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Policy and practice implications of epidemiological surveys on co-occurring mental and substance use disorders

H. Westley Clark, (M.D., J.D., M.P.H., C.A.S., F.A.S.A.M.)[a,*], A. Kathryn Power, (M.Ed.)[b], Charlene E. Le Fauve, (Ph.D.)[c], Elizabeth I. Lopez, (Ph.D.)[d]

[a]*Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Rockville, MD*
[b]*Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Rockville, MD*
[c]*Co-Occurring and Homeless Activities Branch, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Rockville, MD*
[d]*Office of Program, Policy, and Budget, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Rockville, MD*

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Abstract

This article describes factors that influence national policy and practice, with particular focus on the implications of epidemiological survey research. Examples of areas of concern to policymakers include treatment-seeking patterns, access to care at points of service in public health and social service systems, evidence-based practices, workforce development, and the complexities of reimbursement. In responding to data on systemic barriers to care, the Substance Abuse and Mental Health Services Administration (SAMHSA) has sought to promote a *no wrong door* strategy to address the needs of persons with co-occurring disorders (CODs) involving their mental health and substance use. Examples of SAMHSA programs and policies addressing CODs discussed in this article include targeted partnerships with the states, mechanisms to enhance system infrastructure, technical assistance, and initiatives with special populations. Published by Elsevier Inc.

Keywords: Co-occurring disorders; SAMHSA; Epidemiology; NSDUH; Policy

1. Introduction

As federal agencies strive to develop effective policies to help state, tribal, and local governments as well as health care providers meet the complex needs of persons with co-occurring disorders (CODs) involving their mental health and substance use, their choices are informed by epidemiological knowledge of the population and research on effective practices. Policymakers seek to better understand these clients so they can remove the barriers that keep people with CODs from seeking treatment and those that deter their recovery. As they look for ways to make scarce dollars do more for a population known for the high cost of its treatment, policymakers who seek out and analyze available data on the population they serve can better translate those resources into meaningful outcomes.

This article begins by reviewing key findings that emerged from an analysis of epidemiological surveys. It then highlights federal efforts to respond to these data as well as to available information on issues in the field and

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* Corresponding author. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, 1 Choke Cherry Road, Rockville, MD 20857. Tel.: +1 240 276 1660; fax: +1 240 276 1670.

E-mail address: westley.clark@samhsa.hhs.gov (H.W. Clark).

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emerging best practices as agencies develop national programs and policies. Finally, the article gives examples of federal initiatives that have been shaped by an awareness of population characteristics, barriers to effective care, and treatment strategies that support positive outcomes.

2. Key findings of epidemiological data

The following surveys provide much of the epidemiological data available on persons with CODs:

1. The National Epidemiological Survey on Alcohol and Related Conditions (NESARC) is a nationally representative face-to-face survey of the civilian and noninstitutionalized population of individuals who are at least 18 years old in the United States. The most recent survey (2001–2002) included 43,093 respondents. This survey is funded and conducted by the National Institute on Alcohol Abuse and Alcoholism.
2. The National Survey on Drug Use and Health (NSDUH), sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides annual data on drug use in the United States. It provides yearly national and state-level estimates of alcohol, tobacco, illicit drug, and nonmedical prescription drug use. Other health-related questions also appear from year to year, including questions about mental health. Data on several aspects of mental health, including the prevalence and treatment of serious psychological distress (SPD) and major depressive episodes as well as the association of these problems with substance use, are collected. The survey targets civilian and noninstitutionalized individuals who are at least 12 years old. The sample for the 2005 survey included 68,308 respondents.
3. The National Comorbidity Survey–Replication [NCS-R] (2001) is a nationally representative sample of respondents who are at least 18 years old. This survey on the prevalence and correlates of mental health disorders is a replication of the original NCS, which was conducted a decade earlier. The sample for 2001–2003 included 9,282 respondents. This survey is funded and conducted through the National Institute of Mental Health.

All three epidemiological studies use questions about symptoms to obtain rates of mental health and substance use problems. However, a key distinction is that the NSDUH is symptom driven, whereas the NESARC and NCS-R are diagnosis driven. The NSDUH's symptom-driven approach cannot characterize the prevalence of serious mental illness (SMI), a low-frequency occurrence, with precision. The NSDUH collects data on SPD rather than SMI, which refers to those who have experienced a *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) mental disorder and impairment in the past year. In this context, SPD indicates that the respondent exhibited a high level of distress from any type of mental problem that may include symptoms related to phobia, anxiety, and depression. Consequently, the prevalence of SPD is highly correlated with measures of SMI but encompasses persons with moderate mental disorders.

By including most diagnoses in the *DSM-IV*, the NCS-R and NESARC also encompass mild and moderate mental disorders, which account for a large proportion of cases as described subsequently. The NCS-R distinguishes among severe, moderate, and mild disorders. Severe disorders are defined as cases that involve any of the following: suicide attempt in the preceding 12 months with serious lethality intent, work disability or substantial limitation caused by a mental or substance use disorder, psychosis, bipolar I or II disorder, substance dependence with serious role impairment (as defined by disorder-specific impairment questions), an impulse-control disorder with repeated serious violence, or any disorder that resulted in an inability to function in a particular social role for 30 or more days in the year. Cases are defined as moderate if they involve any of the following: suicide gesture, plan, or ideation; substance dependence without serious role impairment; at least moderate work limitation caused by a mental or substance use disorder; or any disorder with at least moderate role impairment in two or more domains of the Sheehan Disability Scale. All other cases are classified as mild (National Institute of Mental Health, 2005).

Epidemiological data from the NCS-R indicate that nearly half of individuals in the United States (46.4%) will meet the criteria for a *DSM-IV* disorder during their lifetime, that almost a third will have two or more lifetime disorders (27.7%), and that almost a fifth will have three or more lifetime disorders (17.3%; Kessler, Berglund, et al., 2005). However, at this time, specific findings on CODs have not been reported from the NCS-R. For the 12-month prevalence of *DSM-IV* disorders, the NCS-R found that 26.2% of patients had some type of disorder (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). This finding is consistent with findings from earlier epidemiological studies such as the Epidemiological Catchment Area Study (28.1%) and the original NCS (29.5%; Kessler, Chiu, et al., 2005). However, from a services point of view, lifetime disorders are not the same as past-year disorders. Past-year prevalence provides a more robust index of the severity of a condition. Severity will inform the demand for treatment services more accurately as compared with lifetime prevalence. This important distinction may result in overestimating the demand for treatment services (Green-Hennessy, 2002; Wu, Ringwalt, & Williams, 2003). Nevertheless, the large number of Americans who may require treatment at some