide rates are also higher than their peers not exposed to combat. Ten percent of inmates in state prisons and local jails are veterans. A comprehensive system for providing services for incarcerated veterans is practically non-existent, although there are some local programs doing good work. However, compared with homeless veterans in the community, jailed veterans obtained few services (and frequently no services at all).\(^{32}\)

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28 Substance Abuse and Mental Health Services (http://media.samhsa.gov/co-occurring/) Co-Occurring Disorders and Primary Care.

29 Substance Abuse and Mental Health Services (http://media.samhsa.gov/co-occurring/) Co-Occurring Disorders in Veterans and Military Service Members.


31 Substance Abuse and Mental Health Services (http://media.samhsa.gov/co-occurring/) Women Veterans with Co-Occurring Disorders.

BRAIN DEVELOPMENT IN YOUTH

A detailed explanation of brain architecture in youth is beyond the scope of this paper; suffice it to say that teenagers’ brains are still under construction during a life stage when they are adapting to their world in deep and long-lasting ways. Evolving into a distinct individual requires the distancing from parents and other adults, and the relative increase in importance of peers and peer pressure. Fears and hopes for the future are brought into focus by increased pressure for educational attainment, and hormones are running rampant, sometimes causing biological urges to overtake common sense. Risky behaviors are at an all-time high as are rebellious thoughts against parents and other adult authority figures. However, it is not all a bad thing. It is a time of huge creativity and intellectual curiosity. Youth have an energy and enthusiasm that is the envy of many adults, and most of them are not yet weighed down by the cares and worries of families, careers, finances, and increasing health issues.

The teenage years have only recently been researched sufficiently that we now have some idea about how the teen brain functions and just how vulnerable teenagers are as they attempt to navigate their world. The backdrop of how the teenage brain works will be a recurrent theme as we look at youth with COD. Their brain chemistry is unstable as their brains grow and change before those brains reach maturity in the individuals’ mid-twenties. Figure 2 clearly shows the fundamental chemical changes as various areas of the brain change and develop through early childhood, the teenage years and into young adulthood.33 When looking at such a graphic it makes sense that what a teenager is exposed to and what he or she experiences impact them in complicated ways, setting up lifelong patterns of behaviors and attitudes that can be negative or positive and anywhere in between.

“The teenage brain is not just an adult brain with fewer miles on it.”

Frances E. Jensen, M.D.
Professor of Neurology at Children’s Hospital Boston and Harvard Medical School (HMS)

So what do these changes mean for co-occurring disorders in youth? The National Institute of Mental Health describes the ramifications of a changing brain:

One interpretation of all these findings is that in teens, the parts of the brain involved in emotional responses are fully online, or even more active than in adults, while the parts of the brain involved in keeping emotional, impulsive responses in check are still reaching maturity. Such a changing balance might provide clues to a youthful appetite for novelty, and a tendency to act on impulse—without regard for risk.

In addition to engaging in risky behavior, it is a sobering fact that half of all adults with mental illnesses were first diagnosed by age 14 and three-fourths by age 24. It has been shown that the first symptoms of mental or emotional illness can show up in young children as early as 2 to 4 years of age. The changing brain chemistry coupled with environmental factors that do not support healthy development creates a fertile ground for co-occurring disorders. With this backdrop of adolescent brain development and the high tendency of youth to engage in risky behaviors, we now turn to data specific to youth with COD.

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The National Academies. Preventing Mental, Emotional, and Behavioral Disorders Among Young People Progress and Possibilities. Report Brief FOR POLICYMAKERS • MARCH 2009
NATIONAL DATA ON YOUTH

Assembling reliable data on COD in youth is more challenging than finding it for adults. Most data relies on separating the two conditions that create COD: mental illness and substance use disorders. Therefore initially we will take a brief look at how American youth are doing on mental illness and substance use separately, and how our Montana youth compare. Sources of data used in this section on youth are listed in the accompanying sidebar.

The reports used for determining youth with COD, both nationally and for Montana, are from several reliable sources:

- Substance Abuse and Mental Health Services (SAMSHA)
- Behavioral Health Barometer, United States, 2015
- Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health
- Data Resource Center for Child and Adolescent Health; Child and Adolescent Health Measurement Initiative Child Health and System Performance Profile
- Centers for Disease Control (CDC): Youth Risk Behavior Surveillance (YRBS) A federally mandated survey administered by states. In Montana, the Office of Public Instruction samples students in grades 9 through 12 in schools across the state in odd-numbered years.

Mental Illness

Figure 3 shows some national data on youth ages 13 – 18 and mental illness. Overall 20% of this cohort has some type of mental illness with 11% having a mood disorder, 10% having a behavior disorder and 8% having an anxiety disorder. The Youth Risk Behavior Survey (YRBS) has only one question that directly asks about a specific mental illness, depression. The question asks if, over the past year, a student has felt so sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities. Montana youth were less likely to report feeling depressed than students nationally (26% in Montana versus 30% nationally).
The National Survey of Children’s Health (NSCH) has questions specifically asking parents about the following seven conditions: ADD/ADHD, anxiety, depression, oppositional defiant disorder/conduct disorder, autism spectrum disorders, developmental delay, and Tourette syndrome. These seven are aggregated to report on children 2-17 who have one or more emotional, behavioral or developmental conditions. The NSCH shows that 12% of children in this age group both nationally and in Montana have one or more of these conditions. Prevalence rates by age group show that Montana youth aged 12-17 have a higher rate than children nationally in the same age group (16% in Montana versus 12% nationally). Children in Montana ages 6 - 11 years have the same rate, 12%, as their national peers.

The mental illness disorders most associated with COD, as mentioned earlier, are behavioral or mood disorder, or an attention-deficit hyperactivity disorder. The above analysis of composite data from NSCH includes all conditions that fall under these categories. However, one disorder is disaggregated, Attention Deficit Disorder/Attention Deficit and Hyperactivity Disorder (ADD/ADHD). The 2011/2012 NSCH survey reports that both nationally and in Montana 5% of children ages 2 -17 have ADD/ADHD and are taking medication for it.

Conversely, it is interesting to look at the question that shows children who are flourishing according to parental reporting. Flourishing was measured by capturing three different areas: (1) child shows interest and curiosity in learning new things, (2) child stays calm and in control when faced with a challenge, (3) child finishes tasks and follows through with plans. Results show that nationally 48% of children ages 6 – 17 met all three measures and 47% of Montana children do also. So lots of children are doing well.

Figure 3. Percentage of children ages 13 – 18 with mental health disorders, 2014.
Source: National Alliance on Mental Illness.

Substance Use Disorders
In 2014, an estimated 5% of all adolescents, representing 1.3 million American children ages 12 to 17, had a substance use disorder. Comparing Montana youth to their cohorts nationally on available substance abuse indicators from the 2013 YRBS (Table 2) shows that Montana youth have very similar rates to their national counterparts in all indicators related to substance abuse. Marijuana use in Montana is less than the national average, but with changing social acceptance and shifting state laws this is a number to watch carefully.
Table 2. YRBS questions and response related to substance abuse.
Sources: Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, Youth Risk Behavior Surveillance, 2013. Montana Office of Public Instruction. 2013 Montana Youth Risk Behavior Survey High School Results NB. Although OPI has analyzed and publicized data from the 2015 YRBS, CDC is not publishing the 2015 national YRBS until July 2016. To keep years consistent, we are comparing national and state data from 2013 results.

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>US versus MT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the past 30 days:</strong></td>
<td></td>
</tr>
<tr>
<td>Had at least one drink of alcohol?</td>
<td>35%</td>
</tr>
<tr>
<td>Drank five or more drinks of alcohol in a row w/in an hour.</td>
<td>21%</td>
</tr>
<tr>
<td>10 or more alcoholic drinks in a row w/in an hour.</td>
<td>6%</td>
</tr>
<tr>
<td>Smoked cigarettes at least one cigarette.</td>
<td>16%</td>
</tr>
<tr>
<td>Used marijuana one or more times.</td>
<td>23%</td>
</tr>
<tr>
<td><strong>During lifetime:</strong></td>
<td></td>
</tr>
<tr>
<td>Ever took prescription drugs without a doctor’s prescription.</td>
<td>18%</td>
</tr>
<tr>
<td>Drank alcohol for the first time before age 13 years.</td>
<td>19%</td>
</tr>
<tr>
<td>Tried marijuana for the first time before age 13 years.</td>
<td>9%</td>
</tr>
<tr>
<td>Used any form of cocaine, including powder, crack or freebase.</td>
<td>7%</td>
</tr>
<tr>
<td>Sniffed glue, breathed the contents of aerosol spray cans or inhaled any paints or sprays to get high.</td>
<td>9%</td>
</tr>
<tr>
<td>Used heroin one or more times.</td>
<td>2%</td>
</tr>
<tr>
<td>Used methamphetamines one or more times.</td>
<td>3%</td>
</tr>
<tr>
<td>Used ecstasy one or more times.</td>
<td>7%</td>
</tr>
<tr>
<td>Taken a prescription drug without a doctor’s prescription.</td>
<td>18%</td>
</tr>
</tbody>
</table>
National data collected on adolescents shows that almost half of all youth receiving mental illness services have been diagnosed with a co-occurring disorder. These data also show that 80% of adolescents with multiple mental illness and substance use disorders report onset before age 20.\textsuperscript{35}

A 2007 Monitoring the Future study showed that nearly half of 12th graders reported using illicit drugs, and almost three-quarter of adolescents used alcohol by the 12th grade. More importantly, among adolescents who seek treatment for substance use problems, co-occurring mental illness problems were common. In digging deeper into which substances were used and what was the co-occurring mental illness disorder it was found that among marijuana users, just over 70% reported two or more problems with attention deficit hyperactivity disorder (ADHD) with conduct disorder problems being the most common. Although other studies confirm that ADHD and conduct disorders are the most frequently found in youth in substance use disorder treatment, problems with depression and anxiety were also common. This appears to reverse in older adolescents, with depression and anxiety showing up more frequently than ADHD and conduct disorders.\textsuperscript{36}

SAMHSA, using data from the National Survey on Drug Use and Health, has estimated that in 2014, about 1 in 10 youth ages 12 to 17 (11%) had a major depressive episode (MDE). The intersection between these 12 to 17 year-olds with a MDE and a substance use disorder is represented in Figure 4, showing that there are approximately 340,000 youth with a COD. Data on MDE is the only mental illness mood disorder in youth specifically collected by the National Survey on Drug Use and Health.\textsuperscript{37}

\textbf{Figure 4.} Past Year Substance Use Disorders and Major Depressive Episode in the Past Year among Youths Aged 12 – 17. Source: Behavioral Health Trends in the United States; 2014 National Survey on Drug Use and Health.

\textsuperscript{35} Judge David L. Brazelon Center for Mental Health Law; Facts on Co-Occurring Mental Illness and Substance Abuse Disorders in Children and Adolescents.

\textsuperscript{36} Reedy, A. R.: Adolescent Co-Occurring Disorders: Factors Related To Mental Health Problems among Substance Using Adolescents. An abstract of a thesis submitted in partial fulfillment of the requirements for the doctor of philosophy degree in social work in the graduate college of the University of Iowa, May 2010.

\textsuperscript{37} Substance Abuse and Mental Health Services (http://media.samhsa.gov/topics) Mental and Substance Use Disorders.
It is important to find some way to look at data on Montana youth to determine more about COD in adolescents in our state. As mentioned above, the only YRBS question on mental illness is on depression. However there are other measures that we can use as surrogates for mental illness disorders: suicide and bullying. The Montana Office of Public Instruction (OPI) used the 2015 YRBS data to produce three excellent reports that allow us to look at these three issues (depression, suicide and bullying) alongside the questions on substance use. Without significantly more statistical analysis, this will not allow us to quantify the number of Montana students with COD, but it can help us make inferences on a weighted sample representative of the Montana student statewide population.
DEPRESSION AND SUBSTANCE USE

In 2015, 29% of all Montana students reported that during the past 12 months they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. OPI analyzed the results from the 2015 YRBS on this question by looking at the association between feeling sad or lonely and 46 other risk factors. They used a standard and statistically valid method of doing this; therefore the findings are very helpful when we look at Montana youth and COD. The risk factors focused on were substance use, unsafe driving practices, violence, bullying, suicide, sexual activity, unhealthy eating patterns and physical activity. (The table showing the findings from all 46 risk-factor associations is in Appendix 1 and includes a paragraph on methodology.)

Table 3 shows students reporting feeling sad and hopeless versus those reporting they did NOT feel sad and hopeless alongside what they reported about their substance use. The table categorizes the results in three ways based on the percentage difference between depressed and non-depressed students using the substance. From these numbers we see that depressed students have a higher propensity to use substances than their non-depressed peers, perhaps indicating a high likelihood for COD. All students, both depressed and non-depressed, are likely to have had a drink at some point in their lives, not necessarily indicating COD, just that this indicator needs to be of great concern to all schools, families, and health care professionals. This analysis doesn’t tell us which students have COD; it does tell us which substances are most likely used by students who reported feeling sad or hopeless: cigarettes, alcohol and marijuana.

Table 3. Depressed and Non-Depressed Students and Other Risky Behaviors.
Source: Montana Office of Public Instruction. 2015 Montana Youth Risk Behavior Survey; Depression Report.

<table>
<thead>
<tr>
<th>Health Risk Behavior</th>
<th>% of All students who reported the risky behavior</th>
<th>% of Depressed students who reported the risky behavior</th>
<th>% of Non-depressed students who reported the risky behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drove when drinking</td>
<td>11%</td>
<td>16%</td>
<td>9%</td>
</tr>
<tr>
<td>Ever tried cigarettes</td>
<td>39%</td>
<td>55%</td>
<td>33%</td>
</tr>
<tr>
<td>Smoked cigarettes in past 30 days</td>
<td>13%</td>
<td>23%</td>
<td>9%</td>
</tr>
<tr>
<td>Used electronic vapor products in past 30 days</td>
<td>30%</td>
<td>41%</td>
<td>25%</td>
</tr>
<tr>
<td>Ever had a drink</td>
<td>70%</td>
<td>82%</td>
<td>65%</td>
</tr>
<tr>
<td>Drank in past 30 days</td>
<td>34%</td>
<td>46%</td>
<td>29%</td>
</tr>
<tr>
<td>Had 5 or more drinks in within 2 hours</td>
<td>21%</td>
<td>28%</td>
<td>18%</td>
</tr>
<tr>
<td>Ever used marijuana</td>
<td>38%</td>
<td>54%</td>
<td>31%</td>
</tr>
<tr>
<td>Used marijuana in past 30 days</td>
<td>20%</td>
<td>31%</td>
<td>15%</td>
</tr>
</tbody>
</table>

- Use of substances much higher for depressed students than non-depressed students
- Use of substances particularly high for both depressed AND non-depressed students
- Use of substances low/very close for both depressed and non-depressed students

- Used smokeless tobacco 12% 13% 12%
- Smoked cigars etc. 13% 15% 11%
- Ever used meth 3% 5% 2%
SUICIDE AND SUBSTANCE USE

The close relationship between suicide and mental illness gives us another way to look at youth at risk of COD. It is generally accepted that at least 90% of all people who died by suicide suffered from some mental illness, whether diagnosed or not. Although suicide and depression are closely linked, anxiety disorders and behavior/disruptive disorders are also highly linked to risk of suicide. Anxiety disorders or behavior disorders are often the mental illness found in youth with COD. Panic disorder and PTSD are, by themselves, often associated with suicide attempts.

Research has also linked suicide attempts and substance use disorders in youth. Although substance use is not the cause per se, it is a significant risk factor as youth who use drugs are about three times as likely to attempt suicide compared to those who do not use substances.

The report OPI generated on the 2015 YRBS analyzed one of the questions specific to suicide, asking students if they had attempted suicide during the past 12 months with 9% reporting that they had. Table 4 shows the substance use questions with the strongest association to students attempting suicide compared to students who did not attempt suicide.

Looking at the association between substance use and suicide attempts, findings show that the students attempting suicide were more likely than those who had not attempted suicide to have:
- Driven when drinking alcohol.
- Used tobacco products.
- Drunk alcohol recently and in excess.
- Used marijuana.
- Used meth, ecstasy or prescription drugs without a prescription.

The table includes only those substances that show significant differences (10 percentage points or greater) between the two groups of students (those who did or did not attempt suicide). Meth, ecstasy and prescription drugs showed up as substances likely to be used by students who attempted suicide, whereas they did not show an association with students feeling depressed. This data confirms that the students who attempted suicide were even more likely to use substances than students who were depressed. This is not entirely surprising, as attempting suicide can be the culmination and outcome of feeling sad or hopeless. That students who attempt suicide also have COD is highly likely and needs to inform the reactions of schools, families, and treatment professionals.

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39 SAMHSA Mental Health Reporting: Facts About Mental Illness and Suicide.
Table 4. Students Reporting Attempted Suicide and Other Risky Behaviors
Source: Montana Office of Public Instruction. 2015 Montana Youth Risk Behavior Survey; Suicide Report

<table>
<thead>
<tr>
<th>Health Risk Behavior</th>
<th>Percentage of ALL Students reporting health risk behavior</th>
<th>Percentage of Students Attempting Suicide reporting risk behaviors</th>
<th>Percentage of Student who DID NOT Attempt Suicide reporting risk behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drove when drinking</td>
<td>11%</td>
<td>27%</td>
<td>9%</td>
</tr>
<tr>
<td>Ever tried cigarettes</td>
<td>39%</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Smoked within past 30 days</td>
<td>13%</td>
<td>35%</td>
<td>11%</td>
</tr>
<tr>
<td>Used electronic vapor products</td>
<td>51%</td>
<td>80%</td>
<td>49%</td>
</tr>
<tr>
<td>Used vapor products past 30 days</td>
<td>30%</td>
<td>51%</td>
<td>27%</td>
</tr>
<tr>
<td>Ever drank alcohol</td>
<td>70%</td>
<td>85%</td>
<td>69%</td>
</tr>
<tr>
<td>Drank in past 30 days</td>
<td>34%</td>
<td>57%</td>
<td>32%</td>
</tr>
<tr>
<td>Had 5 or more drinks within 2 hours</td>
<td>21%</td>
<td>38%</td>
<td>19%</td>
</tr>
<tr>
<td>Ever used marijuana</td>
<td>38%</td>
<td>66%</td>
<td>34%</td>
</tr>
<tr>
<td>Used marijuana past 30 days</td>
<td>20%</td>
<td>42%</td>
<td>17%</td>
</tr>
<tr>
<td>Ever used meth</td>
<td>3%</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>Ever used ecstasy</td>
<td>6%</td>
<td>18%</td>
<td>5%</td>
</tr>
<tr>
<td>Ever took Rx drugs w/o RX</td>
<td>16%</td>
<td>41%</td>
<td>13%</td>
</tr>
</tbody>
</table>
BULLYING AND SUBSTANCE USE

Bullying, whether in person or online, is increasingly being understood as a significant problem, causing mental illnesses that go well into adulthood. According to the government website Stopbullying.gov and based on recent research conducted at Duke University:

- Youth who were victims of bullying had a higher chance of having agoraphobia, anxiety and panic disorders.
- Youth who bullied were at risk for antisocial personality disorder.
- Youth who bullied who were also victims of bullying were at a higher risk for adult depression and panic disorder. For this group, there was an increased risk for agoraphobia in females and suicidality in males.44

This study also showed that victims of childhood bullying have a higher risk of developing mental illness problems later in life. The study followed more than 1,000 youth, starting at the ages of 9, 11, and 13. The youth were interviewed each year until they turned 16 with follow-up interviews being conducted into adulthood.45

The OPI report on bullying looked at the 25% of Montana high school students who reported being bullied on school property during the past 12 months. That a quarter of all our high school students reported being bullied at school is indicative of the seriousness of this problem. And when one associates bullying with substance use, it becomes clear that bullied students are at high risk of having COD.46

Table 5 isolates the substance use questions alongside the students who did or did not report being bullied on school property. The table includes only those substances that show significant differences (10 percentage points or greater) between the two groups of students (those who were or were not bullied). The list of health risk behaviors is far shorter for students reporting being bullied than the lists for suicide or depression. Why this is the case is a question that merits further study beyond the scope of this paper. But it should be noted that even though there are fewer risky behaviors, the overall percentage point differences between columns two and three are still quite large.

45 Ibid.
Table 5. Students Reporting being Bullied at School and Other Risky Behaviors
Source: Montana Office of Public Instruction. 2015 Montana Youth Risk Behavior Survey; Bullying Report

<table>
<thead>
<tr>
<th>Health Risk Behavior</th>
<th>Percentage of ALL Students</th>
<th>Percentage of Students being bullied reporting risk behaviors</th>
<th>Percentage of Student who were NOT bullied reporting risk behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever tried cigarettes</td>
<td>39%</td>
<td>47%</td>
<td>36%</td>
</tr>
<tr>
<td>Smoked within past 30 days</td>
<td>13%</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Used vapor products past 30 days</td>
<td>30%</td>
<td>36%</td>
<td>27%</td>
</tr>
<tr>
<td>Ever drank alcohol</td>
<td>70%</td>
<td>77%</td>
<td>67%</td>
</tr>
<tr>
<td>Had 5 or more drinks within 2 hours in past 30 days</td>
<td>21%</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Used marijuana in past 30 days</td>
<td>20%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>Ever took Rx drugs w/o RX</td>
<td>16%</td>
<td>32%</td>
<td>18%</td>
</tr>
</tbody>
</table>
Data that particularly jumps out from these tables is how smoking cigarettes and electronic vapor product use show up as having high associations with students reporting depression, attempting suicide and being bullied. Although there is relatively little research on the correlation between cigarette smoking and mental illness in youth, what is available shows that nicotine dependence is related to mood, anxiety, and disruptive behavior disorders in youth, and that smoking appears highly prevalent among adolescents with diagnoses of mental illnesses, especially ADHD, oppositional defiant disorder, conduct disorder, major depressive disorder, social phobia, and substance use disorder.\textsuperscript{47} As noted above, youth with COD are more likely to be diagnosed with some type of behavioral or mood disorder, or an attention-deficit hyperactivity disorder.

**Vapor Products**

The use of vapor products or e-cigarettes is a new phenomenon that is growing fast and research on their long-term health impacts is very limited. According to the Center for Disease Control and Prevention (CDC), in 2014 more than 9 million adults smoked e-cigarettes, representing just below 4% of the American public. The use of e-cigarettes tripled between 2013 and 2014 among both high school and middle school children. Additionally, 1 in 5 middle school students who reported ever using e-cigarettes say they have never tried traditional cigarettes.\textsuperscript{48} Probably the most sobering study about the use of e-cigarettes in youth showed that students who have used e-cigarettes by the time they start 9th grade are more likely than others to start smoking traditional cigarettes and tobacco products within the next year.\textsuperscript{49}

30% of adults with mental illness are cigarette smokers, whereas only 17% of U.S. adults as a whole are smokers indicating the susceptibility of adults with mental illness to tobacco products. Although the study was limited to adults it gave empirical evidence that smokers with mental illness are likely to be susceptible to using e-cigarettes.\textsuperscript{50}


\textsuperscript{50}Cummins , Sharon E, Shu-Hong Zhu, Gary J Tedeschi, Anthony C Gamst, Mark G Myers. "Use of E-cigarettes by Individuals with Mental Health Conditions". Tobacco Control, May 2014.
SUBSTANCE USE EARLY ONSET, HIGH USAGE AND COD

Some studies show that there are predictors of adolescents with substance use disorders developing COD. Compared to adolescents with substance use disorders only, those with co-occurring disorders:

- Have an earlier onset of substance use
- Use substances more frequently
- Use substances over a longer period

In addition to substance use, two other predictors have been identified amongst youth who develop COD compared to those who have substance issues only. They are more likely to:

- Have greater rates of family, school, and legal problems, and
- Early life problems such as parental divorce or living in a house where alcohol abuse is present.51

Two sets of questions in the YRBS do not provide completely satisfying surrogates for these predictors of COD; however they are a useful way to look at early onset of substance use, and at more frequent and recent use of substances. The questions pertain to the three substances most used by Montana youth: tobacco, alcohol, and marijuana. They ask if the student tried the substance before age 13 and then ask about usage during the past 30 days.

The following bar graph (Graph 1) shows the questions on cigarette, alcohol, and marijuana use before age 13 and on frequency of use of the same three substances within the past 30 days. The table then juxtaposes them beside student responses on depression, suicide and bullying. This doesn’t say these students have COD, but they exhibit risky behaviors that have been shown to be associated with COD either as youth or later in life. The center bar of each data group shows the high association between the students who experienced depression, attempted suicide, or were bullied at school with the early onset and frequent, recent use of cigarettes, alcohol and marijuana.

Again these numbers do not quantify how many students have COD, but they do indicate a high association between specific substances and a mental illness indicator (depression) and mental illness surrogate indicators (suicide and bullying).

Graph 1. YRBS Sadness/Hopelessness, Suicide and Bullying and Other Health Risk Behaviors.
As part of a federal grant, Montana produced a report, Montana Mental Health, Chemical Dependency & Co-Occurring Financial Map; this report identified youth with COD by analyzing services accessed through different funding streams.

The financial map looked at mental illness or chemical dependency-related services provided to youth ages 12-17 during State Fiscal Year 2012. To identify COD youth, the study looked for a diagnosis associated with both disorders. Although a limited sample of youth in Montana (those who qualified for the services through the specific funding streams), the study gives some data on this population. Of the approximately 8,000 youth, about 11% were identified as having COD, 6% were identified as having only chemical dependency, and just over 80% were identified as having only a mental illness diagnosis.

As useful as this data is in giving us another way to count children with COD, it does not address whether all eligible children are in these systems or if diagnoses made and their associated codes used to bill Medicaid produces a bias to code for the services that are the most likely to be covered.52

Figure 5 is a product of the financial mapping. It shows the number of children aged 12-17 receiving treatment for mental illness, chemical dependency, and co-occurring disorders and in which counties they were living. The map has to be placed in the context of Montana geography and demographics. In a state with around a million people and just under 150,000 square miles, population is dispersed and 46 of the 56 counties have fewer than 6 residents per square mile. More than half of the population lives in just six counties: Yellowstone, Missoula, Flathead, Gallatin, Cascade, and Lewis and Clark. The map shows that over half of the adolescents receiving treatment lived in these six counties and the remaining adolescents were dispersed throughout the state.53 Given that most services for treatment of COD are located in the six populous counties it is not surprising to find most youth with COD in these counties.

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52 Personal Communication Dr. Tim Conley, Clinical and Research Consulting, PLLC, Missoula.
ADVERSE CHILDHOOD EXPERIENCES (ACES)

All the data presented so far helps to tease out a picture of youth in Montana with a high risk for COD; they start using substances early and more often, they are more likely to be depressed or attempt suicide, and they are often bullied. However, negative experiences and traumas from childhood have been increasingly studied to help us understand their long term effects on adolescents and adults and how they put youth at risk of participating in the behaviors that might lead to developing a substance use disorder or mental illness. ACEs are harmful childhood experiences that potentially lead to multiple problems in adolescents and adults. They can be physical, emotional, or sexual abuse; they can stem from poverty, divorce, parental incarceration, historical trauma or many other pains and stresses suffered during childhood. Much research has been done to understand the links between ACES and negative life outcomes, among which are co-occurring mental illness and substance use disorders. Coupled with the challenges faced by youth as their brain chemistry is in flux, ACEs exponentially increase the likelihood of participating in high-risk behaviors.

One such research effort, conducted by Child Trends using 2011/12 National Survey of Children's Health data, looked to quantify the prevalence of one or more ACEs in children ages birth through 17 at both the national level and the state level. Poverty was the number one ACE reported nationally followed by, in almost all states, divorce or separation. However, abuse of alcohol or drugs by a family member, exposure to neighborhood violence, and the occurrence of mental illness within the household were frequently cited as ACEs in all states. Findings showed that 46% of all American children have experienced at least one ACE. Montana unfortunately has the dubious distinction of having, along with Oklahoma, the highest percentage of all children with 3 or more ACEs (17%). Montana is similar to the national ranking in terms of the most common ACEs: economic hardship, divorce, alcohol use by a member of the household, and mental illness present in the household. Our state also had the highest percent of all children and of children aged 0-5 who lived with someone with an alcohol or other drug problem; additionally Montana had the highest percentage of children ages 6-11 who live with someone with a mental illness.54

Figure 6. Percentage of adults aged 18 and older reporting ACES, by number of ACES reported, Montana 2011.
Source: Montana Behavioral Risk Factor Surveillance System.

There is further Montana-specific research conducted as part of the final report on Senate Joint Resolution no. 30 for the Children, Families, Health and Human Services Interim Committee. This data gives us more insight into the nature of the ACEs reported by adults over 18. (Figure 6) Economic hardship was not included as part of this particular analysis. What stands out in Figure 6 is that the most common adverse childhood experience was reported to be a substance-abusing household member and that having a mentally ill household member was the fourth highest ACE reported.

While this does not tell us whether these children have or will not have COD, it can inform policy and program decisions to prevent youth from developing COD. It assists human service agencies in identifying these children earlier and then in providing families and communities the needed support.

While the data on Montana from NCHS is not positive, Montana is to be commended in its proactive response to the data. It became the first state in the nation to hold training in ACEs for all of DPHHS staff. SAMHSA conducted the two-day training in 2013. It is intuitively obvious that it is not enough to just train staff; in addition, awareness of ACEs must be integrated into all service delivery systems.
TREATMENT APPROACHES FOR YOUTH WITH COD

Treatment for youth with COD is a vast topic and can (and does) take up book-length discussions and explanations. Montana KIDS COUNT does not look to describe all treatments and programs for youth with COD; rather we will look at broad approaches, successful programmatic criteria, and the potential policy solutions that have been successfully tried and implemented elsewhere.

The following list of hotlines and websites to access help was developed by SAMSHA and is included as a reminder that help is available.

**Suicide Prevention Lifeline**
1-800-273-TALK (8255)  
TTY: 1-800-799-4889  
Website: www.suicidepreventionlifeline.org  
24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. Your call is routed to the nearest crisis center in the national network of more than 150 crisis centers.

**SAMHSA's National Helpline**
1-800-662-HELP (4357)  
TTY: 1-800-487-4889  
Website: www.samhsa.gov/find-help/national-helpline  
Also known as, the Treatment Referral Routing Service, this Helpline provides 24-hour free and confidential treatment referral and information about mental and/or substance use disorders, prevention, and recovery in English and Spanish.

**Disaster Distress Helpline**
1-800-985-5990  
Website: www.samhsa.gov/find-help/disaster-distress-helpline  
Stress, anxiety, and other depression-like symptoms are common reactions after any natural or human-caused disaster. Call this toll-free number to be connected to the nearest crisis center for information, support, and counseling.

**Veteran's Crisis Line**
1-800-273-8255  
TTY: 1-800-799-4889  
Website: www.veteranscrisisline.net  
Connects veterans in crisis (and their families and friends) with qualified, caring Department of Veterans Affairs responders through a confidential, toll-free hotline, online chat, or text.
INTEGRATED TREATMENT APPROACH

As mentioned above in the history section, treatment for people with COD was most often based on a parallel approach; treatment of the mental illness and of the substance use were often conducted by different professionals under different protocols. Providing dual services proved ineffective, leading to the development of an Integrated Treatment Model. While it seems intuitively obvious -- after all the medical community would not treat only diabetes in a patient who has both diabetes and heart disease -- it has been a hard-won change in service delivery systems tasked with treating mental illnesses and chemical dependency disorders. Treating COD holistically is vital to coordinate medication therapy; to prevent the hesitation of prescribing drugs for the mental illness to people with addiction diagnoses; to provide group therapy appropriate for people with substance use disorders and mental illness; and to ensure that people in drug rehab understand their mood-disorder triggers.55

Treatment for individuals with COD has historically focused on the adult population, and lack of research to help youth has meant that there is still much work to be done in developing well-articulated, empirically tested models from which clinicians serving adolescents can draw. For instance, studies are lacking on how the effects of chemicals on the developing adolescent brain can be different from the same chemicals’ effects on the fully formed adult brain.

In 1995, SAMHSA funded a panel of national experts to establish standards of care for an integrated treatment approach for people with COD.56 The consensus report identified these principles of effective integrated treatment for COD as:

• Welcoming clients with co-occurring disorders into substance abuse treatment instead of excluding them because of a psychiatric condition
• Giving the addictive disorder and the co-occurring psychiatric disorder the same level of attention and care during the rehabilitation process
• Addressing both the mental illness and the substance use disorder as chronic, relapsing conditions that require long-term support
• Ensuring that care is provided by a treatment team that’s trained in addressing co-occurring disorders
• Assessing each client for mental health disorders as early in the rehabilitation process as possible so treatment can begin promptly
• Treating all clients with dignity and respect, even if they are in the midst of a mental health crisis or acutely intoxicated.57

In addition to the development of standards of care, common components of successful integrated treatment have been identified: case management, close monitoring, substance abuse treatment, family psychoeducation, rehabilitation, housing, and medication.58 Looking at this list, it becomes obvious that truly integrated treatment is hard to put into practice. It involves multiple disciplines, multiple funding streams, multiple agencies, community collaboration, and interwoven behavioral health systems.

55 Dual Diagnosis (www.dualdiagnosis.org ), Co-occurring Disorders Treatment.
57 Dual Diagnosis (www.dualdiagnosis.org ), Co-occurring Disorders Treatment.
TRIUMA-INFORMED APPROACH

Research into ACES initiated a new way of looking at providing treatment and support to families and youth who have experienced adversity in childhood called a Trauma-Informed Approach. This is important for youth with COD because of the role trauma plays in individuals with substance use disorders and/or mental illnesses. Again SAMHSA provides multiple levels of information through its website for the National Center for Trauma-Informed Care (NCTIC), including a 342 page treatment protocol book, Trauma-Informed Care in Behavioral Health Services, published in 2014. Its intended audience is professional care providers, program planners, administrators, & project managers. This approach is distinct from trauma-specific treatment interventions and can be used in any type of service setting, organization or for system-wide planning.

- According to the NCTIC, the basic premises of a trauma-informed approach to treatment and care are that it:
  - Realizes the widespread impact of trauma and understands potential paths for recovery;
  - Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
  - Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
  - Seeks to actively resist re-traumatization.  

The principles behind a trauma-informed approach are not intended as specific practices or protocols, rather to infuse the approach into a program’s philosophy. They include (again from the NCTIC) safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues.

BEHAVIORAL HEALTH CARE SYSTEMS

No discussion about integrated treatment is complete without looking at the concept and development of behavioral health care systems. The term behavioral health is repeatedly found in all literature about COD. It is a broad, commonly used term that covers the full range of mental and emotional well-being – from the basics of how we cope with day-to-day challenges of life, to the treatment of mental illnesses, such as depression or personality disorder, as well as substance use disorder and other addictive behaviors. It is used throughout treatment, program and policy discussions on COD to describe a way of thinking about and approaching the problem. Initially behavioral health was used to describe only physical conditions, but it now incorporates mental health issues also.

One of the primary players in creating a Montana behavioral health care system is the Montana Healthcare Foundation (MHCF). Created in 2013, it was mandated by state law as result of the sale of Blue Cross/Blue Shield of Montana to a private corporation. That law required the sale assets to be put into a charitable trust to be managed for public benefit. MHCF provides grants to community providers to establish integrated health care approaches, thereby helping to create a more robust behavioral health care system in the state.

59 National Center for Trauma Informed Care and Alternatives to Seclusion and Restraint, SAMHSA http://www.samhsa.gov/nctic.
60 Ibid.
SYSTEMS WHICH ENCOUNTER, TREAT AND REFER YOUTH WITH COD

The sheer number of systems likely to encounter youth with COD is mind-boggling; it is also sobering to imagine how many possible ways these systems might, or might not, respond to youth who need help tailored to their specific needs. For frequently underfunded, often over-burdened, agencies and service organizations, the likelihood of these children getting the sophisticated level of integrated treatment they need is challenging. This section will take a big picture look at the primary systems that in all likelihood come in contact with youth with COD. It includes what that system looks like organizationally in Montana and some numbers of people that are seen within those systems.

Mental Health Systems

In Montana, the Children’s Mental Health Bureau (CMHB) is in the Developmental Services Division of the Montana DPHHS; it administers both federally-funded and state-funded services for children. Eligibility for these services is based on household income; the level above which families are ineligible varies by program.. CMHB serves approximately 17,000 children under age 18 per year. These children receive treatment for mental illness in a variety of settings such as the 17 mental health centers (treating either only children or children and adults), community health centers, residential treatment facilities, hospitals, therapeutic group homes, schools or private practices.

Adults access mental health services through a different state portal, the Addictive and Mental Disorders Division (AMDD) in DPHHS. AMDD provides adult mental health services by contracting with behavioral health providers throughout Montana.

Chemical Dependency Systems

In Montana, the Chemical Dependency Bureau (CDB) within AMDD manages Medicaid and the block grant funded by SAMHSA and oversees services for adult mental health care and for substance use disorders for youth and adults. In SFY 2013, 768 youth, ages 0-20 years old, received state-approved chemical dependency treatment services. Youth receive chemical dependency services through CDB in a variety of settings: residential treatment facilities, outpatient clinics, public health centers and more.

Because both CMHB and CDB provide services through publicly funded, income-tested programs, youth with chemical dependency or mental health issues who receive public assistance are more likely to receive treatment than youth with private insurance. This discrepancy will be discussed in detail later in this paper.

Primary Care Systems

Mental illnesses are often manifested by physical health problems: sleeplessness, headaches, pain, etc. Therefore, youth with COD are often first seen in primary care settings. In the overall population accessing health care at primary care settings, it is estimated that 20% of patients have a current psychiatric disorder and 20–25% have a substance use disorder. Clearly, these health care providers are in a unique position to identify patients with COD; although many are not able to treat COD, they can make referrals to appropriate agencies. The principle players in Montana’s primary care system are the Community Health Centers (CHCs), of which there are seventeen around the state. Primarily funded by federal and local grants, patient fees, and insurance payments, the CHCs are a vital part of delivering services to Montanans from all income levels. Others come into primary care through hospitals, private physician offices, emergency rooms, and clinics.

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61 DPHHS, Addictive and Mental Disorders, Chemical Dependency Bureau. “State of Montana Snapshot”.
Acute Care Systems

Because youth with COD are participating in risky behaviors, they might frequently be seen at emergency rooms, trauma centers or intensive care units. Given the circumstances and time constraints any treatment within acute care settings is unlikely, but screening for COD can and should be done to ensure that youth are given COD resources and referrals to pursue. In the overall population, prescription and over-the-counter drug abuse accounted for half the ER visits in the US and, despite the many problems youth have with alcohol abuse in the US, prescription drug misuse exceeds alcohol as the cause of youth seeking emergency treatment. Of course, the risk is increased when medications are abused in combination with one another and/or with alcohol.63

Child Welfare Systems

Children experiencing abuse and neglect and those who enter the foster care system are at high risk of mental illness and substance use problems because of their stressful family and environmental situations. Although this is one of the most challenging settings in which to conduct screening or assessment due to the highly charged nature of the family distress, it is still a vital place in which to identify and find appropriate care for youth with COD. If possible, a mental health and substance use screening of the child should be part of the risk and family assessment while the child is still in the home. This approach, however, would not replace the need for a screening or assessment if the child is removed from his or her home to identify possible traumatic effects. In particular, youth who are in or who have ever been in the foster care system have particular needs for trauma-informed care and treatment.64 Child welfare in Montana is run by the Child and Family Services Division (CFSD) of Montana’s DPHHS.

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ORGANIZATIONS THAT PROVIDE COMMUNITY SERVICES

This covers a wide swath of potential settings where families might access services, usually non-profit and often funded through public grants. Youth with COD, with or without their families, might be found in homeless shelters, runaway shelters or domestic violence shelters. Although it is impossible to give a true number of youth who are homeless without their families, it is estimated that annually there are between ½ and one million. Children and youth arriving alone in these settings are most likely to be from abusive families, having suffered physical and emotional traumas from which mental illness and substance use problems can develop. Again, understanding a trauma-informed approach is a vital part of how these service organizations need to meet the needs of these youth. Montana has many community-based programs, especially in the larger urban areas; how they interact with public agencies and utilize public funding to provide cross-agency treatment is very dependent on the local commitment to collaboration from both community-based service providers and local agency personnel.

Juvenile Justice System

Studies have shown that most youth involved with the juvenile justice system have mental illness/or substance use disorders, making this system key in identifying and helping youth with COD. Much progress has been made in screening youth coming into the juvenile justice system for mental illnesses or substance use disorders. Nationally, by 2002, just over 50% of juvenile offenders were held in facilities that screened for mental health and suicide and almost 70% were in facilities that screened for substance use. In addition, many states are now requiring that in-coming youth must be screened for both mental illness and substance use. In one study 11% of youth in a temporary detention center suffered from PTSD.\(^{53}\) In Montana, youth enter the Juvenile Justice system through contact with law enforcement agencies and are referred to Youth Court in the Montana Judicial Branch. In 2014, 4,052 Montana youth were referred to Youth Court with about 80% being handled informally by a Youth Court Justice probation officer. The good news is that the number of juvenile arrests in the state has trended down in the last ten years; since 2005 arrests declined by 39%. If a youth is charged with a crime, he or she goes into the Youth Services Division of the Montana Department of Corrections.

The Montana Board of Crime Control (MBCC) is the Montana agency that collects data, administers grants and programs and is dedicated to crime prevention, public safety and victim assistance. Its 18- member board is appointed by the Montana governor. MBCC’s commitment to juvenile justice is through planning prevention and diversion programs, administering grants, and assuring compliance with the Federal Juvenile Justice and Delinquency Prevention Act of 2002 and other federal regulations. The Youth Justice Advisory Council plays a key role in the MBCC Juvenile Justice work.

School Systems

Early childhood education settings are ideal places to identify, prevent, and intervene for social and emotional problems before children reach school age. However, it is estimated that 70 to 80% of children with significant developmental and behavioral difficulties enter kindergarten without their problems being identified. And even though the federal government mandates that children enrolled in Early Head Start (ages 0–3 years) or Head Start (ages 3–5 years) be screened for social, emotional, and developmental problems, Head Start reaches only 50 percent of eligible children and Early Head Start reaches only 5 percent.

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In general, early care and education providers do not have the training and resources to systematically perform screening, making it important that people working in these settings know how to find resources for assessment, screening and treatment.

Montana has 20 Head Start programs and 19 Early Head Start programs with a total enrollment of 4,598 children. Montana’s OPI reports that 1,229 children are enrolled in public prekindergarten programs, a very small number of children in this age cohort given that in 2012 there were approximately 61,000 children under five in Montana. The Early Childhood Services Bureau within the DPHHS serves as the home for the Best Beginnings Advisory Council, which serves as the collaborating entity for early childhood education and care providers.

K through 12 Schools

In 2014, just over 50 million children in America attended public school, with an additional 5 million attending private schools; in Montana there were 142,689 children enrolled in public schools and just over 8,000 in private. Thus schools interact with more children, more of the time, than anywhere else except their homes. In addition, many school districts have before and after school programs which offer other settings in which to observe and potentially identify youth with COD. Earlier in this paper, we have explored in depth the data on youth with mental illnesses and substance use disorders, but it bears emphasizing that school achievement and academic success for these youth is severely compromised when either disorder is present. All schools are required by federal law to provide special education services to children diagnosed with mental health problems that cause learning challenges.

Montana’s Office of Public Instruction (OPI) is the state education agency and as such cannot make requirements of local school districts beyond areas that are mandated such as accreditation standards and special education monitoring. Local control can be beneficial, as it allows school districts the opportunity to devise interventions and trainings that work to best fit the needs of their students, staff, and communities.
The take-away from this brief overview of settings is that if youth aren’t screened for COD, they might well slip through the cracks. Screening is the key. All these providers and caregivers are uniquely positioned to observe children with behavioral problems in the context of mental health and/or substance use and, if they are aware of COD, to work across systems to get the youth the help they need. The process of developing screening tools and then applying them within all the above settings is beyond the scope of this paper, but the following guiding principles for implementing such screening tools have been developed by SAMHSA within the context of designing an early identification and access-to-care program:

1. First, do no harm.
2. Obtain informed consent.
3. Use a scientifically sound screening process. (See details in Sidebar 5)
4. Safeguard the screening information, and ensure its appropriate use.
5. Link to assessment and treatment services.

Age-appropriate and culturally competent screening tools that adhere to all these principles have been developed for all the settings listed above. Most tools that screen for COD do so by analyzing data on mental illnesses in light of data on substance use disorders, or vice versa. Integrated screening addresses both mental illness and substance use together. It seeks an answer to the question, “Is there sufficient evidence of a substance use and/or other mental disorder to warrant further exploration?” A comprehensive screening process also includes exploration of a variety of related service needs including medical, housing, victimization and trauma, thus expediting entry into appropriate services.

Guiding principles for developing a scientifically sound screening process for early identification of youth with mental health or substance abuse disorders:

- All screening instruments should be shown to be valid and reliable in identifying youths in need of further assessment.
- Screening must be developmentally, age, gender, and racially/ethnically/culturally appropriate for the child or adolescent.
- Early identification procedures and approaches should respect and take into consideration the norms, language, and cultures of communities and families. (5)

Identifying Mental Health and Substance Use Problems of Children and Adolescents
Substance Abuse and Mental Health Services Administration, 2011.

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Moving to an integrated system for treating people of all ages with COD is a national effort. Major federal agencies such as the Centers for Medicare and Medicaid Services and SAMHSA, and large national advocacy organizations such as National Alliance for Mental Illness are all strongly pushing this approach. A comprehensive model to achieve an integrated system of treatment was developed in 2005 by Dr. Kenneth Minkoff: The Comprehensive, Continuous, Integrated System of Care (CCISC). It has a lofty goal: To help develop a system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types (mental health, substance abuse, medical, cognitive, housing, legal, parenting, etc.) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.68

Minkoff is a board-certified psychiatrist with a certificate of additional qualifications in addiction psychiatry; and currently is a clinical assistant professor of psychiatry at Harvard Medical School. He is recognized as one of the nation’s leading experts on integrated treatment of individuals with co-occurring psychiatric and substance use disorders and for developing the CCISC of integrated systems of care for such individuals. His work was referenced in SAMHSA's Report to Congress on Co-occurring Disorders in 2002.

This model is based on eight clinical consensus best-practice principles and twelve steps to implement the model. The model as it appears on Minkoff’s website is reproduced in Appendix 2.

Whereas the Minkoff model tells us how an integrated treatment model should work in practice in mental health and substance use settings, Figure 7 shows a theoretical framework for both the systems of care and the level of service coordination needed to improve outcomes for people with COD in the mental health and chemical dependency systems. It especially shows the increased need for integrated care necessary for individuals with the most severe mental illnesses and substance use disorders. This conceptual framework was developed to replace those based on diagnosis and is not used to classify individuals. It is intended to guide system integration and resource allocation in treating COD.69

Funding Issues

One of the most complex barriers to providing integrated services for youth with COD is the multiple, complex funding streams that agencies and others access to pay for treatment of youth with COD. Another difficulty is that funding from federal agencies to states and local communities remains compartmentalized into paying for either substance use disorders or psychiatric treatment.

The different funding streams make it especially hard to blend treatments for youth with COD. Agencies that fund treatment use distinct and categorized coding systems that are often inflexible and too complex for smaller, community-based providers that lack the financial and technical know-how to access treatment funds.70

Montana uses the following public funding sources to provide services to youth with mental illnesses and/or substance use disorders who met the income eligibility guidelines. Services are administered by DPHHS (CMHB and AMDD), the Montana Department of Corrections (Youth Services Division) and the Montana Department of Justice (Juvenile Justice Program).

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69US Department of Health and Human Services; Substance Abuse and Mental Health Services Administration; Center for Mental Health Services. Co-Occurring Mental And Substance Abuse Disorders: A Guide For Mental Health Planning + Advisory Councils.
70Youth Substance Abuse and Co-Occurring Disorders, edited by Y. Kaminer (2016, APA Publishing); Chapter 2: Relationship Between SUDs and Psychiatric Comorbidity, written by M. Fishman.
Medicaid:
Montana Medicaid provides health care coverage for some low-income Montanans. The state pays about one-third of the cost of Medicaid and the federal government pays the rest. Payments are made directly to health care providers.

Children’s Health Insurance Program (CHIP):
There are two parts to the Montana CHIP: Healthy Montana Kids Plus and Healthy Montana Kids. Healthy Montana Kids Plus is administered similarly to the Montana Medicaid program. Healthy Montana Kids provides free or low-cost health coverage for eligible Montana children up to age 19. The program is administered through the Blue Cross Blue Shield of Montana Provider Network except for services accessed through Federally Qualified Health Centers, Rural Health Clinics and Community Based Psychiatric Rehabilitation and Support Services.

State General Fund:
The state general fund makes up 40% of the entire Montana state budget, with about half coming from state income taxes. It is the discretionary part of the state budget and during each biannual session, legislators determine how this money can be spent. Thus the amount allocated to cover any operation can change and is very sensitive to the current political climate.

Block Grant:
The Community Mental Health Block Grant comes to all states through SAMHSA. Grants can be used flexibly for new and unique programs. Aside from adults with serious mental illness, the block grant target population is children up to age 18 with serious emotional disturbances.

The very brief explanation of these funding sources does not begin to describe the complexities facing public agencies managing these monies. Just two of the added complexities are that they are also limited to being spent on services to youth within certain categories and they are being managed by different public agencies in Montana. In addition, these are only four of the many funding sources that can be accessed by state or local agencies. Some of these monies are used to provide grants to local community-based organizations which also see youth with COD. OPI additionally has some mental health services and/or substance use services which use public funds not included in the DPHHS budget.

Private health insurance is another way that families who do not qualify for the above income-tested programs access treatment if their policy covers it. The issues of parity in treatment for those with mental illness and the gaps in coverage will be addressed later in this paper.

Solutions to Compartmentalized Funding Streams
Addressing funding silos per se is an insurmountable task at the federal level without totally changing departments long established by statute; asking the US Department of Education and the US Department of Health and Human Services to meld and share their budgets is not going to happen any time soon. It is up to the states and local communities to figure out the best ways to coordinate services and integrate funding to best serve youth with COD. States have quite a bit of flexibility in using their funds and can create state-level and local-level collaborations that still use their own “pots” of money but join forces to create integrated delivery systems.

Montana is looking to explore additional ways to fund COD by identifying and collaborating with other agencies through the Montana Co-occurring Capacity Building Project (MCCBP). Although the grant period is still active, progress towards goals to create integrated co-occurring treatment services through state-level collaboration is happening. The Planning Council established for the grant has 16 members and representation from five or more federally-funded grants giving OPI and DPHHS staff opportunity to share information about the SAMHSA grant and other similar grants.
In addition, in 2015, Governor Bullock created a Governor’s Council on Healthcare Innovation. While it is not specific to COD, it is a high level approach to explore different ways to improve coordination between public and private sectors and to improve quality of care along with decreasing costs and improving outcomes. It is hoped that this high level effort will result in Montana exploring some of the innovative ideas that are available to ensure long-term system change, resulting in more effective treatment for COD.

**Fragmented Delivery of Services within Systems**

In addition to compartmentalized funding streams, fragmented delivery systems have been identified as a major barrier to treating youth with COD. Youth can enter any one of the systems listed above: mental health, chemical dependence, child welfare, community-based organizations, juvenile justice or education. But, even if they are identified with COD, they may never access integrated services because they are treated solely within the system into which they entered. Some of this fragmentation can be the fault of compartmentalized funding mechanisms, but entrenched ways of doing things, state legislatures unwilling to fund innovative approaches, and state agencies hamstrung by lack of vision are also at fault.

**Integrated Programs for Youth with COD**

Before looking at some of the ways to address fragmented delivery of services, it makes sense to look at a couple of treatment programs for youth with COD, because they help show how a program can and should work across systems. Unfortunately, evidence-based programs (EPB) that have been proven effective in helping youth with COD are hard to find and the SAMHSA registry of evidence-based programs and practices lists no programs for COD that are targeted at youth.

Programs specifically designed to treat youth with COD are relatively new in practice. Although guiding principles and best practices have been developed, actual program development, implementation and evaluation has lagged, thus the paucity of EBPs. Most experts agree that having a co-occurring disorder leaves the patient at risk for a sub-par treatment experience. Examples of negative outcomes that researchers have identified for these patients include dropping out of treatment early, frequent transfer of the patient between clinicians, and recidivism or relapse.71

Despite the few evidence-based programs designed specifically for youth with COD, there are two which can be highlighted: Integrated Co-occurring Treatment and Family Integrated Transitions.

“A program is judged to be evidence-based if (a) evaluation research shows that the program produces the expected positive results; (b) the results can be attributed to the program itself, rather than to other extraneous factors or events; (c) the evaluation is peer-reviewed by experts in the field; and (d) the program is “endorsed” by a federal agency or respected research organization and included in their list of effective programs.”


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71Hazelton Betty Ford Foundation (www.hazelden.org ).
Integrated Co-occurring Treatment (ICT)

ICT is an integrated mental illness and substance use treatment designed specifically for youth with COD. ICT utilizes an intensive home-based service delivery model to provide a comprehensive set of individual and family-focused mental health and substance use interventions to positively impact functioning in key developmental areas, with an emphasis on addressing safety, risk reduction, developmental skill deficits, and environments that support resiliency and recovery.72

It is reassuring to see that currently Montana provides Integrated Co-occurring Treatment (ICT) services to youth with COD at five sites using some Medicaid funds. Montana’s capacity-building grant looks to extend ICT to other sites around the state that wish to provide it. In addition, the state seeks to increase the ability of mental health providers to deliver ICT to youth with both serious emotional disturbance and substance use disorders. The five sites where ICT is being implemented are in the Billings area (Yellowstone County plus four other neighboring counties), Missoula/Ravalli Counties, Great Falls (Cascade County), Helena (Lewis and Clark, Jefferson and Broadwater Counties), and Kalispell (Flathead County). The state has conducted training sessions in implementing ICT, and will issue sub-grants to more providers to increase the service throughout the state.

Family Integrated Transitions (FIT)

FIT is designed for juvenile offenders with COD and provides individual and family services during the period of transition of the youth from incarceration back to the community. The goals of the FIT program include lowering the risk for recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health status of the youth, and increasing positive social behavior. FIT is an intensive 6-month family and community-based treatment. The first two months work on transitional needs (mental and physical health, academic, housing, safety, support structure and monitoring, etc.) of youth and family.

The next four months is focused on addressing all environmental systems that impact chronic and violent juvenile offenders: in their homes, with families, schools and teachers, neighborhoods and friends.73


What made the above two programs work is the broad spectrum of support services included, services that are provided by many different agencies in many different systems. This broad-spectrum approach is embodied in the behavioral health care system described above. A behavioral health care system by its very nature is set up for successfully treating youth with COD by providing wrap-around services. The care a patient with COD experiences in a true behavioral health care system addresses mental illnesses and substance use disorders, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization. This is 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.

Montana is still struggling in terms of implementing an integrated behavioral health system, as clearly described in a 2015 grant application for a federal planning grant:

Montana does not currently have an integrated behavioral health system. Clients with a mental health diagnosis are treated in one of Montana’s 21 mental health centers or satellite clinics or by a private mental health provider. Chemical dependency concerns are treated at one of Montana state approved substance use treatment facilities of which 27 are designed to serve adults and adolescents and 7 to serve only adults.\(^{74}\)

In 2014, in order to help states establish more robust behavioral health care systems, the U.S. Congress passed the Protecting Access to Medicare Act. One provision in that the act directed the Department of Health and Human Services to administer a Medicaid pilot program to encourage states to create Certified Community Behavioral Health Clinics (CCBHC), based on quality measures, evidence-based treatment, and a new cost-based payment system. With more than $24 million in planning grants available and the promise of higher reimbursements for CCBHCs in the pilot, this program represented the largest federal investment in mental illness and substance use treatment in a generation.\(^{75}\)

Even though Montana applied for but didn’t receive funding from the above grant program, since 2013 DPHHS has been awarded just over $5 million in federal grant funds to implement innovative ways to improve the state’s behavioral health care system:

- Montana Co-Occurring Capacity Building Planning (MCCBP) Grant (3 year grant and 1 year no-cost extension)
- Montana State Youth Treatment Implementation (SYT-I) Grant (3 years)

Montana seeks to implement programs that serve children with COD by referring them to one program and/or to one practitioner to coordinate their wrap-around services, thereby creating integrated treatment for these children.

Improving Existing Fragmented Service Delivery

In the meantime, before a behavioral health care system becomes the norm we need to see what is actually happening, or could happen, to improve service fragmentation within the different systems that encounter youth with COD. There are states at different points in achieving success in solving fragmented funding and service delivery systems. Most states are trying some type of combination of: inter-agency collaboration between the state mental health and substance use agencies; pilot programs to help people with COD access services through multiple channels; planning groups of major stakeholders to re-design or re-configure state agencies to better serve people with COD; or state funds awarded to local or community-based organiza-


tions to try innovative COD services. This next section looks at specific ways that Montana is working to be proactive in developing integrated services systems for youth with COD. Successful, evaluated approaches in other states are also included. Additionally, solutions put forth by federal agencies or national advocacy groups will be included as suggestions for future ideas and directions.

The key to creating systems that are more likely to successfully identify and refer youth with COD is that there is no wrong door for entry into getting help for COD. Youth with COD do not just enter a system specific to mental illness or substance use disorders; they are often found in juvenile justice systems, child welfare systems, and nearly all of them are in schools. They can first be seen in primary care settings, hospital emergency rooms, private physician settings, and organizations that help homeless families or other non-profit organizations focusing on helping struggling families.

**Mental Health and Chemical Dependency Services**

The basic premise of successful integrated programs for youth with COD is that mental health and chemical dependency agencies work closely together. As mentioned before, compartmentalization of treatment in one or other of these systems does not result in successful. However, there are steps that can be taken by states and local communities that will allow them to do a better job in breaking down these silos. Mental health and chemical dependency settings need to take the lead in supporting non-traditional settings to build the continuum of care needed to address the needs of youth with COD.76

All reports from either the Children’s Mental Health Bureau (CMHB) or the Chemical Dependency Bureau (CDB) in Montana’s DPHHS indicate this is happening under committed leadership at all levels. Although we are in the early days of Montana establishing integrated service delivery systems, leadership is committed.77 An example of specific collaboration is the shared grant leadership on some of the co-occurring federal grants that have come into the state.

Montana’s CMHB and CDB are working to solve some of the fragmented federal funding mechanisms that create programmatic silos. There are many reasons barriers to receiving integrated COD treatment exist, just a few being: the way that Medicaid providers are paid in Montana; the many hoops that providers have to jump through to access multiple funding streams to get paid for treating an individual with COD; the lack of providers licensed and qualified to treat COD; and the lack of funding to provide continuing education to bring other providers up to speed.

In the past under Medicaid, only licensed addiction counselors (LAC), approved by the state could bill for substance use disorder treatment, although they could not diagnose (and thus not bill for ) mental illnesses. Under the new Medicaid Expansion program run by Blue Cross/Blue Shield more types of licensees can treat substance use disorders provided their skill set includes treating for substance use disorders. More professionals being able to bill Medicaid opens up the opportunity for more people to be treated for substance use and mental illnesses. These changes, opened up through Montana’s Medicaid Expansion program, have not all been completely worked out, as some will require legislative language change.

Implementing a universal substance use screening tool by mental health providers would be helpful to move to a more integrated behavioral health model.

But for this to happen, all mental health providers need to accept and be convinced that substance use is part of their job; not only screening for it but then, if needed, incorporating substance use treatment into their clients’ mental illness treatment plans.78

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77 Personal Communication Dr. Tim Conley, Clinical and Research Consulting, PLLC, Missoula.

78 Personal Communication Dr. Tim Conley, Clinical and Research Consulting, PLLC, Missoula.
Although a step in the right direction, the Medicaid Expansion opportunity does not address two important questions: Are there enough professionals? And are other counseling professionals qualified to treat chemical dependency given that many counseling programs do not required credits for chemical dependency? In addition, even if a universal screening tool is used by all mental health providers, if there are no chemical dependency specialists, child psychologists, or other highly-trained professionals to which to refer them, doing this screening becomes a moot point. Provider shortages are a significant issue in Montana and will be addressed later.

**Primary Care/Acute Care Services**

The seventeen Federally Qualified Community Health Centers (FQCHC) in Montana are an entry point for many youth with COD. All CHCs list behavioral health as one of their core services; these services encompass comprehensive screening with services provided by a team of professionals from different disciplines who work with families and communities to help individuals in all aspects of treatment and recovery. Systemic change in Montana to build a behavioral health care system providing integrated treatment is starting in these FQCHCs, mostly in those serving larger urban areas where professional workforce shortages are not such an issue.

To help facilitate the establishment by primary care providers in Montana of an integrated treatment approach, in 2015 the Montana Health Care Foundation (MHCF) issued grants to Western Montana Mental Health Center (Western and South Central Montana), Center for Mental Health (Lewis and Clark Counties, Holy Rosary Hospital (Eastern Montana), Beaverhead County Public Health Department, and the Sidney Health Center (Richland County). In addition, in 2016 MHCF established an Integrated Behavioral Health Initiative which will provide grants for organizations seeking to 1) plan for and 2) implement integrated behavioral health services in a variety of different settings, to include but not be limited to primary care settings.  

**Child Welfare Services**

As emphasized above, screening tools to identify youth with COD early in their intake process is critical to successful outcomes. One such tool is the Child and Adolescent Needs and Strengths (CANS). CANS was developed to do far more than screen for COD.

It is designed for children’s services to: support decision making, including level of care and service planning; facilitate quality improvement initiatives; and allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 50 states in child welfare, mental health, juvenile justice, and early intervention applications.

Under the Montana Co-occurring Capacity Building grant, in a six-month period in 2015, nearly 500 professionals from a variety of agencies serving children, (mental health centers, probation officers, etc.) participated in three webinars and three conferences on a variety of topics. All trainings had an underlying message promoting a co-occurring treatment approach.

Comprehensive screenings and assessments for children ages 0-5 continue to be implemented through collaboration between CFSD and other DPHHS divisions (Medicaid, Part C, Early Childhood Services, Maternal Infant Early Childhood Home Visiting (MIECHV), and Children’s Mental Health Bureau).

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79 Montana Health Care Foundation (www.mthcf.org).
Community-Based Services

Community-based organizations are natural partners in preventing health disorders as they often have a good track record of working with under-served, low-income and ethnically diverse communities. Community-based treatment for youth with COD comes in many forms. Some are residential treatment centers offering substance use or mental illness services; others are short-term (30 days) residential, and still others are exclusively out-patient services. Many have to treat both mental illness and substance use because of the likelihood of co-occurring disorders. Non-profit organizations that treat youth with COD often have federal, state or local funding. When this is the case, some rules and regulations can be established and enforced to ensure compliance with best practices.

Montana DPHHS has a long history of working with community non-profits to provide mental illness and substance use services but often still in a fragmented approach. However, under the MCCBP grant, two community-based Montana programs currently serving youth were trained in ICT. Western Montana Addiction Services in Missoula and Intermountain Children’s Home in Helena have been implementing ICT since 2013. A new site in Billings, Rimrock, started implementing it in 2015. Outcomes are showing promise under the ICT programs.

Juvenile Justice Services

Youth with co-occurring disorders often are incarcerated, rather than treated. However, there is significant focus among federal agencies and national advocates to address and change this approach. In the MBCC’s 3 year plan for the state’s juvenile justice system, substance abuse is mentioned in three problem statements addressing:

1) Prevention,
   In order to reduce the number of youth entering the Montana Juvenile Justice system, and later the Montana Adult Justice System, Montana needs to provide evidence-based, culturally sensitive prevention and early intervention programs based on normed, validated, and age and gender appropriate screening and assessment (i.e., mental health, substance abuse, education) to Montana youth and families.

2) Intervention,
   In order to provide Montana’s youth with effective juvenile justice intervention programs, the Montana juvenile justice system needs to develop a continuum of care that includes mental health treatment and drug and alcohol treatment based on normed, validated, and age and gender appropriate assessments; evidence-based, culturally sensitive treatment and intermediate sanctions; and needs to provide appropriate training to reflect these elements as well as system accountability to ensure youth are provided and are engaged in treatment. (Page 9)

3) The rise of arrests related to marijuana and prescription drugs,
   Recent data in Montana indicates there may be a trend upwards of increased referrals and charges related to marijuana use and the abuse of prescription medications by juveniles. This trend needs to be explored and the potential impact needs to be assessed. In this way Montana will be prepared if the trend materializes.

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Mental health issues are identified in the prevention and intervention problem statements.\textsuperscript{83} New Hampshire has conducted evaluations showing encouraging results in treating people with COD in the criminal justice system. This was achieved by local mental health and substance use providers forming a partnership to serve these individuals. Program evaluation shows there have been fewer arrests, emergency room visits, and hospital admissions among those in the program.\textsuperscript{84}

Diversion programs are one of the most successful tools states can use to reduce the number of youth coming into the juvenile justice system. They can exist in a multiple of different systems where at-risk children are likely to be found. The National Center for Mental Health and Juvenile Justice has been instrumental in developing many of these diversion programs. When originally founded in 2001, this organization’s goal was to address improving policies and programs for youth with mental illness in contact with the juvenile justice system. However, as knowledge grew in the field, it was apparent that most youth also had substance use disorders.\textsuperscript{85} Although still in their infancy, the following programs are working within different systems to keep children out of the juvenile justice system.

School-Based Diversion: States that focused on this point of contact made significant strides toward implementing school-based diversion strategies for youth with behavioral health needs. States relied on the examples and model programs developed through the Mental Health/Juvenile Justice Action Network, an arm of the National Center for Mental Health and Juvenile Justice. For example, Minnesota created an implementation manual for developing school-based diversion programs. The Minnesota manual provides a blueprint for shared decision-making, new partnerships, and alternatives that keep students in schools. It describes a comprehensive approach to implementing a school-based diversion initiative, building on existing research, evidence-based and best practices, and guiding principles developed through work group meetings and discussions.

Law Enforcement Diversion: Michigan was the only state to focus on law enforcement as the point of contact. Its participation in the initiative resulted in a dissemination strategy for statewide adoption and implementation of Crisis Intervention Teams (CIT) and Crisis Intervention Teams for Youth (CIT-Y) that were not available prior to participation in this initiative.

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\textsuperscript{83} Montana Board of Crime Control, Juvenile Justice Title II Formula Grant 3 Year Plan 2015–2017.

\textsuperscript{84} Center for Substance Abuse Treatment. Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders. COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

\textsuperscript{85} The National Center for Mental Health and Juvenile Justice (www.ncmhjj.org ).
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Probation-Intake Diversion: States that identified probation-intake as the focus of their efforts sought to develop improved policies and programs for youth with behavioral health needs. For example, New York’s team developed a model probation-intake diversion program for youth with behavioral health needs, which involved developing policies and procedures for implementing behavioral health screening and for directing probation’s response to the potential outcomes of a behavioral health screening tool.86 Montana has determined that diversion is one of its priorities for compliance with the 2002 Juvenile Justice and Delinquency Prevention Act and has made a commitment to funding successful diversion programs. Part of that strategy includes participating in the Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative (JDAI). According to national AECF reports this has proven successful in keeping children from getting more deeply involved in the juvenile justice system. Montana has implemented this approach in four sites around the state.

That many youth come into the juvenile justice system in Montana with mental illnesses and/or substance use disorders is well recognized. The Youth Justice Council (YJC), an advisory committee to the Montana Board of Crime Control (MBCC) has provided data and reports covering this topic in its 2012 Law and Justice Interim Committee Legislative White Paper. This paper outlined many steps Montana can do to reduce incarceration and better meet the needs of youth coming into the system with mental illness and substance use problems.

Examples given were comprehensive screening for mental illnesses, analysis of existing data to better identify and refer children with these problems, and building capacity so all professionals coming into contact with these children understand COD.87

In addition, the MBCC 2015–2017 Juvenile Justice Plan states the need for cross-agency collaboration to provide appropriate services for youth with COD in the Juvenile Justice system. Interestingly, it also identifies the need for education at all levels of the system in adolescent brain development and the impact of trauma. The MBCC authorized their Juvenile Justice Specialist to go through ACES train-the-trainer training; subsequently trainings were conducted in ACES and the impact of trauma on the developing brain with those who work with youth, including nonprofit organizations such as Boys and Girls Clubs and school districts. This will continue to be a MBCC priority.

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87 The Youth Justice Council, an advisory council to the Montana Board of Crime Control; LEGISLATIVE WHITE PAPER, For presentation to Legislative Law and Justice Interim Committee. February 24, 2012.
School Services

Of all systems, schools in Montana can have the single biggest impact on the lives of Montana’s youth. Although not all focused on COD, Montana schools have opportunities through OPI to develop ways to support youth with COD, and to initiate prevention models to divert children from risky behaviors. Most importantly, teachers have access to training in mental illnesses and substance use disorders and how to build positive school environments. OPI has recently launched the New Teachers Learning Hub as a platform to provide access to a plethora of educational topics to teachers around the state. Intermountain Children’s Home, as part of the Montana Co-occurring Capacity Building grant mentioned above, has provided recorded webinars on COD to professionals across the state, including teachers.

Schools also have available through OPI training and support to utilize the Montana Behavioral Initiative (MBI) framework, a national best practices Positive Behavior Intervention and Supports (PBIS). Although not specific to COD, this framework could certainly provide schools a way to think about co-occurring treatment and training within their individual schools.

OPI’s SAMHSA Project AWARE, Now is The Time (MT SOARS) grant is a five-year project period running from 2015 to 2019. Its main focus is to address mental health needs through coordination and collaboration of multiple local agencies and organizations.

However, it also looks to develop a process to assure training in trauma-informed care and provision of evidence-based services, and provides information to local education agencies and community providers of resources available for addressing mental health issues, including co-occurring disorders. In addition, OPI has a SAMHSA-funded Systems of Care Grant that focuses on wrap-around services in some of Montana’s tribal communities.

For youth with COD, School-Based Health Care (SBHC) Centers are a model that has proven effective in addressing the health care needs of youth who are uninsured or under-insured or those without regular access to health care. Most importantly, they have resources to help youth with mental illnesses and behavioral health problems. SBHCs have been found to impact a variety of health and social outcomes. One study showed that approximately 75% of current SBHCs offer mental health services on site, with mental health professionals such as licensed clinical social workers, clinical psychologists, and/or substance abuse counselors. Although there is limited research on outcomes of alcohol or substance use disorder treatment and counseling in SBHCs, most report providing individual prevention, early intervention, and risk-reduction education in both elementary and secondary schools. One study directly tied cigarette and marijuana use to the likelihood of an adolescent going to an SBHC for general and mental health services.

About 85% of all SBHCs bill for health care visits, either via third-party insurers or patient fees, with most revenue sources coming from patient revenue (such as Medicaid, CHIP, private health insurance and self-pay), government grants, partner in-kind contributions (schools and/or local hospitals), and private sector grants or donations.

There are just over 2,000 SBHCs around the country. However, in Montana they are not very common. Three are operating: through the Fort Peck Assiniboine and Sioux Tribes based in Poplar, Lowell School in Missoula and Orchard Elementary School in Billings. In addition, the Montana Health Care Foundation has awarded startup funds to establish additional SBHCs through North Valley Hospital Foundation (three schools in Columbia Falls and Whitefish) and Bighorn Valley Health Center (BVHC), which will partner with the St. Labre School System in Rosebud and Big Horn Counties.

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89 School-Based health Alliance, (www.sbh4all.org ) Who Pays for SBHCs?
Early Childhood Education (ECE) has come a long way in Montana since the benefits of supporting healthy childhood development are beginning to be fully understood and embraced. It is also the ideal, earliest opportunity available to identify and help at-risk children and their families.

ECE providers in Montana are given the opportunity to participate in training in the Pyramid Model to learn more about appropriate milestones in children's socio-emotional development. If the provider is in Montana's Best Beginnings STARS to Quality program, they are mandated to take this training. The Pyramid Model provides guidance for all adults in contact with young children for promoting each child's healthy social and emotional development. It was developed by two national, federally-funded research and training centers: The Center for the Social and Emotional Foundations for Early Learning and the Technical Assistance Center on Social Emotional Intervention for Young Children.

Child Care Resources, a Missoula-based non-profit, will conduct observations and assessments within a childcare setting if a parent requests it. If the child is on a Best Beginnings scholarship and the assessment shows that the provider needs increased training or support to best serve the child, the state will increase payments to cover the provider's costs. If a more serious problem is suspected, recommendation will be made to the parent to follow up with an appropriate agency.

Federal statute requires states to develop expulsion policies; this policy will lay out how a childcare provider can ask a parent to remove their child from their business. Expulsion, which disproportionately affects low income families, often results in a kid being bounced around from provider to provider without the child or his/her family getting the services or support they need to deal with the disruptive behavioral problems or their etiology. Montana has until September 2016 to comply with this federal requirement.

Screening, providing additional training and support to childcare providers is the best prevention strategy for avoiding COD and to avert the negative consequences of Adverse Childhood Experiences.

Representatives from the CMHB are included in the Best Beginnings Advisory Council and provide insights into how Medicaid mental health dollars might be used to best support integrated mental health treatment for children 0-8. Providing such treatment for children under 8 who have mental illnesses or behavioral problems would be the ultimate prevention strategy to avoid so many negative life issues later often resulting in expensive, long-term treatment.
WORKFORCE SHORTAGES IN MONTANA

No examination of service delivery in Montana would be complete without reporting on the workforce available to provide those services. This is especially true for treating youth with COD. DPHHS conducted an in-depth analysis of professionals in Montana who are trained and licensed to treat mental illness, substance use disorders and COD. Mapping where providers exist and what their credentials are was undertaken as part of the MCCBP grant work and is being used to inform the allocation of training resources from the SYT-I grant. The findings were not encouraging, especially in terms of professionals licensed in both chemical addictions and mental health. These dually licensed professionals are those uniquely positioned to treat youth with COD, but there are only 194 in the state. As can be seen on the map (Figure 8) most of these professionals are concentrated in Yellowstone and Missoula Counties while most of the counties and all of Montana’s Indian reservations have none.

In addition, the mapping project found that in Montana there are:

- 599 licensed addiction counselors although 18 counties have none
- 1110 licensed clinical professional counselors although 13 counties have none
- 708 licensed clinical social workers but 15 counties have none
- 124 licensed marriage and family therapists in the state, the majority of counties having none or between 1 – 5. Again reservations have few to none.
- 214 licensed clinical psychologists in the state mostly located in Missoula, Gallatin and Yellowstone counties. Most counties have none.90

Figure 8. Number of Dual-Licensed Individuals, Montana; Source: Montana Department of Health and Human Services, Chemical Dependency Bureau.

90 Presentation from work funded by SAMHSA as part of Montana’s Co-occurring Capacity Building (MCCB) Project, SAT-ED Grant ID: TI024269. Slides Created by Clinical and Research Consulting, LLC, Missoula MT with maps produced by Montana DPHHS, AMDD.
Policies to Improve Behavioral Health Care and the Identification, Treatment and Outcomes for Youth with COD

Because addressing co-occurring disorders as part of an integrated behavioral health model is such a new field, most experts talk about sweeping policy needs but give few specific policy suggestions. Requiring agencies to train all personnel in trauma-informed care or use a unified screening tool can be put into policies at the state level although either can be achieved through less time consuming programmatic changes. However, some policymakers can promote integrated treatment through:

- Addressing workplace shortages through examining and potentially changing credentialing and/or licensing processes.
- Workforce training, including development of prevention training standards and training programs across disciplines including health, education, and social work.
- Increasing funds for integrated treatment programs and psychosocial and ancillary services that focus on developmentally appropriate programs to address the needs of children and adolescents with COD.
- Supporting multidisciplinary treatment teams and family education training programs that focus on effective evidence-based treatments.
- Funding initiatives to attract and maintain diverse and qualified service providers.
- Eliminating gaps in coverage by promoting parity for mental health and substance abuse services.91, 92

Workplace Shortages

Addressing the shortage of professionals available in Montana to work with youth with COD is an obvious start to improving services. Other states have sometimes made changes in administrative rules or practices by addressing workforce credentials/licensing. Some examples of how they did this are:

Connecticut: grants waivers to existing licensing regulation so that mental health and substance abuse treatment provider agencies could be cross-licensed.

Arizona: mandates that provider agencies be either “dual-diagnosis enhanced,” meaning that they are qualified and able to deliver both types of services, or “dual-diagnosis capable,” meaning that they can link patients to complementary services outside their agency.

Illinois: has a clinician certification program and an optional accreditation for provider agencies in co-occurring disorders competencies.93

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92 Judge David L. Brazelon Center for Mental Health Law; Facts on Co-Occurring Mental Illness and Substance Abuse Disorders in Children and Adolescents.
Workforce Preparation and Training

Policy can address some of the issues around workforce training though legislatively mandating certain training and education standards, and by requiring the establishment of competencies for working with youth with COD.

Ensuring that practitioners are prepared and trained to treat co-occurring disorders can be addressed through curriculum changes in colleges and universities. Additionally states can mandate the establishment of practitioner competencies defining roles and creating a common framework for working collaboratively across social service systems. Once developed, these core competencies can be incorporated into existing job descriptions, training plans, supervision meetings, personal evaluation, and credentialing and licensure.

Very few university-based programs offer a formal curriculum on COD; although there are programs qualifying graduates to treat mental illnesses and chemical dependency, few provide the cross-training needed to effectively treat youth with COD. Additionally, because youth with COD can present with physical or psychiatric manifestations (or both), it is equally important for medical students, internal medicine and general practice residents, and general psychiatry residents to be educated in the problems of COD. Too few hours of medical education are devoted to the problems of substance use and mental illness. Since pharmacologic therapies play a critical role in the treatment of those with COD, it is important to have adequately trained physicians who can manage the medication therapies for those clients. Primary care physicians untrained in COD might miss a key opportunity to refer youth to appropriate treatment. Although many states are talking about developing clinician standards for co-occurring disorders, only a few have done so.94

GAPS IN HEALTH INSURANCE

Even if youth with COD qualify for publicly funded health insurance, they frequently still do not access treatment. In the only study that looked to document the rates of, and factors associated with, behavioral health treatment among adolescents with COD (in this study only youth with depression and substance use disorders) less than half of the adolescents received any form of mental health treatment in the past year, and only 10% received any form of treatment for their substance use disorder.

However, public insurance was associated with an increased likelihood of receiving treatment for depression, but not with an increased likelihood of receiving treatment for both depression and substance abuse disorder. Data from the 2011/2012 National Survey of Child Health tells us about inadequacies in insurance coverage for children age 0-17 years, comparing national statistics to that of states. Table 6 shows that Montana rates are very similar to national rates, indicating that this needs to be addressed in the nation as a whole. Implementation of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act (MHPAEA) may provide an opportunity to improve access to appropriate treatment for youth with COD.

In 2015 the Montana legislature did expand its CHIP program to cover more children in higher income brackets. Thus the provision in ACA to widen coverage for youth has already been accomplished in the state. This is an extremely important point that should and will help children with COD who live in families where substance use or mental illness is present but without access to treatment. Expanding treatment to adults with these disorders helps reduce the trauma and ACES experienced by their children.

Table 6. Inadequacy of Health Insurance Coverage and the Type of Health Insurance Coverage.
Source: 2011/2012 National Survey of Children's Health

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<th>Montana</th>
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<td>75%</td>
</tr>
<tr>
<td>Inadequate Coverage</td>
<td>24%</td>
<td>25%</td>
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</tbody>
</table>

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MHPEA is a very important piece of federal legislation which helps youth with COD, therefore a detailed explanation of the act and its intent is included in Appendix 3. The MHPAEA provides a unique opportunity for states to implement adequate parity laws; as stated in a peer-reviewed paper on the topic:

In several states with adequate parity laws, the MHPAEA promises to address the disparities in insurance coverage across medical, chemical dependency, and psychiatric problems. The laws typically require that insurance plans providing both psychiatric and substance abuse treatment coverage cannot impose restrictions on benefits different from those imposed on medical and surgical treatment. However, they do not mandate coverage of either, and they typically apply only to larger employers and Medicaid managed care plans, but not to other publicly funded health insurance, such as Medicaid fee-for-service. The federal law defines neither the types of covered disorders nor the scope of benefits, leaving these determinations to the health plans themselves or deferring to state regulations. Thus states vary widely; some require comprehensive coverage and others limit covered diagnoses to severe mental illness or certain “biologically based” psychiatric disorders. Often excluded are the types of problems experienced by youth such as dangerous use but not abuse of substances. An adolescent with serious substance use-related legal or school-related consequences, who would clearly benefit from treatment, might not be considered medically “at risk.” Despite these limitations, however, the new federal laws promise to address historical inequities in insurance coverage and to increase access to substance use and psychiatric treatment for adolescents.96

In addition to implementation of national laws, states can do more to reduce the barriers when youth with COD need treatment. Changes in state regulations and state billing structures can ensure providers get paid for treatment services without multiple billing systems and complex interwoven payment sources. NAMI – Montana is working to eliminate barriers to effective co-occurring services for mental illness and substance use treatment by closing gaps in care that have resulted from different regulations or payment methods based upon diagnosis or treatment type. The intent of legislation would be for DPHHS to create a single contracting process, with a single set of regulations and billing criteria to facilitate mental health centers provision of:

1. Children mental health services,
2. Adult mental health services,
3. Substance abuse services,
4. Primary care services, and
5. Geriatric services.97

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97 Personal Communication Matt Kuntz, J.D. Executive Director, NAMI Montana.
POLICY OPPORTUNITY IN THE JUVENILE JUSTICE SYSTEM

To improve the juvenile justice system in Montana for youth with COD, the Youth Justice Council (YJC) recommends some very specific capacity-building strategies that would require a significant funding commitment:

- Training for law enforcement officers, public defenders, detention officers, teachers, juvenile probation officers and others so that they can recognize mental illness and make appropriate referrals.
- Create a centralized funding mechanism that makes assessments available for all referring agencies or parents.
- Support smaller, community-based services and encourage family participation. Reserve the larger facilities for youth with severe mental health disabilities.98

All research to find specific policies to address youth with COD in the juvenile justice system points to the need to mandate the use of comprehensive, standardized assessment tools that take into account cultural factors, as well as education level, exposure to trauma, and family strengths. Then if a youth with COD is identified the juvenile justice system should be required to refer him or her to an integrated treatment program. Policymakers’ support for diversion programs to keep children out of the juvenile justice system is needed at all levels of government.

In addition, there are some specific policy recommendations made by the YJC:

- Montana state law (MCA 41-5-206) determines how youth committing certain offenses are handled. For youth 12 and older, it is at the discretion of the county attorneys. Cases involving youth age 17 and older who commit these offenses are required to be filed in adult court. The recommendation is to remove the statutes that allow youth to be transferred or direct-filed into adult court.
- Appoint a designated Youth Court Judge or Special Master for Youth Court in each of the larger court districts so that this duty is not shared by all judges within multi-judge districts. Instead, a judge or special master can be specially trained to understand youth brain development, co-occurring disorders and other problems that play out in unique ways in youth.
- Current Montana law (MCA 45-7-309) needs to be amended to add a third section that says, “(3) A youth cannot be found delinquent solely for committing the offense of criminal contempt.” Currently under this law a youth could be charged as a delinquent offender and placed in secure confinement. The above addition is needed to remove any conflict with the Youth Court Act.

RESEARCH NEEDS

It is clear that more information is needed to adequately address COD in youth; good epidemiological data on COD is a major source of information for effective policymaking.

“Policymakers must identify unmet treatment and prevention needs, set priorities, anticipate workforce demands, and determine appropriate resource allocations. It is difficult to imagine fulfilling these responsibilities at the Federal, State, or local level without a clear understanding of the nature and extent of COD.”99

98 The Youth Justice Council, an advisory council to the Montana Board of Crime Control; LEGISLATIVE WHITE PAPER, For presentation to Legislative Law and Justice Interim Committee. February 24, 2012.
Funding for research on COD, especially youth with COD, needs to be allocated. The current national studies using survey research that shed some light on COD do not target specific populations in which COD is a serious issue (for instance veterans) and often the questions are only on mental illness or substance use, not both. As seen earlier, the only question on the NSDUH survey covering youth and mental illness is on “major depressive episode” and does not ask anything about many other mental illnesses.

IMPROVING MANAGEMENT INFORMATION SYSTEMS

State tracking systems to assess needs and measure performance of public services to youth with COD can be fragmented and limited. These systems need to be reviewed and, if necessary, improved so that basic questions about children and adolescents with COD can be better answered. Many states are planning or have undertaken improvements in their systems to address these limitations. Efforts include the development of standardized intake protocols that would document co-occurring disorders at entry into either mental illness or substance use treatment facilities, making systems linkable so that people appearing in one system can be found in the other, and developing common service definitions and coding that allow comparisons across systems and data elements that specifically identify integrated co-occurring disorders services.¹⁰⁰

The Montana Board of Crime Control has been successful at creating a data-gathering and information-sharing system on at-risk youth across state agencies, including local law enforcement. This was achieved during the 2005 and 2007 Montana legislative sessions.

CONCLUSION

For adolescents with co-occurring conditions, this is a time of both deep concern and significant opportunities. Because of the complicated systemic and financial barriers discussed, too often patients and their families are forced to navigate separate systems of care, often both public and private, and to coordinate their own care because appropriate linkages between providers and organizations are lacking and insurance and financial support is limited or nonexistent.

What the future might hold for Montana youth with COD is being determined now with some promising changes in the organizational and financial fragmentation within Montana state agencies. However, finding solutions to integrating the deep, significant system differences is challenging and will take commitments of time and money underpinned by the philosophical belief that change must and can happen to help these youth.

Montana Youth Risk Behavior Survey

The Montana Youth Risk Behavior Survey (YRBS) is administered by the Montana Office of Public Instruction every two years to students in grades 7 through 12. The purpose of the survey is to help monitor the prevalence of behaviors that not only influence youth health, but also put youth at risk for the most significant health and social problems that can occur during adolescence. While all schools in Montana can participate in the survey on a volunteer basis, approximately 50 high schools are randomly selected to be included to provide the Montana statewide data to be used in other national YRBS reports.

The 2015 YRBS was conducted in February 2015. Schools administering the survey were provided with detailed written instructions on conducting a random survey in their schools. To encourage accurate responses to sensitive questions, a strict protocol was implemented to protect the privacy and confidentiality of all participating students. The questionnaire was designed without skip patterns to ensure survey completion by students in a similar period of time.

Survey Validity, Limitations and Results

Data used in this report from the 2015 YRBS are based on a random sample survey of Montana high school students. The weighted data results contained in this report can be used to make inferences about the priority health-risk behaviors of all high school students in grades 9 through 12 in all schools in Montana. However, users should be careful in using the data since respondents in self-reported surveys may have a tendency to underreport behaviors that are socially undesirable, unhealthy, or illegal (alcohol consumption, drug use, seat belt non-use, etc.) and overreport behaviors that are socially desirable (amount of exercise, etc.).

For the purpose of this report, youth who are classified as depressed are those Montana youth who, during the past 12 months, reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. Forty-six separate risk behaviors were queried for association with feelings of sadness or hopelessness. These findings are presented in bullet, table and graph forms in the following report.

During the past 12 months, 29.3 percent of Montana high school students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.
Montana high school students who reported feelings of depression are more likely than those students who had not reported feelings of depression to have:

- Ridden with a driver who had been drinking alcohol during the past 30 days (29% of depressed students compared to 21% of non-depressed students).
- Driven when drinking alcohol during the past 30 days (16% of depressed students compared to 9% of non-depressed students).
- Not gone to school because they felt unsafe at school or on their way to or from school during the past 30 days (10% of depressed students compared to 3% of non-depressed students).
- Been threatened or injured with a weapon on school property during the past 12 months (10% of depressed students compared to 3% of non-depressed students).
- Ever been physically forced to have sexual intercourse when they did not want to (18% of depressed students compared to 5% of non-depressed students).
- Been bullied on school property during the past 12 months (46% of depressed students compared to 17% of non-depressed students).
- Been electronically bullied during the past 12 months (39% of depressed students compared to 10% of non-depressed students).
- Been the victim of teasing, name calling, or bullying because someone thought they were gay, lesbian, or bisexual during the past 12 months (28% of depressed students compared to 9% of non-depressed students).
- Seriously considered attempting suicide during the past 12 months (50% of depressed students compared to 6% of non-depressed students).
- Actually attempted suicide during the past 12 months (24% of depressed students compared to 3% of non-depressed students).
- Ever tried cigarette smoking (55% of depressed students compared to 33% of non-depressed students).
- Smoked a cigarette during the past 30 days (23% of depressed students compared to 9% of non-depressed students).
- Smoked cigars, cigarillos, or little cigars during the past 30 days (15% of depressed students compared to 11% of non-depressed students).
- Ever used electronic vapor products (63% of depressed students compared to 46% of non-depressed students).
- Used electronic vapor products during the past 30 days (41% of depressed students compared to 25% of non-depressed students).
- Ever had a drink of alcohol in their lifetime (82% of depressed students compared to 65% of non-depressed students).
- Had a drink of alcohol during the past 30 days (46% of depressed students compared to 29% of non-depressed students).
- Had 5 or more drinks of alcohol within a couple hours during the past 30 days (28% of depressed students compared to 18% of non-depressed students).
- Ever used marijuana in their lifetime (54% of depressed students compared to 31% of non-depressed students).
- Used marijuana during the past 30 days (31% of depressed students compared to 15% of non-depressed students).
- Ever used methamphetamines in their lifetime (5% of depressed students compared to 2% of non-depressed students).
Montana high school students who reported feelings of depression are more likely than those students who had not reported feelings of depression to have:

- Ever used ecstasy in their lifetime (9% of depressed students compared to 5% of non-depressed students).
- Ever took prescription drugs without a doctor’s prescription [such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax] (34% of depressed students compared to 17% of non-depressed students).
- Ever had sexual intercourse in their lifetime (56% of depressed students compared to 39% of non-depressed students).
- Had sexual intercourse with four or more persons during their life (18% of depressed students compared to 12% of non-depressed students).
- Had sexual intercourse during the past 3 months (43% of depressed students compared to 28% of non-depressed students).
- Not drank milk during the past 7 days (19% of depressed students compared to 14% of non-depressed students).
- Not eaten breakfast during the past 7 days (17% of depressed students compared to 11% of non-depressed students).
- Played video or computer games 3 or more hours per day on an average school day (40% of depressed students compared to 32% of non-depressed students).
- Received help from a resource teacher, speech therapist, or other special education teacher during the past 12 months (20% of depressed students compared to 9% of non-depressed students).

Montana high school students who reported feelings of depression are less likely than those students who had not reported feelings of depression to have:

- Been physically active for at least 60 minutes per day on 5 or more of the past 7 days (45% of depressed students compared to 58% of non-depressed students).
- Played on at least one sports team during the past 12 months (53% of depressed students compared to 66% of non-depressed students).
- Had 8 or more hours of sleep on an average school night (21% of depressed students compared to 38% of non-depressed students).
- Made mostly A’s or B’s in school during the past 12 months (65% of depressed students compared to 79% of non-depressed students).
<table>
<thead>
<tr>
<th>Health Risk Behavior by percentage of students</th>
<th>Depressed Students</th>
<th>Non-depressed Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever had a drink of alcohol in their lifetime</td>
<td>81.7% (79.2-84.3)</td>
<td>65.0% (62.8-67.2)</td>
</tr>
<tr>
<td>Had a drink of alcohol during the past 30 days</td>
<td>46.4% (43.1-49.8)</td>
<td>29.2% (27.1-31.2)</td>
</tr>
<tr>
<td>Had 5 or more drinks of alcohol within a couple hours during the past 30 days</td>
<td>28.4% (25.4-31.5)</td>
<td>17.5% (16.0-19.0)</td>
</tr>
<tr>
<td>Ever used marijuana in their lifetime</td>
<td>54.0% (49.7-58.4)</td>
<td>30.5% (27.0-34.1)</td>
</tr>
<tr>
<td>Used marijuana during the past 30 days</td>
<td>30.5% (27.0-34.1)</td>
<td>14.8% (12.8-16.9)</td>
</tr>
<tr>
<td>Ever used methamphetamines in their lifetime</td>
<td>5.1% (3.6-6.5)</td>
<td>2.0% (1.2-2.7)</td>
</tr>
<tr>
<td>Ever used ecstasy in their lifetime</td>
<td>9.4% (7.8-11.0)</td>
<td>4.5% (3.4-5.5)</td>
</tr>
<tr>
<td>Ever took prescription drugs without a doctor’s prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax)</td>
<td>33.6% (30.1-37.1)</td>
<td>16.7% (15.3-18.2)</td>
</tr>
<tr>
<td>Ever had sexual intercourse in their lifetime</td>
<td>56.2% (51.8-60.6)</td>
<td>39.0% (36.1-41.8)</td>
</tr>
<tr>
<td>Had sexual intercourse with four or more persons during their life</td>
<td>18.2% (15.3-21.1)</td>
<td>11.5% (9.6-13.3)</td>
</tr>
<tr>
<td>Had sexual intercourse during the past 3 months</td>
<td>42.9% (38.8-47.1)</td>
<td>27.9% (25.6-30.3)</td>
</tr>
<tr>
<td>Drank alcohol or used drugs before last sexual intercourse</td>
<td>21.7% (17.8-25.7)</td>
<td>18.4% (15.3-21.6)</td>
</tr>
<tr>
<td>Did not eat fruit or drink 100% fruit juice during the past 7 days</td>
<td>5.4% (4.0-6.8)</td>
<td>4.9% (4.1-5.8)</td>
</tr>
<tr>
<td>Did not eat green salad, potatoes, carrots, or other vegetables during the past 7 days</td>
<td>6.5% (4.7-8.3)</td>
<td>4.5% (3.5-5.5)</td>
</tr>
<tr>
<td>Drank a can, bottle, or glass of soda or pop daily during the past 7 days</td>
<td>20.9% (18.5-23.3)</td>
<td>17.6% (15.9-19.3)</td>
</tr>
<tr>
<td>Did not drink milk during the past 7 days</td>
<td>19.2% (16.8-21.6)</td>
<td>14.3% (12.9-15.7)</td>
</tr>
<tr>
<td>Did not eat breakfast during the past 7 days</td>
<td>16.7% (14.0-19.4)</td>
<td>10.7% (9.6-11.9)</td>
</tr>
<tr>
<td>Were physically active at least 60 minutes per day on 5 or more of the past 7 days</td>
<td>44.5% (40.9-48.0)</td>
<td>58.1% (56.0-60.2)</td>
</tr>
<tr>
<td>Watched 3 or more hours of TV on an average school day</td>
<td>24.3% (21.4-27.1)</td>
<td>20.9% (18.6-23.2)</td>
</tr>
<tr>
<td>Played video or computer games 3 or more hours per day on an average school day</td>
<td>40.2% (37.1-43.4)</td>
<td>31.8% (30.0-33.5)</td>
</tr>
<tr>
<td>Played on at least one sports team during the past 12 months</td>
<td>52.7% (49.7-55.7)</td>
<td>66.4% (64.3-68.5)</td>
</tr>
<tr>
<td>Had 8 or more hours of sleep on an average school night</td>
<td>20.7% (18.3-23.1)</td>
<td>37.6% (35.2-39.9)</td>
</tr>
<tr>
<td>Made mostly A’s or B’s in school during the past 12 months</td>
<td>65.1% (61.8-68.5)</td>
<td>79.3% (77.0-81.5)</td>
</tr>
<tr>
<td>Received help from a resource teacher, speech therapist, or other special education teacher during the past 12 months</td>
<td>19.7% (17.4-22.1)</td>
<td>9.3% (7.8-10.8)</td>
</tr>
<tr>
<td>Health Risk Behavior - percentage of students</td>
<td>Depressed Students</td>
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</tr>
<tr>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Never or rarely wore a seat belt when riding in a car driven by someone else</td>
<td>11.5% (9.2-13.7)</td>
<td>8.6% (7.2-10.1)</td>
</tr>
<tr>
<td>Never or rarely wore a seat belt when driving</td>
<td>8.9% (6.6-11.1)</td>
<td>7.8% (6.3-9.3)</td>
</tr>
<tr>
<td>Rode with a driver who had been drinking during the past 30 days</td>
<td>28.5% (25.9-31.1)</td>
<td>20.5% (18.7-22.4)</td>
</tr>
<tr>
<td>Drove when drinking alcohol during the past 30 days</td>
<td>15.8% (12.8-18.8)</td>
<td>8.7% (7.0-10.4)</td>
</tr>
<tr>
<td>Texted or e-mailed while driving a car or other vehicle during the past 30 days</td>
<td>55.8% (51.5-60.1)</td>
<td>54.1% (50.4-57.7)</td>
</tr>
<tr>
<td>Talked on a cell phone while driving during the past 30 days</td>
<td>56.9% (53.1-60.6)</td>
<td>58.5% (55.0-62.0)</td>
</tr>
<tr>
<td>Carried a weapon such as a gun, knife, or club during the past 30 days</td>
<td>28.2% (25.2-31.2)</td>
<td>25.5% (23.4-27.6)</td>
</tr>
<tr>
<td>Did not go to school because they felt unsafe at school or on their way to or from school during the past 30 days</td>
<td>9.7% (7.8-11.7)</td>
<td>2.8% (2.1-3.5)</td>
</tr>
<tr>
<td>Were threatened or injured with a weapon on school property during the past 12 months</td>
<td>9.6% (7.4-11.8)</td>
<td>3.4% (2.8-4.1)</td>
</tr>
<tr>
<td>Ever physically forced to have sexual intercourse when they did not want to</td>
<td>17.8% (15.2-20.3)</td>
<td>4.9% (4.1-5.7)</td>
</tr>
<tr>
<td>Were bullied on school property during the past 12 months</td>
<td>46.3% (42.7-49.9)</td>
<td>16.5% (14.6-18.4)</td>
</tr>
<tr>
<td>Were electronically bullied (e-mail, chat rooms, instant messaging, websites, or texting) during the past 12 months</td>
<td>38.9% (35.8-42.0)</td>
<td>10.0% (8.7-11.3)</td>
</tr>
<tr>
<td>Were the victim of teasing, name calling, or bullying because someone thought they were gay, lesbian, or bisexual during the past 12 months</td>
<td>28.1% (25.4-30.9)</td>
<td>9.1% (7.9-10.2)</td>
</tr>
<tr>
<td>Seriously considered attempting suicide during the past 12 months</td>
<td>50.1% (47.5-52.7)</td>
<td>5.9% (4.9-6.9)</td>
</tr>
<tr>
<td>Actually attempted suicide during the past 12 months</td>
<td>23.5% (20.8-26.1)</td>
<td>2.6% (1.8-3.3)</td>
</tr>
<tr>
<td>Ever tried cigarette smoking</td>
<td>54.9% (51.2-58.7)</td>
<td>32.5% (29.2-35.7)</td>
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<tr>
<td>Smoked a cigarette during the past 30 days</td>
<td>22.7% (19.7-25.7)</td>
<td>9.0% (7.2-10.9)</td>
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<tr>
<td>Used smokeless tobacco (chewing tobacco, snuff, or dip) during the past 30 days</td>
<td>12.7% (10.5-14.9)</td>
<td>11.9% (10.5-13.4)</td>
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<td>Smoked cigars, cigarillos, or little cigars during the past 30 days</td>
<td>15.3% (13.0-17.7)</td>
<td>11.3% (9.8-12.7)</td>
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<td>Ever used electronic vapor products (e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens such as blu, NJOY, or Starbuzz)</td>
<td>62.5% (59.1-65.9)</td>
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<td>Used electronic vapor products during the past 30 days</td>
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Did not go to school because they felt unsafe at school or on their way to or from school/past 30 days

Were threatened or injured with a weapon on school property/past 12 months

Ever physically forced to have sexual intercourse when they did not want to

Were bullied on school property/past 12 months

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Depressed Students

Non-Depressed Students
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Seriously considered attempting suicide/past 12 months
Actually attempted suicide/past 12 months
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Smoked a cigarette/past 30 days
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Smoked cigars, cigarillos, or little cigars/past 30 days
Ever used electronic vapor products (e-cigarettes, e-cigars, e-pipes, vaping pens, e-hookahs, and hookah pens such as blu, NJOY, or Starbuzz)
Used electronic vapor products/past 30 days
Ever had a drink of alcohol in their lifetime
Had a drink of alcohol/past 30 days
Had 5 or more drinks of alcohol within a couple hours/past 30 days
Ever used marijuana in their lifetime
Used marijuana/past 30 days
Ever used methamphetamines in their lifetime
Ever used ecstasy in their lifetime
APPENDIX B: COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE (CCISC) MODEL

The Comprehensive, Continuous, Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005) is a vision-driven system “transformation” process for re-designing behavioral health and other related service delivery systems to be organized AT EVERY LEVEL (policy, program, procedure, and practice)—within whatever resources are available—to be more about the needs of the individuals and families needing services, and the values that reflect welcoming, empowered, helpful partnerships throughout the system. The ultimate goal of CCISC is to help develop a system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types (mental health, substance abuse, medical, cognitive, housing, legal, parenting, etc.) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

In a CCISC process, every program and every person delivering clinical care engages in a quality improvement process—in partnership with each other, with system leadership, and with individuals and families who are receiving services—to become welcoming, recovery- or resiliency-oriented, and co-occurring capable. Further, every aspect of clinical service delivery is organized on the assumption that the next person or family entering service will have multiple co-occurring conditions, and will need to be welcomed for care, inspired with hope, and engaged in a partnership to address each and every one of those conditions in order to achieve the vision and hope of recovery.

This model is based on the following eight clinical consensus best practice principles (Minkoff and Cline, 2004, 2005) which espouse an integrated recovery philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system.

1. Co-occurring issues and conditions are an expectation, not an exception. This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues.

2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship. Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition.

3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations. Assignment of responsibility for provision of such relationships can be determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the psychiatric and substance disorder.

4. When co-occurring issues and conditions co-exist, each issue or condition is considered to be primary. The best practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time.

5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue. Mental illness and substance dependence (as well as other conditions, such as medical disorders, trauma, and homelessness) are examples of chronic, biopsychosocial conditions that can be understood using a disease and recovery (or condition and recovery) model. Each
condition has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.

6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue. For each co-occurring condition or issue, treatment involves getting an accurate set of recommendations for that issue, and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. In order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward is much more effective than negative consequences in promoting learning.

7. Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual diagnosis program or intervention for everyone. For each individual or family, integrated treatment interventions and outcomes must be individualized according to their hopeful goals, their specific diagnoses, conditions, or issues, and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition.

8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring capable. Each program has a different job, and programs partner to help each other to be successful with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships, in which each co-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based community-based learning for each condition, in order to help the individual or family make progress toward achieving their recovery goals.
TWELVE STEPS FOR CCISC IMPLEMENTATION

1. Integrated system planning and implementation process.

Implementation of the CCISC requires a system-wide integrated strategic planning process and quality improvement partnership that creates an empowered partnership between all levels of the system, including consumers, families, and front line clinicians. This partnership can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system; include all key funders, providers, and consumer/family stakeholders; have the authority to oversee continuing implementation of the other elements of the CCISC; utilize a structured process of system change (e.g., continuous quality improvement); and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer- and family-driven outcomes that measure satisfaction with the ability of the system to be welcoming, recovery-oriented, accessible, trauma-informed, and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of individuals in service and their families. The COFIT-100™ (Zialogic, Albuquerque, NM) [30] has been developed to facilitate this outcome measurement process at the system level.

2. Formal consensus on CCISC implementation.

The system must develop a clear mechanism for articulating the CCISC process, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, chartering the quality improvement partnership and process, and disseminating this consensus for action to all providers and consumers within the system.

3. Funding plan within existing resources.

CCISC implementation involves a formal commitment that each funder will promote recovery-oriented, co-occurring capable services within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with CCISC principles, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model. CCISC supports developing the flexibility to use limited resources more creatively to design services across a whole system that are more accurately matched to the needs of complex populations, and supports using any available incentives to support providers engaged in the transformative quality improvement process.

4. Strategic prioritization and population based planning.

CCISC encourages alignment of all “initiatives” in a common transformation vision, and building energy for change from existing strategic opportunities or priorities, including funding increases or reductions. In addition, using the national consensus four-quadrant model, the system develops a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually start the process with high-need high-cost priority populations (commonly in quadrant IV) that have no system or provider clearly responsible for engagement and/or treatment. As the CCISC process unfolds, the integrated system planning process is
able to more easily create a plan for how to address the needs of these populations within existing resources.

5. Development and implementation of recovery oriented co-occurring capable programs.

A crucial element of the CCISC model is the expectation that all child and adult programs in the service system must meet basic standards for recovery-oriented co-occurring capability, whether in the mental health system or the addiction system. There needs to be consensus that each program can begin its own quality improvement process to achieve recovery-oriented co-occurring capability. As programs make progress, the system can develop co-occurring capability standards, and, over time, those standards can be built into funding and licensing requirements. (See items 2 and 3 above), as well as a plan for programs to make step by step progress toward implementation. COMPASS-EZ (ZiaPartners, 2009) is a program self-assessment tool for recovery-oriented co-occurring capability that can be helpful in initiating the program quality improvement process.

6. Inter-system and inter-program partnership and collaboration.

CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in collaborative partnerships for shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A component of this process includes the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative partnerships to manage a shared population.

7. Development and implementation of recovery-oriented co-occurring capable practice guidelines.

CCISC implementation requires system-wide transformation of clinical practice in accordance with the above principles. This can be realized through dissemination and incremental developmental implementation via CQI processes of clinical consensus best-practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (www.bhrm.org) are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor compliance. Quality improvement processes to facilitate welcoming, access and identification, and to promote empathic, hopeful, integrated continuous relationships are a particular priority for implementation.

8. Facilitation of welcoming, access, integrated screening and identification of multiple co-occurring conditions.

This requires a quality improvement partnership that

- Addresses welcoming and “no wrong door” access in all programs
- Eliminates arbitrary barriers to initial access and evaluation
- Improves clinical and administrative practices of screening, clinical documentation, MIS reporting, and appropriate next-step intervention for individuals and families with co-occurring conditions.

9. Implementation and documentation of integrated services.

Integrated treatment relationships are a vital component of the CCISC. Implementation requires creating a quality improvement process in which clinicians and managers work in partnership on the process of developing and documenting an integrated treatment or recovery plan in which the client or family is
assisted to make progress toward hopeful goals by following issue-specific and stage-specific recommendations for each issue simultaneously. This expectation must be supported by clear definition of the expected “scope of practice” for singly licensed clinicians regarding co-occurring disorder [35, 36], and incorporated into standards of practice for reimbursable clinical interventions—in both mental health and substance settings—for individuals who have co-occurring conditions.

10. Development of recovery-oriented co-occurring competencies for all clinicians. Creating the expectation that all clinicians can make progress to develop universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC process. Available competency lists for co-occurring conditions, such as the 12 Steps for Clinicians, can be used as a reference for beginning a process of consensus-building regarding the competencies. Mechanisms can be developed to establish competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure and support clinician attainment of competency. Competency self-assessment tools (e.g., CODECAT-EZ™ ZiaPartners, 2009) can be utilized to facilitate this process.

11. Implementation of a change agent team.

In the CCISC quality improvement process, both program capability development and clinician competency development occur through a top-down, bottom-up partnership, in which front-line clinicians and consumer/family change agents in each program work in partnership with leadership to effect the change. Further, the change agents in a system ideally become an empowered team to represent the principles and values of front-line service delivery and service recipients in the system planning and implementation process. ZiaPartners has developed a Change Agent Curriculum Manual for Michigan and provided initial training to hundreds of change agents statewide to initiate this process.

12. Development of a plan for a comprehensive program array.

The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency with regard to provision of recovery-oriented co-occurring-capable service for people with co-occurring conditions, within the context of available resources. This plan should also identify system gaps that require longer-range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC process are:

Evidence-based best practice: There needs to be a specific plan for identification of any evidence-based best practice for any mental illness (e.g., Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g., buprenorphine maintenance), or an evidence-based best-practice program model for a particular co-occurring disorder population (e.g., Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that facilitates access to co-occurring clients that might be appropriately matched to that intervention.

Peer dual recovery supports: The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous has been identified in Michigan) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports, such as recovery coaching, peer outreach and peer counseling.

Residential supports and services: The system should begin to plan for a comprehensive range of
programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services with the recognition that co-occurring conditions are an expectation. This range of programs should include:

- DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs) [41]
- Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities
- Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
- Consumer-choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness. [42]

**Continuum of levels of care:** All categories of service should be available in a range of levels of care, including outpatient services of various levels of intensity, intensive outpatient or day treatment, residential treatment, hospital diversion programming, and hospitalization. This can often be operationalized in managed care payment arrangements and may involve more sophisticated levels of care assessment capacity.

**CCISC implementation is an ongoing quality improvement process that encourages the development of a plan that includes attention to each of these areas in a comprehensive service array.**
APPENDIX C

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the “Affordable Care Act”) to also apply to individual health insurance coverage. HHS has jurisdiction over public sector group health plans (referred to as “non-Federal governmental plans”), while the Departments of Labor and the Treasury have jurisdiction over private group health plans.

Employment-related group health plans may be either “insured” (purchasing insurance from an issuer in the group market) or “self-funded.” The insurance that is purchased, whether by an insured group health plan or in the individual market, is regulated by the State’s insurance department. Group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-funded group health plans. Private employment-based group health plans are regulated by the Department of Labor. Non-Federal governmental plans are regulated by HHS. Contact your employer’s plan administrator to find out if your group coverage is insured or self-funded and to determine what entity or entities regulate your benefits.

The Mental Health Parity Act of 1996 (MHPA) provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.

MHPAEA preserves the MHPA protections and adds significant new protections, such as extending the parity requirements to substance use disorders. Although the law requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does NOT require large group health plans or health insurance issuers to cover MH/SUD benefits. The law’s requirements apply only to large group health plans and health insurance issuers that choose to include MH/SUD benefits in their benefit packages. However, the Affordable Care Act builds on MHPAEA and requires coverage of mental health and substance use disorder services as one of ten EHB categories in non-grandfathered individual and small group plans.

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