

# WORKING P A P E R

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## State Activities to Improve Services and Systems of Care for Individuals with Co-Occurring Mental and Addictive Disorders

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## Summary

### Background

Over 10 million individuals in the United States are estimated to suffer from a co-occurring substance abuse related and a mental disorder, or COD (SAMHSA National Advisory Council, 1998). Despite extensive data documenting the high degree of co-occurring psychiatric and substance-abuse related conditions, and the need to link services and systems to provide effective treatment, the capacity to provide needed care is limited by significant policy, financing, organizational, programmatic and professional barriers. As a result, many individuals receive no treatment or are treated for one problem and not the other, or receive care that is uncoordinated and inconsistent.

The lack of a coherent system of collaboration between MH and SA systems at multiple levels, has had a substantial negative impact on care. While there is a growing body of literature on specific treatment interventions for people with COD, few studies have focused on such systems-level issues as financing and organization of care. Most literature has also focused on the population suffering from serious mental illness (SMI), paying much less attention to the large number of people whose disorders do not meet the SMI definitions (e.g., many individuals with mood and anxiety disorders with co-occurring substance abuse).

### Aims of this Study

Despite these problems, many states are actively planning and implementing strategies to improve service delivery systems for the COD population. This report describes the results of a cross-sectional (FY 2003) comparative study that investigated such strategies. The study addresses the need for 1) more evidence-based data and systematic research that investigates the range of state and local practices and policies that facilitate and create barriers to providing COD care, and 2) strategies that can help achieve large-scale dissemination of research and practice-based knowledge to improve COD care at state and local levels. Part of an ongoing research effort at The RAND Corporation known as the “*Building Bridges*” initiative, the study was designed to help fill in some of the gaps in our knowledge by investigating the ways in which states and local programs have been overcoming clinical, financial and organizational barriers to providing care for persons with COD.

### Methods

A range of start-up activities (e.g. establishing expert panels, conducting an environmental scan of state and local COD service delivery via a project website, assessing the COD literature and state websites) were conducted to support the project. To learn about the strategies that states are pursuing to improve services for the COD population, we attempted to identify 9 states that had undertaken specific initiatives in this area. States were selected based on recommendations made by the project’s advisory board and funders, project website responses, and our review of the COD literature. The following 9 states were selected for the study: Arizona, Connecticut, New York, Ohio, Oregon, South Carolina, Texas, Tennessee, and Wyoming.

Selection of 9 local programs was based on initial recommendations by state directors and telephone screening criteria. Solicitation letters were sent to targeted respondents—state MH, SA and Medicaid directors, and local program executive directors (see Appendix C)—and intensive follow up communications were made for each state. Qualitative research methods were used to collect and analyze survey and secondary data. State and local program interview protocols (see Appendices D, E, and F) were developed to include particular domains of interest: facilitators and barriers to COD care; organizational characteristics; consensus building activities; COD population definition; mode of COD treatment

(parallel/coordinated, integrated); financing & policy regulations; coordination of care; treatment program and Medicaid services characteristics; workforce training; information systems; quality assurance; and future plans and sustainability of COD services.

Research synthesis techniques were used to analyze the data collected. Profiles were written for each state and local program. Content and thematic analysis techniques were used to analyze cross-cutting trends and themes according to the domains of interest for state and local program COD services delivery.

## **Findings and Implications**

In brief, highlights from the state and local analyses included the following trends:

Facilitators of COD care at both the state and local levels were strong director leadership; specialized COD funding; agency commitment to serving the COD population; staff training; extensive stakeholder, cross-system and within agency consensus-building activities; and strategies that addressed the separation between MH and SA systems and providers. Barriers to delivering COD care at both the state and local levels were lack of integration of MH and SA systems; Medicaid eligibility limitations for SA services; historical and philosophical differences between MH and SA providers; lack of substantial funding for COD and SA services; and maintaining a trained workforce over time. Factors that were associated with sustaining COD services at the state and local levels were enthusiasm and pride about improving COD care; desire to roll out COD models statewide over time; plans to implement strategies that improve COD care, such as maintaining current COD approaches and service menus, planning demonstration projects and expanding COD services and staff training.

At the state level, the leadership of the State Mental Health Authority in all states has been central to improving COD care. All states considered the COD population to be an important priority over a sustained period of time. Familiarity with the “Four Quadrant Framework” (see page 8 and Appendix A), and defining the COD population broadly, has helped to mitigate conflict and misunderstanding that has arisen from the different perspectives that MH and SA providers have held regarding the COD population. Breaking down disciplinary barriers between MH and SA providers has also been addressed through extensive consensus building and workforce training activities in all states. The delivery of COD care through parallel treatment approaches prevails in all states. While states envision expanding the availability of coordinated or integrated COD services that they have piloted, or plan to pilot and/or disseminate using the New Hampshire/Dartmouth or Dual Diagnosis Toolkit model (see Appendix A), few have been steadily expanding coordinated or integrated treatment services, and most have not yet attempted a statewide roll out.

States continue to face other organizational and fiscal issues that challenge their capabilities to develop coordinated, longitudinal systems of care or integrated services for the COD population and generally meet the need for COD care. States have leveraged Medicaid under the Medicaid Rehabilitation Option to enable the delivery of many COD services for their Medicaid eligible populations. Most states were reimbursing Medicaid MH and SA service under traditional fee-for service arrangements with only a few having implemented managed care reforms that provided flexibility for delivering integrated COD services under Medicaid. Beyond cross-training, states have generally not focused on improving the coordination of care between separate MH and SA systems. This observation has important ramifications for the COD population whose locus of care is primarily through the SA system. Many substance abuse treatment clients are not Medicaid-eligible. Even when Medicaid reimbursement is available for SA clients, reimbursement rates are often much lower than for MH providers, inhibiting the development of more intensive coordinated or integrated care models. Integrated program models mostly rely on Medicaid financing, and typically focus on SMI populations only. Coordination of MH and SA care is further inhibited by various Medicaid regulations, such as those concerning the licensing and credentialing of

provider facilities and practitioners, and eligibility requirements for those seeking care. In addition, because Medicaid pays only for specific services delivered, the system gives providers few financial incentives to pursue collaborative relationships.

In order to address these limitations, states are attempting policy and regulatory changes to better serve the COD population such as braiding Medicaid funding; expanding Medicaid benefits to include SA outpatient services (e.g. residential care); changing provider agency licensing requirements to require COD assessment capability for all providers; planning changes to information systems to include COD indicators; and planning to more fully develop routine quality assessment and improvement strategies that support COD services.

At the local level, all programs, regardless of agency type (MH, SA, integrated MH and SA, public or private), or license held (MH and/or SA), maintain a broad COD population focus. Services offered to the COD population ranged from a usual menu of MH, SA and wrap-around services, to specialized COD services and/or a specialized COD program. Most programs engaged in more informal (referrals, informal working relationships and collaborations) rather than formal linkage activities (memorandums of understanding, interagency agreements) with other agencies in their communities to coordinate and/or link services for their COD, MH and SA populations. Almost all local programs were using both parallel and integrated treatment models (often based on principles of the Dartmouth model and Kenneth Minkoff) to deliver COD care. While most programs considered the majority of their staff capable of delivering COD care, all agencies were highly committed to expanding opportunities to cross-train staff on an ongoing basis.

All local programs primarily received funding from public sources (with Medicaid being the largest source) and were proactively seeking other public and private dollars to maximize their abilities to deliver MH, SA and COD services. Although all programs perceived the current Medicaid billing system as procedurally adequate, they noted the need for higher reimbursement rates for SA services, and a more standardized way to bill for COD services as an integrated MH and SA service. Only a few programs had developed outcomes and quality improvement models to support COD care. All planned to improve their information and quality improvement systems in the near future.

The report concludes with a discussion of a conceptual framework (that links state authorities, local provider agencies, care that individuals receive, outcomes of care for health and functioning of treated individuals, and costs) that can be used to further our understanding of the extent to which state initiatives, policies and practices are successful in achieving their goals to improve access to and quality of COD services. Based on Donobedian's classic quality of care model (Donobedian, 1966), the framework can be used to evaluate whether state and local provider strategies and initiatives are improving processes of COD care, and/or whether improvements in clinical processes are associated with expected improvements in outcomes. The study's results, and concluding framework, underscore the need for ongoing evaluation so that we can continue to learn how to implement more effective and evidence-based strategies that bring us closer to meeting the unmet need for COD care across a population spectrum.

## Acronyms

ACT	Assertive Community Treatment
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
BAI	Beck Anxiety Inventory
BDI	Beck Depression Inventory
COD	Co-occurring disorder(s)
COSIG	Co-Occurring State Incentive Grant
CMHC	Community Mental Health Center
CMHS	Community Mental Health Services block grant
DALI	Dartmouth Assessment of Lifestyle Inventory
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
FFS	Fee-for-service
MCO	Managed Care Organization
MH	Mental health
MINI	Mini Mental Status Examination
MOU	Memorandum of Understanding
NAMI	National Alliance of the Mentally Ill
NCQA	National Committee for Quality Assurance
PTSD	Post-Traumatic Stress Disorder
QA	Quality Assurance
QI	Quality Improvement
SA	Substance abuse
SAMI	Substance Abuse/Mental Illness
SAPT	Substance Abuse Prevention and Treatment block grant
SASI	Substance Abuse Social Indicators
SMI	Serious Mental Illness

## **Chapter 1. Introduction**

### **The Problem of Co-Occurring Disorders (COD)**

According to best estimates, up to 10 million individuals in the United States suffer from a co-occurring substance-related and a mental disorder, or COD (SAMHSA National Advisory Council, 1998). Extensive research has shown that individuals with both substance abuse (SA) and mental health (MH) problems experience higher rates of disability, homelessness, violent behavior, and HIV infection, as well as more severe and chronic medical conditions and psychosocial problems (Belcher, 1989; Cournos et al., 1991; Drake et al., 1989; Kalichman et al., 1994; Steadman, 1999). As a result, the presence of both conditions is associated with higher rates of treatment utilization and increased use of emergency and hospital services (Maynard and Cox, 1998; Narrow et al., 1993). In addition, individuals with both conditions often progress more slowly in treatment than do individuals with a mental health or addiction problem alone (SAMHSA, 1999).

Despite extensive data documenting the high degree of co-occurring psychiatric and substance-related conditions and the need to link services to provide effective treatment, the capacity to provide needed care is limited by significant policy, financing, organizational, programmatic, and professional barriers. As a result, many individuals receive no treatment or are treated for one problem and not the other.

Because the MH and SA infrastructures have developed independently, there are generally two separate systems, each with its own administrative agencies. Communication and collaboration between departments and levels of government are often lacking or nonexistent, and there are both public and private delivery systems within each area. Even when mental health and substance abuse systems are overseen by the same state government authority, distinctive funding streams, regulatory requirements, service reimbursement rates, and workforce resources present challenges to the delivery of services appropriate for persons with co-occurring disorders. The state's Medicaid program can complicate the fragmentation of the service system through regulations that reinforce distinctions between mental health and substance abuse services and by offering a different set of benefits for Medicaid beneficiaries than is available for the uninsured. Also, service delivery systems in the public or private sector may be called on to serve different populations (e.g., the public sector has a higher percentage of individuals with schizophrenia).

The fact that there are two separate systems has ramifications at both the system level (difficulty merging treatment services and coordinated or integrated treatment programs) and at the individual client level. Individuals are often excluded from one system because of their additional problems (e.g., disruptive behavior or variations in eligibility criteria), or they are transferred from one system to the other and, as a result, fall between the cracks. The lack of either a coherent system of collaboration between the two existing systems or a single agency or infrastructure to address the needs of people with both types of conditions has had a substantial negative impact on individuals' care.

Moreover, the care individuals receive is further fragmented by a lack of connection and coordination with other health care agencies and social services that address the needs of individuals with mental health and substance abuse problems, such as those related to housing, general medical care (e.g., emergency rooms), and the criminal justice system.

Finally, although there is a growing body of literature on specific treatment interventions for people with co-occurring disorders (Brunette and Drake et al., 2001; Carmichael and Tackett-Gibson, 1998; Drake and Essock et al., 2001; Drake and McHugo et al., 1998; Drake and Yovetich et al., 1997; Greenberg, 2002; Ho and Tsuang et al., 1999; Jerrell and Ridgely, 1995; Watkins and Burnam et al., 2001), few studies have examined such systems-level issues as the financing and organization of care (Goldman and Ganju et al., 2001; NASMHPD, 2002; NASMHPD and NASADAD, 1998; NASMHPD and NASADAD, 1999; Ridgely and Johnson, 2001; Ridgely and Lambert et al., 1998; SAMHSA, 2002). Furthermore, most of the literature focuses on the population suffering from serious mental illness (SMI), paying much less attention to the large number of people whose disorders do not meet the SMI threshold (i.e., the non-SMI).

Despite these problems, many states are actively planning and implementing strategies to improve the service delivery system for the COD population. Several states, for example, have adopted the conceptual framework for addressing symptom severity and levels of service system coordination created by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) (sometimes referred to as the “Four Quadrant Model” (SAMHSA, 2002) and often attributed to mental health and substance abuse officials in New York). These states are using the model to assess the impacts of state policies on different co-occurring populations and to plan services. In brief, the model provides a Four Quadrant framework that conceptualizes the full spectrum of people with co-occurring substance abuse and mental disorders. The framework implies that persons may “move back and forth among the quadrants during their stages of illness and recovery” (SAMHSA, 2002). Persons whose MH and SA disorders are both of low severity typically receive care in primary health care settings, or Quadrant I. Persons whose severity of MH disorder is high, and severity of SA disorder is low, typically receive care in the MH system, or Quadrant II. Persons whose severity of SA disorder is high, and severity of MH disorder is low, typically receive care in the SA system, or Quadrant III. And persons whose severity of MH and SA disorders are both high (or SMI) typically receive care in state hospitals, jails, prisons and/or emergency rooms, or Quadrant IV.

### **Aims of This Study**

This report summarizes part of an ongoing research effort at RAND known as the “Building Bridges” initiative. Funded by the Robert Wood Johnson and John D. and Catherine T. MacArthur Foundations, as well as the Center for Substance Abuse Treatment (CSAT), the goal of the initiative is to identify effective treatment programs and ways to overcome clinical, financial, and organizational barriers to care for people with COD.

This particular report was funded solely under a contract to CSAT and describes the findings from a specific part of the “Building Bridges” research effort. To fill specific gaps in our knowledge of systems-level and financing issues, we investigated the efforts of nine states to improve the service delivery system for the COD population in their states. Specifically, we collected and analyzed information on the current activities of state MH and SA agencies in the realms of financing and organizing services, with an emphasis on what is happening at the systems level. In addition, we gathered information on the efforts of specific local provider agencies in each of these nine states to improve services for people with co-occurring MH and SA disorders.

## **Organization of This Document**

More detailed information on our methods for collecting and analyzing these data can be found in Chapter 2. This chapter is followed by separate chapters for each of the nine states (Chapters 3 through 11). Chapter 12 summarizes general findings that emerge from an assessment of information collected from all nine states, and Chapter 13 provides recommendations for next steps.

## Chapter 2. Methods

This project is a cross-sectional and exploratory survey of current activities that states and local programs are conducting (and planning) to improve care for adult persons with co-occurring (COD) mental health and substance abuse disorders. Nine states were selected from an initial group of 23 states that were included in the Building Bridges research initiative because they had engaged in state-level efforts to develop services for persons with co-occurring disorders. In each of the nine states telephone interviews were conducted with the state mental health commissioner/ director, state substance abuse commissioner/director, state Medicaid director, and a local program executive director. The study was conducted from the fall of 2002 through the fall of 2003. All interviews were conducted from January through October 2003, and interview respondents were given a chance to review their respective state and local profiles between December 2003 and February 2004.

### *Description of the Building Bridges Initiative*

This study is one part of the larger Building Bridges initiative. Building Bridges is a collaborative between RAND Health and the Robert Wood Johnson Foundation and John D. and Catherine T. MacArthur Foundation (who have funded the project). The goals of the overall initiative were to

- Develop a conceptual framework and recommendations for a strategic research and action agenda that aims to improve care for COD;
- Investigate existing examples of system and organizational designs currently in place for the treatment of COD;
- Learn from and summarize approaches to service delivery that appear to be transferable to other settings and that show promise for improving the quality of routine COD care in public and private sectors; and
- Finalize the development of a conceptual and methodological basis for a final multi-site demonstration project that would evaluate state and local/agency strategies for specific populations with COD (i.e. evaluation of the activities of the states who have received COSIG grants). This activity would prepare the way for testing the effectiveness of the most promising and broadly implementable models of care identified from previous work.

To achieve these goals, we undertook a number of activities. We convened panels of experts on COD, including researchers, clinicians, foundation staff, county directors, state commissioners and insurers. We then invited a subset of these experts to serve on a core advisory panel. The panel provided direction and technical assistance to the research team, and was a source of initial referral with respect to model programs and states to consider. Panel members also helped us draft a conceptual framework for the project. The framework takes into consideration the heterogeneity of the population; the context of real-world financing constraints, institutions, organizations and providers; and the rapidly changing healthcare marketplace.

In addition, we conducted an environmental scan searching the published literature and websites and solicited information (through a project website) from states and localities on innovative projects, programming, research, and organizational and financing strategies to treat people with co-occurring mental health and substance abuse disorders. Furthermore, an alert about the project was published in mental health and substance abuse trade newsletters and other publications. From the information collected through these efforts, we gained a much better understanding of the clinical, organizational, funding, and other policy issues relating to the treatment of the co-occurring population. We then used

this information to inform our selection of states for telephone interviews and for interview guide development.

We identified states engaged in state-level efforts to develop or improve COD services. States were identified using three main sources: recommendations made by experts in COD treatment, and the project's advisory board and funders; state respondents to the project's website call for reports on COD innovations; and the COD literature. A final set of 25 states was selected for the study: Alaska, Arizona, California, Connecticut, Delaware, Georgia, Illinois, Iowa, Indiana, Massachusetts, Michigan, Missouri, Montana, North Carolina, New Mexico, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Washington, Wisconsin, and Wyoming.

A telephone interview guide for state mental health and substance abuse commissioners/directors was developed using the conceptual framework discussed in the initial expert meetings. The guide was designed to investigate a broad range of state activities that may have been undertaken to improve access to or quality of care for persons with COD. The guide's domains include: how the population with COD is defined and prioritized; how COD services are financed; the extent to which access to COD services has been achieved in the state, including delivery of integrated or parallel service delivery models (see Appendix A for definitions of these terms); consensus building activities; changes in state policy or regulation to improve COD services; the extent to which information systems support monitoring of services and outcomes for persons with COD; workforce/training activities for COD services; quality assurance for COD services; COD service demonstrations and research; and future plans to develop or improve COD services. (See Appendix D.)

A solicitation letter for state mental health and substance abuse commissioners/ directors was developed and sent to officials in the 25 states selected. (See Appendix C.) Lists for state mental health, substance abuse and Medicaid commissioners/directors were obtained from the National Association of State Mental Health Program Directors, and the National Association of State Drug and Alcohol Directors. A list of state Medicaid directors was developed by the research team from various sources. Interviews were conducted with officials in 23 states. (Two states, Michigan and North Carolina, did not respond to several letter and phone call requests, and were dropped from the study.) In consultation with the CSAT project officer, 9 states were selected for participation in this study. The research team will produce a separate RAND report that presents the findings from all 23 states. In addition, under a separate component of the overall Building Bridges project, the team will produce a RAND report that assesses clinical treatment guidelines for COD.

#### *Investigating State Activities to Improve Service Delivery for COD in Nine States*

This particular component of the overall initiative, which was funded by CSAT, focuses on investigating existing examples of state and local system and organizational designs currently in place for the treatment of COD in a subset of nine states.

State mental health and substance abuse interview data were preliminarily analyzed to determine which states were best candidates to further investigate. In consultation with our CSAT project officer we attempted to select states on the basis of their COD initiatives that were likely to be instructive to other states addressing the challenges of improving COD, including states that had developed fairly broad access to COD services and those that had engaged in particularly innovative strategies.

The states selected were: Arizona, Connecticut, New York, Ohio, Oregon, South Carolina, Tennessee, Texas and Wyoming. In these states, interviews were conducted with state mental health and substance abuse officials and members of their staffs. (Directors often included other staff in the interview, and some directors designated other staff people, such as a director of policy, to participate on their behalf.)

Local provider agencies in these same states were also selected to be interviewed. Initial recommendations for provider agencies that delivered model integrated or parallel COD services were solicited during interviews with state mental health and substance abuse commissioners/directors. In order to showcase a variety of approaches to delivering COD treatment, a mix of mental health and substance abuse agencies was targeted. In addition to being nominated as a model for providing COD services, we attempted to select a mix of programs that delivered a range of COD services and served a broad population of persons with COD. Three mental health provider agencies, 4 substance abuse provider agencies, and 2 integrated mental health and substance abuse provider agencies were recruited.

Telephone interview guides for state Medicaid directors and local programs were developed using the state mental health and substance abuse interview guide. In order to complement the state mental health and substance abuse data, the Medicaid domains were similar: definition of COD and influence of the Four Quadrant Model on care; the Medicaid agency's financial and regulatory role with regard to COD, including services covered under Medicaid fee-for-service and managed care arrangements; agency involvement in state planning and consensus-building activities; changes to facilitate the provision of COD services; and future plans. (See Appendix E.) The local program interview guide domains mirrored the state level, and also included more specific information on treatment delivery: definition of COD; organizational characteristics; financing issues; facilitators and barriers to providing COD treatment; COD treatment program characteristics; and sustainability of COD services. (See Appendix F.)

Solicitation letters for state Medicaid and local program respondents were developed and sent to state Medicaid directors and local program executive directors in each of the states selected for study. Follow up calls were made and all recruits responded. (See Appendix C.)

Interviews were conducted with state Medicaid directors and other staff members. (Directors often included other staff in the interview, and some directors designated other staff people, such as a director of policy, to participate on their behalf.) Nine interviews were completed with local program executive directors and their staff. Interviews were conducted by telephone conference with two RAND research staff, with one researcher conducting the interviews and the other taking detailed notes. Using these notes, written documentation of responses all interviews was prepared. This documentation was synthesized to create state and local program profiles for each of the 9 states. States reviewed these profiles and provided corrections or feedback, and these comments were integrated into the final profiles.

Chapters 3 through 11 in this report provide the profiles for each of the states. Chapter 12 summarizes our observations across the 9 states. Chapter 13 provides some suggestions for next steps in learning from ongoing state initiatives in order to further improve access to and quality of COD services.

## **Chapter 3. Arizona State Profile**

### **COD Population Focus**

Arizona has a single state behavioral health services agency, the Division of Behavioral Health Services (DBHS), located within the Arizona Department of Health Services (ADHS). DBHS administers a unified system of mental health and substance abuse treatment services, including prevention services and inpatient psychiatric care. The state has focused broadly on the population with COD, including people with both SMI and less serious mental disorders and co-occurring substance abuse or dependence.

### **Financing and Access to Services**

Behavioral health services in Arizona are funded with a mix of Medicaid, federal block grant, and state general revenue funds. The state relies heavily on Medicaid financing to support its public behavioral health system, with about two-thirds of the total budget composed of Medicaid federal dollars and state match. The Arizona Health Care Cost Containment System, Arizona's single state Medicaid agency, contracts with ADHS for behavioral health services for all Medicaid eligible individuals. ADHS subcontracts with community based agencies, known as Regional Behavioral Health Authorities. The Regional Behavioral Health Authorities, which are private, nonprofit or for-profit organizations, operate much like managed behavioral health organizations. There are five Regional Behavioral Health Authorities serving six geographic service regions. Each is a managed care organization at risk for services delivered to the Medicaid population; it also manages the care for the non-Medicaid population under an administrative-services only arrangement. In addition, ADHS contracts with three Tribal Regional Behavioral Health Authorities to administer behavioral health services via intergovernmental agreements. The Tribal Regional Behavioral Health Authorities are American Indian Tribes that coordinate services for members of their respective Tribes. The Tribal Behavioral Health Authorities provide services on a fee-for-service basis, with ADHS assuming full risk. The Arizona State Hospital is directly funded by ADHS.

The Regional and Tribal Behavioral Health Authorities organize and deliver COD services through a variety of arrangements. One Regional Behavioral Health Authority provides all services directly. Others contract with provider agency networks, and still others contract with individual providers on a fee-for-service basis.

Behavioral health benefits are the same for the Medicaid and non-Medicaid populations and include a broad array of mental health and substance abuse services; the managed-care arrangements contain the State's costs, while allowing for a flexible array of services to be provided. For mental health, both Medicaid fee-for-service and Medicaid managed care cover inpatient, physician, outpatient, day treatment/partial, case management, pharmacy, residential, vocational, and self-help/peer support services. For substance abuse, both Medicaid fee-for-service and Medicaid managed care cover inpatient detox, outpatient detox, outpatient, case management, methadone therapy, pharmacy, residential, vocational, and self-help/peer support services. In addition, Medicaid FFS benefits include inpatient (detox plus rehabilitation) services for substance abuse.

While there remain some barriers to financing and delivering coordinated or integrated COD care, ADHS/DBHS has systematically pursued the removal of these barriers. For example, in preparation for

the implementation of the national HIPAA transaction set, the state Medicaid agency and ADHS/DBHS re-designed the array of covered behavioral health services and service procedure codes to standardize all services and codes across mental health and substance abuse. Today the same matrix of services is available to Medicaid enrolled members regardless of diagnosis and these are billed using the same codes (e.g. assessment, counseling, case management, residential treatment day rate). Specialized services are available through “set-asides” of the Substance Abuse Block Grant, including access to programs for women with children. In addition, new funds for services to individuals with serious mental illness require clinicians to address co-occurring substance abuse disorders.

Mostly, COD services are delivered by separate MH and SA providers, but some provider agencies have developed integrated COD programs, particularly in the two largest urban areas. In rural areas, MH and SA providers are often in the same facility, which facilitates coordination of care. ADHS/DBHS has established contract standards and expectations that all behavioral health provider agencies are competent to identify and address a minimal level of co-occurring disorders in the patient population. All providers in the state are considered to be either “dual diagnosis capable” or “dual diagnosis enhanced”. Providers who are “capable” generally provide COD care in parallel fashion, referring individuals to providers in the other system. Providers who are “enhanced” are able to provide integrated treatment for those with COD. ADHS/DBHS has not created financial incentives to encourage providers to reach the “enhanced” level of service provision, but rather pushes providers in this direction through contract language and case monitoring. State officials estimate that 15 to 20 percent of providers deliver “enhanced” COD services.

### **Collaboration and Consensus Building**

Led by the state’s director of DBHS, ADHS has engaged in an extensive consensus building approach that began in 1999. With the help of national consultants (Minkoff, Mee-Lee, Muesser, and others), the state developed broad principles and guidelines for COD services in a process that included key stakeholders and brought MH and SA providers together to align values. DBHS reviewed state policies and procedures to identify barriers to COD treatment and aligned incentives with stated principles. (For example, because people with serious mental illness were previously ineligible for housing if they had a substance abuse problem, these rules were changed so individuals could receive housing support regardless of their concurrent substance abuse.) The state Medicaid agency has been involved in this effort and has worked closely with ADHS/DBHS to create reimbursement for a flexible and diverse array of MH and SA services.

In addition, the three largest Regional Behavioral Health Authorities have their own local stakeholder panels that focus on enhancing COD treatment services and training to improve competency.

### **Training and Workforce Development**

DBHS sponsored the development of a training package that was created with help from faculty at the University of Arizona’s Addiction Technology Transfer Center. Regional Behavioral Health Authorities use this training package across the state on an ongoing basis to train both MH and SA provider staff. A primary goal of the training is to ensure that assessments are comprehensive and training is consistent across the state. Standards for provider skills/competencies have been built into the training package, but individual providers are not specially certified to deliver COD services.

### **Information and Data Systems**

Arizona recently implemented the use of a standardized intake instrument for all provider agencies. The assessment tool includes comprehensive mental health and substance abuse modules, ensuring that all individuals are screened for SMI or substance abuse disorders upon entry into the system. In addition, the state maintains a management information system that links across MH and SA services, both Medicaid and non-Medicaid. The state is working on incorporating measures of COD diagnoses and services into these systems.

In cases where referrals for specialized services are necessary, ADHS/DBHS expects that mental health and substance abuse providers will share clinical information to coordinate COD care. RBHAs are responsible for providing oversight to ensure such practices.

### **Quality Assurance/Quality Improvement**

ADHS/DBHS maintains a comprehensive quality assurance and quality improvement program, with additional quality improvement responsibilities delegated to the Regional Behavioral Health Authorities. DBHS reviews the Regional Behavioral Health Authorities on annual bases to confirm that the providers are in compliance with state performance-based standards. DBHS also tracks whether consumers are receiving MH and SA services and other support services.

### **Pilot Projects**

Several pilot integrated treatment demonstrations have been undertaken, including the Ladder Program in Phoenix and ADMIRE in Tucson. Based on the success of these pilots, the Regional Behavioral Health Authorities are expanding the availability of program focusing on the most complicated and severe COD patients.

## **Local Program Profile**

**Local Program:** LaFrontera, AZ

### **Type of Agency and COD Population Focus**

LaFrontera is a public, nonprofit, community-based provider of MH and SA services. The agency serves a large population of people with MH and SA disorders. Specifically, it serves anyone with an Axis I or II mental health or psychiatric diagnosis, including COD clients. Approximately 60 percent of its clients receive COD services. The staff treat both SMI and non-SMI cases and define COD rather broadly.

LaFrontera has a diverse caseload, consisting of Medicaid-eligible and Medicaid-ineligible clients, Temporary Assistance for Needy Families (TANF) recipients, HIV/AIDS cases, forensic cases, and the homeless. Only a small proportion of clients are Native Americans, since most Native Americans receive care through a separate treatment system.

Arizona does not issue MH or SA licenses, instead licensing providers in specific levels of care, such as outpatient, residential, and so on. LaFrontera is licensed to provide a full array of services (see below).

### **Services Offered to the COD Population**

LaFrontera offers a comprehensive menu of services for both MH and SA: individual and group treatment, partial hospitalization/day treatment, psychosocial rehabilitation, case management, Assertive Community Treatment (ACT) teams, physician services, vocational rehabilitation, self-help/peer support, illness management, medication management, inpatient detox, methadone maintenance, screening, assessments, residential care, dialectical behavioral therapy, a homeless outreach team, and housing services (group homes and halfway homes).

Clients are screened for both types of disorders using state-mandated (and state-developed) instruments. All clients also receive a Diagnostic and Statistical Manual (DSM) and psychosocial assessment, and some assessments are conducted using ASAM, SASI, or ASI criteria.

Care provided to COD clients most resembles the New Hampshire/Dartmouth integrated care model, but staff also draw on other external models, including Assertive Community Treatment (ACT), the Comprehensive, Continuous, Integrated System of Care (CCISC) model, and others (see Appendix A). In addition, some staff, along with consumers, lead community SMART groups based on the self-help/12-step model developed by Mary Copeland. LaFrontera has also developed its own best-practice guidelines for COD.

For clients who need services that LaFrontera does not provide, referrals are made to other agencies. In particular, LaFrontera does not have an outpatient detox program, but it has an agreement with an outpatient detox provider who accepts all referrals.

### **Treatment Implementation and Staffing**

LaFrontera has 19 treatment facilities throughout the county, and in each facility services are located on the same floor. Some services are specialized for those with a COD, while others target both COD and

single diagnosis cases. LaFrontera does not generally have separate treatment tracks for SMI and non-SMI clients.

Most clients are treated by multidisciplinary treatment teams consisting of a physician, therapist, case manager, and various paraprofessionals. Typically, one lead therapist/clinician (sometimes a case manager) is assigned to each client, and the lead clinician develops a single treatment plan, with input from other team members and the client. The multidisciplinary team determines whether to refer patients to other agencies for certain services. Most COD clients receive a mix of individual and group treatment, although most SA services take the form of group treatment. Clinicians and case managers attempt to tailor service plans to the particular needs of each client.

### **Financing Issues**

LaFrontera's largest funding source is Medicaid. It receives Medicaid funding on an at-risk basis from an RBHA, which, in turn, contracts with the state Health Department's Division of Behavioral Health Services (DBHS). Under this managed-care arrangement, LaFrontera does not bill for services; instead, it receives a certain amount of funds from the RBHA, based on capitated case rates. These rates vary for SA, non-SMI, and SMI cases.

In addition to Medicaid, the agency depends on SAPT and Community Mental Health Services (CMHS) block grant funds (which are also funneled through the RBHA but are not risk-based), especially for the non-Medicaid population. State general revenue is another important funding source, and LaFrontera charges fees to the non-Medicaid population based on a sliding scale.

### **Training and Quality Assurance**

All staff are trained and tested (on a pass/fail basis) in the COD best-practice guidelines that LaFrontera has developed. There is an integrated care work group that focuses on implementing these guidelines.

New employees are given two days of training in COD in their first year. They may receive an additional day of training, but there is no other required COD training. In addition, LaFrontera offers internship training programs in COD and often sends staff to RBHA-sponsored training sessions. For some sessions, the RBHA has brought in Ken Minkoff, Ken Muesser, David Mee-Lee, and other outside consultants. LaFrontera is also considering cross-training activities in which staff would learn new skills by serving in other agencies for a while.

### **Facilitators for Providing Co-Occurring Treatment and Sustainability of Services**

A National Institute of Drug Abuse (NIDA) grant LaFrontera obtained in 1994 was a major facilitator; the grant enabled LaFrontera to expand and evaluate COD services. A second facilitator has been the managed care model under which the agency operates. By not having to concern themselves with the issues surrounding billing and reimbursement, staff have more time to focus on service delivery for COD (and other) clients. Finally, the planning and consensus-building work at the state level (funded by a grant from CSAT) has had a positive effect at the provider level.

LaFrontera administrators are confident they will be able to continue to provide COD services well into the future and are hopeful they will be able to expand services for the COD population.

## **Barriers to Providing Co-Occurring Treatment**

MH and SA professionals participate in separate training tracks, and the content of the training is quite different. LaFrontera administrators believe that these separate tracks perpetuate philosophical divisions between professionals in the two fields. Maintaining a staff well trained in COD is a challenge, and funding for training is limited.

In addition, many people with COD are addicted to nicotine, but nicotine is not considered a drug in Arizona. The staff at LaFrontera regard this as a barrier to treating COD, as well as the fact that treatment services for smokers are part of the physical health care system.

## Chapter 4. Connecticut State Profile

### **COD Population Focus**

The public MH and SA systems in Connecticut are integrated at the state departmental level within the Department of Mental Health and Addiction Services (DMHAS). DMHAS officials endorsed a broad definition of COD, including in this category any persons who have a simultaneous, diagnosable mental health and substance abuse disorder. DMHAS is familiar with the Four Quadrant Model for characterizing COD and has reportedly used the model in grouping COD patients. However, Connecticut reportedly has not focused its delivery of services on particular quadrants within the model; instead it has endeavored to balance its provision of services to persons with primary MH and SA diagnoses.

### **Financing and Access to Services**

DMHAS administers the public sector MH and SA treatment systems and primarily serves as a purchaser of clinical services from state operated MH and SA providers. On the MH side, DMHAS delegates its purchasing authority to designated local mental health authorities, while the Department engages in direct contracts with providers on the SA side. DMHAS does not engage in risk-based contracting with managed-care organizations (MCOs), although the Department does have an ASO arrangement with at least one administrative services company. DMHAS also serves as the operator of several hospitals and inpatient facilities that provide treatment for severe MH and addiction problems.

The Connecticut Department of Social Services (DSS) has the primary administrative responsibility for Medicaid in Connecticut. Medicaid in the state includes both fee for service (FFS) and managed-care options, and DSS contracts with four MCOs, each on a statewide basis, to manage general Medicaid benefits. Management of behavioral health benefits under Connecticut Medicaid is subcontracted to two other MCOs.

Notably, most MH and SA providers in the state reportedly receive funding both from Medicaid and non-Medicaid sources, and according to MHDAS officials, available behavioral health services are similar, regardless of whether a consumer is a Medicaid beneficiary (including utilization of the Medicaid Rehab Option). Adult mental health and substance abuse services covered under the State's Medicaid FFS and Medicaid managed care plans include inpatient, physician, outpatient, day treatment/partial, case management (mental health only), inpatient detox, outpatient detox, methadone therapy, and pharmacy services. Residential services are covered only under the Medicaid FFS service plan for mental health. Vocational, self-help/peer support, substance abuse inpatient (detox plus) and substance abuse case management are not covered under either plan.

Connecticut officials did not identify Medicaid restrictions as creating a major barrier in delivering COD services in the state. However, low provider reimbursement rates under Medicaid were noted as a challenge for the Connecticut system. Other identified challenges for COD care included recent reductions in services and benefits covered by Medicaid, limited availability of medical and nursing staff at most SA service providers, restrictions on cross-licensing of SA and MH provider agencies, and credentialing burdens at both agency and individual provider levels.

Provision of public-sector COD services in the state occurs largely through a mixture of parallel and integrated delivery models. The state has reportedly focused on pressing an integrated delivery model for

consumers with SMI, and evidence from a state survey suggests that a majority of Connecticut SA providers describe themselves as “dual diagnosis capable” (with regard to the non-SMI population). Barriers to integrated or coordinated COD services include readiness of individual provider agencies, discrete DMHAS contracting mechanisms for MH and SA providers, and insufficient incentives to encourage integrated or coordinated services. Facilitators have included dozens of state waivers granted for cross-licensing of MH and SA providers, state investments in COD training, and aggressive efforts to obtain federal grant funding for COD initiatives.

### **Collaboration and Consensus Building**

State MH and SA authorities in Connecticut are both housed in a single state department (DMHAS); consequently, there has not been a formal interagency consensus-building process on COD issues. Nevertheless, collaboration on COD between MH and SA officials has reportedly been going on since 1995 and has involved regular meetings with clinical providers across the state in both the MH and SA systems. COD has been a focus for several state-level commissions and advisory groups in the past five years, including the Mental Health Policy and Provider Advisory Council, The Dual Diagnosis Task Force, The DMHAS Preferred Practice COD Work Groups (or standing committee on COD), and the Behavioral Health Partnership Council (BHPC). The BHPC is a collaborative effort that includes both DMHAS and DSS in an effort to eliminate policy and funding “silos” across Medicaid and non-Medicaid state-funded populations. Formal policy recommendations on COD were published in a report by the Dual Diagnosis Task Force, and most of those recommendations have reportedly been implemented by the state. Both the Dual Diagnosis Task Force and the BHPC have issued guidelines for delivering clinical services to COD consumers.

### **Training and Workforce Development**

DMHAS participates in a triennial Alcohol and Drug Policy conference with providers and policymakers from across the state, and the conference includes significant attention to COD. In addition, DMHAS sponsors regular cross-training initiatives designed to enhance the clinical skills of MH and SA providers in Connecticut. Many of these training initiatives include a focus on treatment for COD. State-sponsored COD training for mental health providers has been based on the evidence-based Toolkit for dual disorders (see Appendix A), supplemented by ongoing supervision and consultation by Drake’s group, as well as on peer discussion through a web-based listserv. The state’s training curriculum also involves a “Train the Trainers” focus. DMHAS has spent approximately \$500,000 on offering the Drake COD training (i.e., the New Hampshire/Dartmouth model) to local MH authorities, contracting agencies, and more than 80 percent of local mental health authorities have reportedly received the training and related technology transfer support. The state does not engage in any formal credentialing related to COD clinical competencies.

### **Information and Data Systems**

DMHAS does not currently mandate the use of a standardized clinical intake instrument across MH and SA treatment settings, but it is reportedly working to develop such an instrument. DMHAS does not require clinical information sharing by providers across MH and SA settings, except in connection with referrals. DMHAS does maintain a linked management information system (MIS) across the state’s MH and SA authorities, and (as of January 2003) the state system has the capacity to track consumers by

primary and secondary diagnosis. Refinement of the MIS with regard to COD status is a target of ongoing state efforts.

### **Quality Assurance/Quality Improvement**

DMHAS is engaged in routine monitoring of quality of care for COD by tracking utilization and outcome measures, and the Department is engaged in quality improvement efforts in connection with the COD population as well. In particular, DMHAS hired a new quality improvement coordinator, whose focus has included looking at COD, recovery-oriented measures, and ways to incentivize providers to provide quality treatment to high-risk clinical cases. These efforts have been complemented by the state's Connect to Care initiative, which examines follow-up service use by consumers seven days after their discharge from inpatient care.

### **Pilot Projects**

DMHAS has aggressively pursued federal grant funding for COD initiatives and, in partnership with local providers, has obtained more than \$30 million for these initiatives in 2001–2003. This funding has supported seven special demonstration programs for COD services, targeting a range of special populations, including prison inmates, homeless persons, and at-risk children.

## **Local Program Profile**

**Local Program:** Connecticut Counseling Centers, Inc., CT

### **Type of Agency and COD Population Focus**

Connecticut Counseling Centers, Inc., is a private, nonprofit agency that provides both SA and MH treatment services. Established almost 20 years ago, the agency operates treatment facilities in Waterbury and Norwalk (and has a corporate office in Middlebury). The agency has been in the process of addressing COD since its inception in 1984, but began to implement an integrated treatment approach five years ago using special funding from DMHAS.

Connecticut Counseling serves adults who have a DSM-IV diagnosis in either MH or SA, including clients who have both. The agency lacks the capacity to treat SMI clients and refers SMI cases to other mental health providers. However, some staff specialize in treating non-SMI COD patients with a wide range of substance abuse disorders. The most common substance abuse problems are addiction to heroin and cocaine. Approximately 30 percent of the agency's caseload has a COD, while 60 percent has a substance abuse disorder only, and 10 percent has a mental health disorder only. Many clients are on Medicaid, including TANF recipients. The agency also serves the elderly, as well as HIV/AIDs, homeless, and forensic cases.

The Connecticut Department of Public Health does not offer dual licensing for provider agencies, but instead licenses providers in one or more discrete service categories. Thus, Connecticut Counseling has a separate license for all of the services it offers, from outpatient detox to partial hospitalization.

### **Services Offered to the COD Population**

The same services are provided at both the Waterbury and Norwalk facilities, which are a one-hour drive from each other. Clients receive services in either one facility or the other. For both mental health and substance abuse, services offered include individual, group, and family/couples treatment, day treatment/partial hospitalization, psychosocial rehabilitation, case management, physician services, psychiatric services, vocational rehabilitation, medication management, methadone maintenance (including anonymous group sessions and an intensive outpatient program for women with COD), screening, and assessments, as well as outpatient detox services for substance abuse.

All clients are given BDI and BAI assessments and a standard supervised urine screen. Certain patients are also given a homegrown PTSD assessment.

The agency collaborates with several residential care and other inpatient facilities, including Connecticut Valley Hospital. Some of these interagency relationships rest on formal, written agreements, while others are informal.

### **Treatment Implementation and Staffing**

Connecticut Counseling has 50 clinical and support staff people in its Waterbury facility and 15 in its Norwalk facility. COD clients (those with a BAI/BDI score greater than 20) are placed in a special COD service track, which has its own counselors who focus solely on serving COD patients. The agency uses a

modified New Hampshire/Dartmouth integrated treatment model and also employs a cognitive-behavioral therapy model and uses Lisa Najavits' "Seeking Safety" model.

Clients receive a great deal of individualized treatment, with services planned and coordinated using a multidisciplinary team approach and regular team meetings to discuss cases. Some clients receive both MH and SA treatment from the same clinician or counselor. Only COD clients typically receive treatment from one MH and one SA clinician or counselor. The two clinicians work together and with the client to develop a treatment plan.

Over the years, the agency has also shifted more of its COD treatment from psychiatrists to certified counselors. This less expensive means of providing care has allowed the agency to serve more clients within its resources. Psychiatrists supervise counselors providing treatment to COD patients (and also provide direct care), while other counselors are supervised by master's level clinicians.

### **Financing Issues**

Connecticut Counseling has service contracts with all four Medicaid managed care organizations in the state and depends heavily on Medicaid funding. In addition, the agency greatly relies on SAPT block grant funds. Another revenue source is the agency's own training program for internal staff and professionals from other provider agencies.

Billing Medicaid for services has become more difficult under managed care, because prior authorization for services must be obtained and funds must be tracked more closely. Furthermore, the agency has experienced some difficulty receiving Medicaid payments under managed care arrangements. In contrast, agency administrators like the flexibility associated with grant funding (e.g., the SAPT block grant). For Medicaid clients, staff bill using separate mental health and substance abuse codes depending on which diagnosis is primary.

### **Training and Quality Assurance**

Connecticut Counseling offers a great deal of COD training opportunities for its staff, and some of these sessions are provided through the agency's own training program. Four staff provide training under the program, and they lead training sessions for internal staff and other professionals. External consultants have also been brought in to train staff in COD treatment issues. A major goal is to get more staff capable of providing both MH and SA treatment. The state recently developed a COD certificate, and Connecticut Counseling's training program is one of the institutions that prepares and recommends students for certification.

### **Facilitators for Providing Co-Occurring Treatment and Sustainability of Services**

The special funding from DMHAS five years ago was instrumental in enabling Connecticut Counseling to deliver COD services in a more intensive and integrated fashion. In addition, the board of directors has fully supported the delivery of integrated COD services, as have all administrators and clinical staff.

Agency administrators would like to expand COD services and provide more training for staff in the future, especially so that more staff will be able to provide treatment for both types of disorders.

## **Barriers to Providing Co-Occurring Treatment**

In addition to the barriers associated with Medicaid managed care mentioned above, Connecticut Counseling has had to deal with a shortage of office space and limited funding. The agency would like to purchase more psychiatric and counseling time but lacks the necessary funds.

## Chapter 5. New York State Profile

### COD Population Focus

The Office of Mental Health (OMH), directly operates psychiatric facilities across New York and regulates, oversees more than 2,500 MH programs that are operated by local governments and non-profit agencies and manages the public MH system in the state. The public SA system in New York is managed by the State Office of Alcoholism and Substance Abuse Services (OASAS), which directly operates more than a dozen SA treatment centers and oversees and regulates over 1200 treatment sites and 300 prevention programs, and provides administrative oversight to public-sector SA providers in the state.

Both OMH and OASAS utilize the conceptual framework of the Four Quadrant Model to define and address COD. Quadrant IV of the model (high severity MH and SA disorders) represents a significant focus for service delivery in New York, and OMH and OASAS have conceptually divided Quadrant IV into SMI and non-SMI subcategories. Quadrant IV(a) consists of individuals with SMI and co-occurring substance abuse. Quadrant IV(b) consists of those with severe mood, anxiety, or personality disorders that do not meet the threshold for SMI and co-occurring substance abuse. OMH and OASAS also focus, through their respective service delivery systems, on Quadrants II (high severity MH and low severity SA disorders) and III (low severity MH and high severity SA disorders) of the model. Quadrant I (low severity MH and SA disorders) of the model reportedly remains a target of opportunity for future prevention efforts.

### Financing and Access to Services

Medicaid financing (including utilization of the Medicaid Rehab Option), policy development and monthly capitation rates for COD services in New York are controlled by the State Department of Health (DOH), an agency independent of OMH and OASAS. New York is gradually implementing mandatory Medicaid managed care under the “Partnership Plan” (established pursuant to a Section 1115 federal waiver for most of the non-elderly non-institutionalized Medicaid population). Medicaid managed care had achieved greater than 60 percent penetration in New York as of August 2003, with more than 1.6 million persons enrolled. Note that mandatory Medicaid managed care in New York only partially covers individuals with behavioral health problems. Most persons with SMI remain in Fee-For-Service, and are not enrolled in managed care as enrollment is voluntary for this group and those eligible for SSI. Benefits for almost all behavioral health services are excluded for individuals with SSI who enroll in managed care. Benefits for those individuals without SSI (TANF/Safety Net aid categories) include a limited mix of managed care and fee-for-service (FFS) MH and SA services.

Adult mental health and substance abuse services covered under the state’s Medicaid FFS and Medicaid managed care plans include physician, outpatient, and residential (mental health only) services. For mental health, Medicaid FFS covers case management, day treatment/partial hospitalization, and pharmacy services. For substance abuse, Medicaid FFS covers inpatient detox, methadone therapy, pharmacy, and vocational services. Mental health services not covered under the state’s Medicaid FFS or Medicaid Managed Care plans include inpatient, vocational, and self-help/peer support. Substance abuse services not covered include inpatient detox plus, outpatient detox, case management, residential, and self-help/peer support services.

Managed care contracting under Medicaid is mostly risk-based, although stop-loss provisions limit the financial risks born by MCOs, particularly in connection with the administration of behavioral health benefits for non-SSI enrollees. The Medicaid health plan financial risk for covered behavioral health services is limited by stop loss arrangement, which requires health plans to pay for 20 outpatient MH visits and 30 combined MH/SA inpatient days annually. Health plans must continue to provide and manage necessary visits and days beyond the 20/30-day stop loss.

Medicaid-related barriers to COD services in New York include the absence of a Medicaid case management benefit for SA treatment, loss of eligibility for Medicaid benefits in connection with fluctuating welfare (TANF) status, and disparities in Medicaid reimbursement rates for physical and behavioral health services.

Provision of public-sector COD services in New York occurs largely under parallel or coordinated delivery models, with a trend toward more integrated services for COD consumers. Access to COD services also varies by region within New York State. General barriers to the provision of COD services include organizational culture and competency issues, absence of COD billing codes, professional licensing, budgetary environment constraints, and the complexity of payment structures for COD services. Leadership and innovative thinking at state, county, and clinic director levels has been a facilitator for developing more parallel and integrated COD services in New York.

### **Collaboration and Consensus Building**

OMH and OASAS have been involved in consensus-building activities on COD for more than a decade. The two agencies signed a Memorandum of Understanding (MOU) on COD in 1998 and created an Interagency Workgroup to stimulate COD policy development, implementation, and reform efforts. The 1998 MOU also formalized the commitment of OMH and OASAS to work together in (1) developing COD treatment guidelines, (2) establishing training programs for MH and SA providers, (3) enacting mutual screening and assessment processes for COD, and (4) exploring ways to facilitate more seamless delivery of COD services. Consistent with the foregoing, the Interagency Workgroup has worked on developing COD guidelines and competency standards. OASAS is reportedly doing further work to enhance COD guidelines (e.g. using the American Society of Addiction Medicine's dual disordered capable and enhanced criteria as prototypes) as applied to SA providers.

Additional collaborative efforts between OMH and OASAS from 1999 to 2001 took the form of a Quadrant IV (high severity MH and SA disorders) Task Force. This task force consisted of representatives from OMH, OASAS, and a range of outside experts and providers and provided recommendations to the two agencies for improving COD service delivery targeted at consumers with the most severe forms of COD.

To date, consensus-building activities on COD have not formally involved DOH (the New York state Medicaid agency), but they have involved outreach to some consumers and clinical providers. However, DOH does work closely with OMH and OASAS through its Bureau of Policy Development and Agency Relations. The staff in this office collaborate informally but frequently with OMH and OASAS on various policy issues, including those pertaining to COD. Collaboration between OMH and OASAS on COD financing and regulatory issues was identified as a target of opportunity for future consensus-building efforts.

## **Training and Workforce Development**

Both OMH and OASAS have undertaken significant COD training initiatives for their respective provider groups, and the agencies have also engaged in some collaborative cross-training efforts to address organizational culture and competency issues. For example, a relatively recent collaborative effort involved an advanced clinical training series on COD, which included more than 500 MH and SA clinicians from across New York State. Development of COD training curricula by OMH and OASAS had largely been a parallel process. However, the two agencies collaborated on a basic curriculum and advanced training services, which involved a combination of internal agency resources and external consultants. Both OMH and OASAS are continuing to develop COD training programs for their respective providers. As of this writing, neither OMH nor OASAS had undertaken specific licensing, certification, or continuing education reforms in connection with COD.

## **Information and Data Systems**

OMH and OASAS do not currently mandate the use of a standardized intake instrument across MH and SA domains. However, both agencies have been in the process of completing validation studies of two MH and SA screening forms, the M.I.N.I. and the D.A.L.I. While the two agencies do not require information sharing by clinicians across MH and SA sectors, information sharing is encouraged in line with federal and state confidentiality requirements.

## **Quality Assurance/Quality Improvement**

As of this writing, neither OMH nor OASAS are engaged in systematic QA/QI activities focusing specifically on COD. However, DOH, OMH, and OASAS work together to develop clinical profiles of client and utilization patterns as defined by the Four Quadrant Model.

## **Pilot Projects**

OMH and OASAS are currently running a pilot program that provides dual recovery coordinators (DRC) to New York City and 14 New York counties in support of COD programs (e.g. creating capacity to address issues of coordination and integration of care at local system level) and service delivery in various parts of the state. A few other state initiatives—“Assisted Outpatient Treatment”, “Single Point of Access”, and participation in the national evidence-based practice Toolkit project (see Appendix A)—do not focus on COD services per se, but effectively serve client populations that consist largely of COD patients.

## **Local Program Profile**

**Local Program:** Chemical Dependency Services (CDS) program at Lutheran Medical Center, NY.

### **Type of Agency and COD Population Focus**

The Chemical Dependency Services (CDS) program at Lutheran Medical Center is a private non-profit SA agency that provides treatment services in the Brooklyn/Sunset Park area of New York City. While primarily a provider of SA services, CDS also offers an array of MH services. Approximately 60 percent of the program's caseload receives treatment for COD. CDS generally treats these patients in an integrated fashion, although some clients are referred to outside providers for certain services or to other programs within Lutheran Medical Center's Behavioral Health Services.

The program's client base is ethnically diverse and includes a large Hispanic population and a growing Russian population. In recent years, the proportion of clients with COD has increased significantly. These clients exhibit a wide range of both SA and MH disorders and include both SMI and non-SMI. Thus, CDS conceptualizes COD very broadly and uses the state's Four Quadrant Model in assessing its client population. CDS is licensed by OASAS to provide chemical dependency treatment.

CDS serves both adolescents and adults. COD cases include both groups. Clients include those who are Medicaid-eligible and Medicaid-ineligible, TANF recipients, the elderly, those with HIV/AIDs, and forensic cases. The program serves very few homeless patients.

### **Services Offered to the COD Population**

For both MH and SA, CDS provides a mix of outpatient services, including individual and group treatment, case management, vocational rehabilitation, self-help/peer support services, and medication management. The program also operates a 16-bed detoxification unit. CDS does not utilize any formal, external treatment models; rather, it has developed its own approaches to treatment, (e.g. continuum of care of three COD treatment modules).

Most clients receive some form of both individual and group treatment (e.g. specialized COD groups). Clinicians attempt to tailor treatment plans to individuals' needs as much as possible. They generally begin by helping patients understand the relationship between MH and SA disorders. Getting clients to accept that they have an MH disorder is often a challenge.

Program staff screen all new clients for both types of disorders using a homegrown screening instrument and maintain ongoing assessments with standardized and non-standardized tools. In the future, they may adopt an MH screening instrument being piloted by OASAS (modified mini-international neuropsychiatric interview). For assessments, the staff use a homegrown mental status exam and a standardized mini-mental status exam (in select cases). In addition, they conduct psychosocial, psychiatric, family history, and SA history assessments, as well as diagnostic summaries, using homegrown instruments.

CDS has formal interagency agreements with other programs (e.g. housing) and maintains informal relationships (e.g. referrals) with other units within the organization and with external providers. Thus, it often receives patients who have left Lutheran's inpatient psychiatric unit for outpatient care, and receives patients from the Mental Health Unit upstairs. Some COD clients receive parallel treatment, obtaining SA

services from CDS and MH treatment from the Mental Health Unit. However, the vast majority of CDS's COD clients obtain all their needed services from CDS staff in an integrated fashion.

### **Treatment Implementation and Staffing**

CDS has 24 clinicians on its staff, and 8 are capable of providing both SA and MH services. These staff are not dually certified but have received extensive training in both disciplines. Clinicians have a wide range of backgrounds and include one psychiatrist (who is co-located at the Mental Health Unit for two days per week), several MSWs, and nine credentialed chemical dependency counselors.

A single clinician oversees care for a given client. The clinician develops a treatment plan, which is reviewed by a supervisor and the psychiatrist. Treatment plans are also discussed during regular staff meetings and during case rounds. The psychiatrist is in charge of medication management for all clients. Staff are supervised very closely, and supervision does not vary by whether services are provided to COD or singly diagnosed clients.

All program staff are on the same floor of a single building. Lutheran's Mental Health Unit is only one floor above them, an HIV/AIDS services unit is one floor below them, and a day treatment hospital is two floors below them. Program staff maintain close working relationships with staff in these programs, as well as with staff at Lutheran Hospital, which is only a half-mile away.

### **Financing Issues**

Because the program has a chemical dependency license only, it must rely mainly on SA system funding. 90–95 percent of all clients are assigned a primary SA diagnosis; therefore, staff usually bill for services using SA codes. (COD clients typically have a secondary MH diagnosis.) CDS depends a great deal on Medicaid FFS funding, as well as on federal block grant and city funding. In addition, CDS receives some private pay revenue through use of a sliding fee scale and some revenue from commercial insurers. Billing Medicaid—and billing in general—has not been problematic for CDS. Last year, the state carved SA services (except for detox) out of the Medicaid managed care program, which has made it easier to bill for SA services.

### **Training and Quality Assurance**

CDS has relied heavily on training to ensure that its staff is capable of treating both types of disorders. Most training is provided in-house, although the program has sent staff to training sessions on COD sponsored by OASAS and OMH. However, some of the state-sponsored training sessions have been too rudimentary for their needs, since CDS has been focused on treating COD for many years. Much of the in-house training has focused on making proper assessments for COD and on relevant diagnostic categories. Training includes a competency exam for all clinical staff.

The program does not utilize any quality improvement initiatives that are specific to COD, although it does employ general performance indicators and reviews outcome measures tracked by OASAS.

### **Facilitators for Providing Co-Occurring Treatment and Sustainability of Services**

A major facilitator has been CDS's participation in several federal demonstration projects since the late 1980s, some of which pertained to COD treatment. Other facilitators include a heavy emphasis on training; having a psychiatrist on staff; the program's proximity to the Mental Health Unit and other programs; and the establishment of inpatient psychiatric and detox units. Program administrators also note that the increase in the number of COD clients that they see has forced them to address COD issues head on.

The agency would like to make COD services more specialized in the future but is awaiting more guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA) about best practices and performance indicators, as well as the OMH/OASAS follow-up report on COD treatment guidelines.

### **Barriers to Providing Co-Occurring Treatment**

CDS relies heavily on a single psychiatrist and would like to hire more. Currently, patients must wait an average of eight weeks for a routine psychiatric assessment. In addition, access to medications is limited for patients who lack prescription coverage.

## Chapter 6. Ohio State Profile

### **COD Population Focus**

Ohio has separate MH and SA treatment authorities—the Department of Mental Health and Department of Alcohol and Drug Addiction Services, respectively. Both authorities have focused principally on the COD population with severe mental illness, although the SA treatment agency has also developed some pilot programs that target individuals with SA and gambling addiction.

### **Financing and Access to Services**

Ohio is a home-rule state. This means that federal and state financing for MH and SA treatment passes through the state to 50 local boards, which contract with and provide oversight to local providers. Local boards also control funds generated through local levies. Strong state leadership has nonetheless been able to push forward a broad initiative (begun in 1998) to develop integrated COD services for the population with severe mental illness. In the first stage of this initiative, the state MH and SA departments solicited proposals from local boards and targeted funds for the implementation of integrated COD treatment services in nine sites, based on the New Hampshire/Dartmouth treatment model. The initiative was termed the Substance Abuse and Mental Illness, or SAMI initiative. Both the MH and SA authorities contributed funds to support the SAMI initiative. The SAMI project lasted about 3.5 years.

To further expand evidence-based COD treatment services, the department of mental health created a SAMI Coordinating Center of Excellence (SAMI CCOE), focused on COD services. (Six other CCOEs in Ohio focus on other treatment services.) The CCOEs partner with the State to market and disseminate evidence-based models into the local provider communities and to provide technical assistance and training. While the COD CCOE is mainly funded through the state MH department, the SA authority has also contributed some funding. As a result of these initiatives, access to integrated services is available in over 20 of 50 mental health board areas around the State. There has been little effort in the state to develop COD services (either integrated or parallel) for those with less than severe mental illness.

Integrated COD services are financed through a combination of Medicaid (including utilization of the Medicaid Rehab Option) and other community resources but not by the SAMI CCOE. Provider agencies jointly certified as MH and chemical dependency programs deliver services. Mental health benefits covered for adults by the state's Medicaid FFS plan include inpatient, physician, outpatient, day treatment/partial hospitalization, case management, and pharmacy services. Substance abuse services covered by Medicaid FFS include inpatient detox, outpatient detox, outpatient, case management, methadone therapy, and pharmacy services. Residential, vocational, self-help/peer support and inpatient (detox plus) services are not covered.

While there are some Medicaid managed-care health plans in Ohio that are required to coordinate with local boards around behavioral health benefits and services, all behavioral health services are reimbursed using a prospective based budget to set rates that are reconciled at the end of billing periods on an FFS basis. Mental health services covered by the Medicaid Managed Care plan include inpatient, physician, case management, and pharmacy. Covered substance abuse services include inpatient detox, outpatient detox, outpatient, case management, methadone therapy, and pharmacy services. Services not covered include residential, vocational and self-help/peer support, mental health outpatient, day treatment/partial hospitalization, and substance abuse inpatient (detox plus) services. The state operates a common client

billing system for SA and MH treatment services, which maps to Medicaid reimbursement codes and facilitates Medicaid reimbursement for COD services. Currently, different components of COD services are billed and reimbursed separately, but the MH authority is working with the Medicaid agency to develop a bundled rate for ACT services that would be applicable to IDDT model COD services.

Over the years, the State has effectively leveraged Medicaid funds for both MH and SA services. However, services for the non-Medicaid population in both the MH and SA system have been limited since a very large share of state and local MH dollars are directed to the Medicaid match and the system's ability to provide services is severely strained. Some MH providers are redefining priority populations and services because of these resource problems.

### **Collaboration and Consensus Building**

The state MH and SA authorities describe their relationship in developing COD services as “cooperative” rather than “collaborative.” While the SA authority has been at the table and contributed funding and training expertise to the state's major COD initiatives, the MH authority has been the leading agency. Because the COD service initiatives have focused on the SMI population and have relied heavily on Medicaid funding, the initiatives are not central to the mandate of the SA authority, where the population to be served is largely neither Medicaid-eligible nor severely mentally ill. The Medicaid agency has played a supportive role in the development of COD services, working closely with the MH and SA agencies in determining service coverage and reimbursement rates. Broader consensus building (for example, with NAMI and with consumers) has occurred largely at the local level.

### **Training and Workforce Development**

The CCOE is responsible for training and implementation of COD services at the provider agency level. There is no cost to the agency. The SAMI CCOE and the MH department also sponsor an annual conference that offers statewide training on a voluntary basis. All training is based on the IDDT model and has included external trainers from the Dartmouth group, as well as training and curriculum developed by Case Western Reserve University. While the SA agency was involved in MH and SA treatment provider cross-training in an early phase (prior to 1999), this training effort has not continued. There are no plans by either authority to develop special credentials or licensing for COD services, or standards for COD competencies.

### **Information and Data Systems**

The MH department is working toward developing a standardized record keeping instrument to be used by all MH providers that will include information about COD. The MH department maintains a sophisticated outcomes measurement and reporting system, but as yet, the system does not address outcomes specific to the COD population. The SA authority does not intend to implement a standardized intake system, but it is developing an outcomes measurement system that is independent of the one maintained by the MH authority system. While there appears to be no plans to link information across the two systems, MH and SA have implemented a client focused information system referred to as the Multi-Agency Community Services Information System (MACSIS), that allows both departments and their local boards to manage, measure and monitor the service utilization of Medicaid and state and local public funding.

### **Quality Assurance/Quality Improvement**

Quality oversight is a responsibility of both the local boards and the state. The State specifies quality requirements from local boards. Local boards contract with local provider agencies and review quality assurance aggregate plans and accomplishments. The State certifies agencies and licenses residential and other facilities such as private psychiatric hospitals.

The SAMI CCOE is a vehicle for influencing and encouraging quality improvement among providers and with the mental health and/or substance abuse local boards. For example, the SAMI CCOE, in partnership with the State, measures adherence to the New Hampshire/Dartmouth model at least yearly. This information is compared over time and benchmarked with state and national provider groups. The agency may choose to share this information with the local boards.

### **Pilot Projects**

The state is participating in a multi-state research project that is implementing and evaluating integrated COD treatment at using the New Hampshire/Dartmouth model in 8 sites. Unlike the earlier SAMI initiative, this demonstration project uses recently developed “toolkits” that include implementation guidance, training protocols, and standardized fidelity monitoring.

## **Local Program Profile**

**Local Program:** Central Ohio Mental Health Center, OH

### **Type of Agency and COD Population Focus**

Central Ohio Mental Health Center is a private non-profit MH agency that primarily provides MH services and a special (SAMI) program for COD in two (Delaware and Morrow) counties. The Center is the only community MH center in its two-county area. The Center is one of the national evidenced-based Toolkit dual diagnosis sites (see Appendix A) and is applying for SA certification so it can become a dually certified agency.

Currently, the Center serves a general outpatient population of persons who have primary and/or secondary MH and SA DSM-IV diagnoses, including SMI and non-SMI, Medicaid-eligible and non-eligible, children and families, persons who are homeless, persons who have HIV/AIDS, and forensic histories. Approximately 50–60 percent of adult SMI clients served by the Center have COD.

### **Services Offered to the COD Population**

Except for ACT and SAMI (the Center's specialized COD/Toolkit program), the same services are delivered in both Delaware and Morrow counties. Delaware County provides services mostly for the SMI COD population and a general outpatient population, including children and families and emergency services. Morrow County provides services to a general outpatient population. SAMI team staff travel between counties to deliver specialized COD team services.

The Center directly provides an array of services, including screening, assessment, individual, group, dialectical-behavioral therapy (DBT), psychosocial rehabilitation, ACT-Lite, SAMI, case management, physician services, family intervention, medication management, residential treatment, 24-hour emergency behavioral health services and triage services. Informal and formal linkage activities with other agencies allow the Center to offer detox, vocational rehabilitation, self-help/peer support, consumer outreach, housing and forensic services. To limit travel, most referrals for such services are within a client's county of residence.

Toolkit services have been in place since August 2002. ACT-Lite has been in place since October 2002. The original SAMI services started in 1996.

### **Treatment Implementation and Staffing**

The Center has 33 staff in Delaware county and 15 staff in Morrow county, 7 of whom comprise the SAMI team and are able to deliver COD services on COD or ACT teams, or individually. While some staff are dually certified, this is not a requirement to provide services. To implement the Toolkit model, some staff were restructured and others were hired with dual credentials. Changes in the peer review process were also made to help maintain fidelity to integrated models of care. Recently, both team leaders for ACT and SAMI left the Center. The plan is to hire one person to cover both jobs to forge a cross-training model.

The Center delivers both integrated and parallel COD treatment through four models of care: the dual diagnosis integrated Toolkit SAMI model, ACT-Lite, and general menu of MH services. The Toolkit and ACT-Lite approaches are used with clients with more severe MH and/or SA disorders. Clients with less severe disorders receive the other services. All clients are screened and assessed on their first visit with homegrown and standardized instruments. Currently, COD teams can treat only about 40 severe or SMI clients.

Different modes of COD treatment are associated with two treatment plan approaches. A single integrated treatment plan is generated for clients who receive integrated team or individual treatment. Two treatment plans, which need to be coordinated, are generated for clients who receive parallel treatment (e.g., MH treatment at the Center and SA services in an outside agency). Staff who deliver COD treatment via the SAMI team or individually, receive supervision by one of staff member who is dually credentialed. In general, the Center is learning how to provide more specialized supervision for mental health and substance treatment.

### **Financing Issues**

The Center's most important funding sources are Medicaid and state general revenue. The local MH board funds and evaluates the Center's services. The board distributes Medicaid and state dollars, and its matching funds, to the Center and reimburses services rendered through a FFS system. Of the Center's \$6 million budget, \$300,000 is used for COD treatment.

A new statewide billing process has established payment rates based on bundled services. While there is a unit cost for every service provided, there is no separate cost rate for COD. This new process has had some initial problems; delays in payment to providers continue, and redefinitions of services (e.g., the amount of time associated with whether a service can be billed) are beginning to reshape service delivery. When the Center becomes a certified SA provider, it will constantly need to determine which system to bill for services. Since SA services are typically reimbursed at a lower rate, the Center anticipates that it will bill to MH codes more often.

### **Training and Quality Assurance**

The Center is engaged in ongoing training activities that are provided by the SAMI-CCOE, other outside consultants, in-house staff, and state conferences. Most training is done in Delaware County, which at times poses coordination difficulties with staff in Morrow County. The SAMI CCOE provides training in Toolkit implementation and integrated COD treatment, as well as other types of training. The Center and the SAMI CCOE are planning a spring training on SA assessment. In-house motivational interviewing, stages of change, and DBT trainings are also planned. The Center is determining how to implement a consumer-to-consumer training model more effectively.

The Center uses general quality assurance/quality improvement methods, such as utilization review, to support all services, including COD. While standards for competency are covered in supervision, the Center has adapted the SAMI CCOE fidelity measures to develop a COD team fidelity measure. The Center collects performance indicators and service utilization for COD. These indicators, and other outcome measures important to the Center, the state, MH board and SAMI CCOE, are tracked. The Center and SAMI CCOE are determining how to best use all these indicators.

## **Facilitators for Providing COD Treatment and Sustainability of Services**

The Center's desire to make changes to better serve the COD population and achieve more positive outcomes has been the biggest facilitator in providing COD care. Implementing the dual diagnosis Toolkit has helped to identify service and training gaps and has solicited positive feedback from consumers. Consultations and trainings provided by the state SAMI CCOE have also had a huge impact on staff competency and programming. Outside consultation was instrumental in securing the support of the local county board (see below) to move toward the use of an integrated treatment model.

Even though the Center considers its chance of sustaining COD services to be 50/50, and funding to be its greatest barrier, it is still optimistic that its COD services will continue. Ongoing consultation with the SAMI CCOE is key in supporting this effort. The Center has plans to expand integrated COD services by continuing to make changes in staffing and training.

## **Barriers to Providing COD Treatment**

The Center's biggest initial hurdle to implementing integrated COD services was the local county board. It took time, as well as meetings with an independent consultant and the SAMI CCOE, to stop the board's advocacy of the parallel treatment approach and to decrease its resistance to an integrated treatment model in which one team delivers services. Lack of start-up funding for COD services remains a problem for the Center, as it lost thousands of dollars implementing the Toolkit project. The Center is also concerned about the potential for staff turnover and about the fact that the state's universities are not training new professionals to deliver COD services effectively.

## Chapter 7. Oregon State Profile

### **COD Population Focus**

The public MH and SA systems in Oregon are integrated at the state departmental level within the Office of Mental Health and Addiction Services (OMHAS). OMHAS functions under the same umbrella agency as the Medicaid Agency, the Department of Human Services. The two agencies work very closely together, and OMHAS plays a major role in managing MH and SA services for the Medicaid population (as well as for the non-Medicaid population). Though OMHAS administers both the public-sector MH and SA treatment systems, the two systems are largely separate because of separate funding streams and regulations.

County governments exercise a great deal of authority and discretion over the MH and SA services in their counties. Most counties contract with Community Mental Health Centers (CMHCs) to provide all public MH services and many SA services. There are 33 CMHCs (including one Native American CMHC) operating in a total of 36 counties. SA services are provided by a variety of provider agencies, including CMHCs. Most counties do not contract with MCOs (but rather serve as the MCO for MH, contracting with the state Medicaid Agency and OMHAS).

OMHAS officials conceptualize COD broadly, defining the COD population as those suffering from both types of disorders, and not exclusively those with SMI. Agency staff are familiar with the Four Quadrant Model for characterizing COD and use the model to some extent in thinking about the population and planning services.

### **Financing and Access to Services**

The MH and SA service systems operate under separate funding streams. Most significantly, the Medicaid agency contracts with MCOs on an at-risk basis to manage both physical health and MH. MH is carved out to separate plans, and SA is folded into the physical health benefit. The Medicaid Agency contracts with ten MH MCOs, and eight of these are county agencies or regional organizations created by two or more adjacent counties. There are between 15 and 20 physical health MCOs. Both MH and physical health managed-care arrangements are statewide, except for a few very rural areas with a small number of health care providers. In those areas, and in some counties in which MH MCOs have dropped their contracts with the Medicaid Agency, Medicaid MH benefits are funded on an FFS basis.

Benefits for adults that are covered vary depending on Medicaid FFS or Medicaid managed care plan. Medicaid FFS benefits for mental health include inpatient, physician, outpatient, day treatment/partial hospitalization, case management, pharmacy, residential, and vocational services. For substance abuse they include inpatient detox, outpatient, methadone therapy, pharmacy, and residential services. Mental health benefits covered under the state's Medicaid Managed Care plans include inpatient, physician, outpatient, day treatment/partial hospitalization, case management, vocational and self-help/peer support services. Covered substance abuse benefits include inpatient detox, outpatient detox, outpatient, case management, methadone therapy, and pharmacy services. Medicaid FFS does not cover self-help/peer support for mental health, and does not cover inpatient (detox plus), outpatient detox, case management, vocational, and self-help/peer support services for substance abuse. Benefits not covered under the Managed Care Plan include mental health pharmacy and residential, and substance abuse inpatient (detox plus), residential, vocational and self-help/peer support services.

OMHAS and Medicaid officials believe that the structural separation between MH and SA poses a challenge for providers attempting to serve the COD population, especially if they are pursuing an integrated treatment model. OMHAS and Medicaid officials would like to see the MH and physical health MCOs interact more closely. However, OMHAS officials believe that managed care has facilitated the delivery of care to the COD population.

The structural divide is further complicated by enduring philosophical differences between some MH and SA provider agencies and staff. Despite these philosophical differences, Oregon has move steadily toward providing COD services in an integrated fashion. Overall, providers offer a mix of parallel and integrated services, with most Quadrant IV clients (high severity MH and SA disorders) receiving some type of integrated treatment, usually in a CMHC. In the most rural areas, access to services is more limited, with fewer providers and greater distances that people must travel. In these areas, outreach efforts are crucial, and certain interventions, such as peer support groups, are impractical.

Other funding sources include the federal SAPT and CMHS block grants, Medicaid Rehab Option, state general revenues, and county government revenues. Oregon maintains separate billing systems for MH and SA. For Medicaid, there is no COD treatment billing code; rather, there are separate codes for each type of disorder.

In recent years, Oregon has sought to expand services and health coverage for the poor, including those with a COD. In particular, state officials have recognized that access to care has been limited for low-income people ineligible for Medicaid. In October 2002, the state received a federal waiver to expand Medicaid coverage to low-income people who do not meet categorical eligibility criteria. The newly eligible were primarily pregnant women and children and childless adults with incomes up to 185 percent of the federal poverty level, including people with a COD. However, facing declining revenues, the state legislature has recently enacted mandatory premiums and co-payments for this population, and many have left the Medicaid rolls as a result.

OMHAS has also reduced administrative barriers to providing coordinated or integrated treatment and has worked to eliminate the misconception among some providers that separate assessments and treatment plans for MH and SA are required (SAMHSA, 2002). As an additional means of encouraging coordinated or integrated treatment among providers, OMHAS has revised MH and SA program regulations so that they are more closely aligned.

### **Collaboration and Consensus Building**

State MH and SA officials began investigating ways to improve service delivery for the COD population in the mid-1980s. A state-level Dual Diagnosis Task Force was convened and published a report in 1986. A second task force, convened in 1999, produced a report in 2000. Drawing on Ken Minkoff's ideas, the report presents recommendations for improving the system of care for COD at both the state and provider levels and includes specific descriptions of what constitutes COD "capable" and "enhanced" care (SAMHSA, 2002). The report also spells out guidelines for providing culturally competent care to the state's large Native American and Hispanic populations. In the future, OMHAS may develop financial incentives to encourage providers to meet these guidelines. OMHAS has been working to implement the report's recommendations about the easement of regulatory and administrative obstacles to providing

coordinated or integrated treatment, but this work has slowed recently as attention has shifted to dealing with budget cuts.

The Medicaid Agency has been directly involved in OMHAS's planning activities since 1995, when it added MH services to the array of services offered under managed care. The agency also has a Medicaid Policy Council, which works to ensure that other agencies inside and outside of DHS are kept informed of Medicaid policy and funding changes and whose members interact closely with staff from OMHAS and other agencies on COD and other issues.

OMHAS has also made efforts to involve consumer advocacy organizations in the planning and consensus-building process. Consumers had representation on the second Dual Diagnosis Task Force, and OMHAS maintains a working relationship with the state's NAMI chapter.

### **Training and Workforce Development**

OMHAS and Medicaid officials have emphasized training as a means to improve coordination and integration of care for the COD population. In particular, the state has sponsored annual one- to three-day training sessions for provider staff in both systems since 1986. Each year, external trainers lead sessions on COD assessments, referrals, and treatment options for approximately 50 people. In recent years, this training has focused on Quadrants I (low severity MH and SA disorders), II (high severity MH and low severity SA disorders), and III (low severity MH and high severity SA disorders) of the COD population. OMHAS staff would like to target more training to Quadrant IV (high severity MH and SA disorders) as well, to improve the quality of integrated treatment that population is receiving. In addition, some counties and CMHCs have contracted with Minkoff, Drake, Pepper, and other consultants to provide technical assistance.

### **Information and Data Systems**

OMHAS mandates that MH and SA providers' assessments include domains for both types of disorders, but it does not require the use of a standardized assessment instrument. The agency also requires providers in each system to share clinical information. MH and SA service data are entered into the same database, but the Medicaid Agency maintains a separate data system. OMHAS and the Medicaid Agency are in the process of investigating ways to integrate the two data systems.

### **Quality Assurance/Quality Improvement**

Neither OMHAS nor the Medicaid Agency is implementing any quality improvement models or performance indicators specific to COD. OMHAS is interested in possibly doing so in the future, if funding becomes available. As a first step, OMHAS officials plan to identify the kinds of outcomes they want to achieve and measure for the COD population.

### **Pilot Projects**

State officials are not currently pursuing pilot or demonstration programs. Rather, they are more interested in pushing broad, systems-level changes to improve service delivery for the COD population.

## **Local Program Profile**

**Local Program:** Best Care Treatment Services, OR

### **Type of Agency and COD Population Focus**

Best Care Treatment Services is a private, nonprofit provider of integrated SA and MH services, with facilities in the towns of Redmond, Bend, and Madras, in central Oregon. Best Care was established in 1997 by a partnership among four local behavioral health agencies: Network Behavioral Healthcare/Bridgeway, ADAPT, New Directions Northwest, and the Center for Human Development (Best Care website). The program operates in a very rural—almost frontier—area of the state and serves as the sole CMHC for Jefferson County.

The agency began exclusively as an SA treatment provider, but gradually added MH services and expertise to several of its programs. It currently provides a large menu of residential and outpatient services to a diverse client base, including those with an MH and SA diagnosis only, and those with a dual diagnosis. COD clients account for approximately 60–70 percent of the agency’s total caseload.

Best Care serves both SMI and non-SMI clients. Based on a full assessment, clients are assigned to one or more of six MH diagnosis categories: chronic psychosis, bipolar, PTSD, borderline disorder, adult Attention Deficit Hyperactivity Disorder (ADHD), and depression/anxiety. With regard to SA, COD clients’ disorders span a wide range in terms of severity. The most common types of SA disorders exhibited are abuse of alcohol, marijuana, methamphetamines, and prescription drugs. A growing number of clients are heroin abusers, but their numbers remain relatively small.

The agency serves adults only, including Medicaid-eligible and Medicaid-ineligible clients, TANF recipients, the elderly, and HIV/AIDs, homeless, and forensic cases. In addition, the agency serves a large Native American and Hispanic population.

### **Services Offered to the COD Population**

Best Care offers an extensive continuum of care for COD clients through a wide array of outpatient and residential programs. Services include screening and assessment for both MH and SA disorders, individual and group therapy, case management, drop-in self-help/peer-support services, illness management, medication management, a social detoxification program, and a residential treatment program (in which clients typically remain for 30 to 60 days). Additional services include dialectical behavior therapy, outreach/crisis intervention (though not using the ACT model), and specialized services for Spanish-speaking clients (including a separate Spanish-speaking residential program).

Agency staff draw on a variety of treatment models, including the New Hampshire/Dartmouth integrated model (for the SMI population), Najaritz’s “Seeking Safety” model, Sullivan’s “Treating the Addicted Survivor” model, and Mason’s model for illness management and schizophrenia diagnosis, as well as on Copeland and Bourne’s workbooks on depression, anxiety, and phobias.

All clients are screened and assessed at intake. Staff do not use an integrated screening or assessment instrument, but instead screen and assess based on whether the client has requested MH or SA services. Nonetheless, the instruments used include questions that address both sets of disorders. For MH, staff use

a homegrown screening tool and a standardized biopsychosocial assessment instrument that they have modified for their own use. For SA, staff use ASAM screening criteria and a screening tool developed by a local MH MCO, and a homegrown, comprehensive assessment tool.

Best Care has interagency agreements with several other providers, such as a local hospice crisis center, hospitals, and the local health department. Some clients are referred to these agencies for case management and wraparound services. Best Care also refers clients to employment counseling programs, but it is developing its own vocational rehabilitation program.

### **Treatment Implementation and Staffing**

Best Care has not had to relocate or reassign staff to treat COD clients. In each of its three outpatient facilities, all staff are located on the same floor of the same building. The residential program is located in a separate building, but program staff coordinate closely with outpatient staff (e.g., when a client leaves the residential program but still needs periodic outpatient services).

Approximately 80 percent of the clinical staff has expertise in SA treatment, while the remainder has expertise in MH. Each client has a primary therapist who oversees a single treatment plan for the client. However, services are provided through separate MH and SA treatment teams (with the primary therapist leading one of these teams). Most clinical staff are certified in one field or the other; Oregon does not offer a dual certificate or license. Nevertheless, teams work closely together in developing and implementing a treatment plan for each COD client. They also involve the client in treatment planning (e.g., having the client identify goals). Supervision of treatment for COD clients does not differ from supervision of treatment for those with a single diagnosis.

### **Financing Issues**

The agency pays for services through a variety of sources. Medicaid is its most important funding source, followed by federal SAPT and CMHS block grant funds, and state general revenue funding (which has been declining sharply). Best Care receives no local government funding. Private pay has become increasingly important, and the agency receives a small amount of private donations.

Best Care must bill separately for MH and SA services under Medicaid. Residential services must be billed under SA codes, because the residential facility has only a state SA license. Best Care's outpatient programs are dually licensed in both fields, and are thus able to bill Medicaid under both sets of codes. In general, however, the agency reports that it experiences few problems with billing Medicaid and notes that Medicaid managed care has resulted in greater flexibility at the provider level in delivering MH services.

Because funding streams for MH and SA services are generally separate and have distinct reporting requirements, administrative staff maintain separate files and spend much time carefully tracking resources. The agency views the bifurcated funding system as an administrative burden, but attempts to make services as seamless as possible for clients. Moreover, in the face of decreasing state general revenue funding, Best Care has recently laid off some of its administrative staff.

## **Training and Quality Assurance**

Best Care receives no funds for training from the state and has few other sources of training funds. Thus, most training is done in-house, typically with staff certified in one field leading cross-training sessions for staff in the other field. The agency does send staff to external training sessions sponsored by the state or other organizations, but there are few of these opportunities. A regional MCO offers training and certification in drug and alcohol abuse, and Best Care occasionally enrolls staff in those classes.

Best Care does not utilize any specific quality improvement models or standards. The agency has implemented aspects of certain models in the past, such as the Deming and NCQA models. But management and staff are still exploring how they will define and measure “quality improvement.” The agency has also not developed performance indicators or outcome measures that are specific to COD, but it may pursue this in the future.

## **Facilitators for Providing COD Treatment and Sustainability of Services**

The most important facilitator of Best Care’s implementation of services for COD clients has been strong and stable leadership. Executive Director Rick Treleaven, who has led the agency almost since its inception, has substantial clinical and management experience in both fields. He led the effort to incorporate a MH component into a treatment menu that was focused on SA. In addition, directors of individual programs are committed to treating both disorders and have been with the agency for some time. Management and staff have also found much of the recent literature on COD to be very useful at the clinical level. They did not find earlier research literature to be particularly useful.

In the future, agency administrators also hope to market their residential program to the MH MCOs as an alternative to hospitalization for COD clients.

## **Barriers to Providing COD Treatment**

In addition to the burden of a bifurcated funding system (mentioned above), lack of funding has been a major barrier to serving the COD population. The recent decline in state funding has been especially problematic. Maintaining a staff that is well trained in COD has been a challenge, both because of limited training funds and the philosophical differences of the MH and SA fields. Best Care has had to replace some SA treatment staff that were not inclined to receive training in MH. Similarly, some MH clinicians have difficulty understanding the issues surrounding addiction.

## Chapter 8. South Carolina State Profile

### COD Population Focus

South Carolina has separate MH (Department of Mental Health) and SA treatment (Department of Alcohol and Other Drug Abuse Services) authorities. However, for the past two years, these agencies (and others) have been working together on an interagency initiative (the SAMI Collaborative) to improve care for persons with COD. The state has a broad population focus—both on those with a primary mental disorder in the MH system and those with a primary SA disorder in the SA treatment system.

### Financing and Access to Services

South Carolina is attempting to move from the prevailing model in which COD services, if provided, are delivered in a parallel fashion to a model of integrated care. The predominant model care for COD, given separate systems and provider agencies, has been that persons identified as needing COD services in one provider agency are referred to another service provider for relevant services. However, there are also some MH and SA centers in South Carolina that have co-located MH and SA staff to form teams that deliver integrated COD services.

Recently, the MH and SA agencies have taken the lead in an interagency collaboration focused on addressing the needs of persons with COD (called the SAMI Collaborative); the Medicaid agency has been involved and supportive of the collaborative. The state hopes to develop better systems and more integrated care for persons with COD and expects that integrated COD care will be largely financed through Medicaid FFS billing.

The Medicaid FFS plan has broad coverage (which includes utilization of the Medicaid Rehab Option), which for adult substance abuse patients includes reimbursement for inpatient detox, inpatient detox plus, outpatient detox, outpatient, case management, methadone therapy, and pharmacy. Covered mental health services include inpatient, physician, outpatient, day treatment/partial hospitalization, case management, pharmacy, residential, vocational and self-help/peer support services. Residential, vocational and self-help/peer support services are not covered for substance abuse. While voluntary Medicaid managed-care plans are operating in some regions of the state, these plans carve-out MH and SA services. Thus, MH and SA services for the Medicaid beneficiaries are reimbursed on a FFS basis. As part of the SAMI Collaborative, the MH and SA agencies are working with the Medicaid agency to develop a distinct billing code for Medicaid-reimbursable COD services. (Currently, the services are billed for under either a MH or SA code.) However, the state is currently faced with a budget deficit and so financial resources are limited. As a result of the state budget crisis, in the future, cuts are likely to be made in rates service providers receive for Medicaid-reimbursable services.

While the state in principle has a broad population focus on persons with COD in both the MH and SA systems, in practice, there are considerable financial barriers to providing COD services for the non-Medicaid-eligible indigent population. The SA agency budget is particularly constrained now, limiting even basic services to the indigent; thus, supporting integrated services is a challenge in this fiscal environment. Low reimbursement rates for SA services may discourage providers from identifying those with COD. The MH agency also experiences financing limitations in providing services for the non-Medicaid population. The agency has recently experienced state budget cuts, and they are hoping to

obtain additional federal funding (e.g., through the SAMHSA COSIG grants) to help provide COD services for the non-Medicaid uninsured population.

### **Collaboration and Consensus Building**

Consensus building began two years ago with the creation of the SAMI Collaborative, which brought together the MH and SA agencies, as well as the Medicaid agency, hospitals, sheriffs, and others. The activities initiated by this collaboration included a first annual conference on COD in October 2002 (that featured Ken Minkoff and others). The initiative to fund the integrated treatment pilot programs was also developed as part of this Collaborative. Representatives from these agencies continue to meet monthly to improve services for COD and are working on issues such as a Medicaid billing code for COD services, a standardized intake form, and, ultimately, a common MH/SA data system. Overall, there is a great deal of excitement about the progress that has been made in developing interagency relationships and improving COD services; there is also optimism that further improvements in services will be implemented and sustained through this collaboration.

### **Training and Workforce Development**

The annual conference on COD in October of 2002 was the first major training activity for COD and was attended by MH, SA, and other providers. Conferences are planned annually, including 2003 and 2004. The pilot projects have developed site-specific plans to address staff training needs. Other cross training sometimes occurs at the local level but not systematically across the state (e.g., Kathleen Brady of the Medical University of South Carolina is brought in as a consultant to do training).

To meet ongoing training needs, the MH agency is working with two universities to develop Centers of Excellence (modeled after Ohio) to support evidence-based practice with tools and ongoing training for integrated treatment for COD and other evidence-based practices.

There is interest in the Dual Diagnosis toolkit (see Appendix A) to use in the state's further training efforts. While the toolkit has been requested, it has not yet been received. The MH agency envisions the centers of excellence rolling out evidence-based practices for COD services using the toolkit, but the SA agency notes that the toolkit has limited applicability to SA treatment settings.

### **Information and Data Systems**

The MH agency has developed a standardized intake instrument that includes MH and SA domains, while the SA agency is working on developing one. Currently, the SA agencies have a uniform clinical records system that includes MH and SA assessment domains. At the time of our interviews, both the MH and SA agencies maintained separate data collection and information technology systems, and these did not link.

Currently, providers do not share clinical information because of concerns about privacy and HIPAA regulations. A longer-term goal, however, is to develop a single, shared web-based medical record and linked MIS systems, with appropriate privacy protections in place.

Furthermore, Medicaid claims data are not yet linked to either MH or SA data. The Medicaid agency has signed a formal agreement to form a relationship with the other two agencies to combine data across

agencies in a data warehouse and to create procedural reports that can provide comprehensive information on services by provider and diagnosis.

### **Quality Assurance/Quality Improvement**

Aside from evaluations of the pilot projects, there is little in the way of quality assurance for COD services. However, the MH agency is planning to mandate that all MH centers use performance measures relevant to COD services and to require that every MH center have an MOU with the SA provider agency. The MH agency is working with SAMHSA to develop performance contracts with CMHCs that will include these mandates. The MH agency is also anxious to get the Dartmouth-developed toolkits from SAMHSA (see Appendix A) to begin to promote and monitor fidelity to evidence-based integrated care for COD. The Centers of Excellence will be a vehicle for promoting quality improvement by providing training and technical assistance to support evidence-based practices and will also likely involve a focus on monitoring the fidelity with which delivered services correspond to evidence-based guidelines.

### **Pilot Projects**

As part of the recent SAMI Committee, the MH agency recently provided funds for MH centers to develop integrated programs in conjunction with SA. The SAMI Committee charged all MH centers and SA commissions to jointly develop community teams that were comprised of MH, SA, law enforcement, judges, hospitals, advocacy groups and other local groups interested in providing COD care. Twelve MH centers submitted proposals to compete for these funds, with four funded in the first round. Plans are to fund four additional pilot sites in the near future, and ultimately, to implement integrated treatment for COD statewide. All community teams, including the pilot sites, were charged to develop a plan of action for collaboration (across SA, MH, law enforcement, hospitals, and other groups) using a process, and guidelines/principles from Minkoff best-practice recommendations. While the state has set requirements for the pilot sites, most of the action (in terms of needs assessment, planning, and implementation) is at the local level.

## **Local Program Profile**

**Local Program:** Spartanburg Alcohol and Drug Abuse Commission, SC

### **Type of Agency and COD Population Focus**

The Spartanburg Alcohol and Drug Abuse Commission (SADAC) is a public SA treatment agency that serves Spartanburg County, South Carolina. SADAC provides an array of SA services, but recently has begun to also offer MH services to COD patients in its detox and intensive outpatient programs. In addition, the agency has a close working relationship with the local MH agency. In general, the two agencies treat COD clients through a coordinated, parallel approach.

SADAC employs a broad definition of COD, considering anyone with at least one DSM-IV MH and one DSM-IV SA diagnosis to have a COD. The agency treats a total of about 3,000 clients per year, and nearly 90 percent are adults. Approximately 25 to 30 percent of the agency's total caseload has a COD. Of the COD population that SADAC serves, most, though not all, are non-SMI cases. Staff often refer SMI cases to the MH agency if they believe they lack the capability to treat these cases.

The agency serves both Medicaid-eligible and Medicaid-ineligible clients. Its caseload used to include TANF recipients, but the agency currently does not receive funds from the state Department of Social Services to treat the TANF population. The agency also treats children, the elderly, and homeless individuals.

SADAC is licensed by the Department of Health and Environmental Control to provide SA services. Agency administrators are unlikely to pursue a MH license because they believe that they can provide the COD population with sufficient services without one.

### **Services Offered to the COD Population**

SADAC has only recently begun to offer both MH and SA treatment to COD clients in its detox and intensive outpatient programs. In addition to these programs, the agency offers clients with SA diagnoses individual and group treatment, case management, physician services, employment assistance (but not vocational rehabilitation), residential services (in the detox program only), driving under the influence (DUI) prevention programs, screening, and assessments. The MH agency manages clients' medications and coordinates with local housing agencies.

Agency staff have not adopted any particular treatment model, especially since they are in the beginning stages of offering COD treatment. All clients are screened and assessed at intake. The agency has adopted a screening tool that is used by the local MH agency and hospital, to which it has added domains pertaining to SA. Assessments are conducted using a biopsychosocial instrument developed at the state level and used by all SA providers throughout the state. (The MH agency uses a different assessment instrument.) Staff also utilize ASAM placement criteria to determine the appropriate level of care for clients.

SADAC has a formal MOU with the local MH agency that lays out guidelines for sharing information on cases (e.g., biopsychosocial assessments) and coordinating care for COD clients. The agreement also stipulates that the two agencies will accept each other's biopsychosocial assessments so that clients are not

assessed twice. (Both agencies also share information on cases with the local hospital, and vice-versa.) In addition, the agency has close, informal relationships with the local hospital and the local sheriff's and police departments. (Spartanburg is one of the SAMI pilot sites.) All are working to reduce the number of admissions of COD cases to the hospital's emergency room by diverting more people to the outpatient and residential programs at SADAC and the local MH agency. SADAC also collaborates informally with a local rescue mission.

### **Treatment Implementation and Staffing**

SADAC has 25 full-time and 15 part-time staff people. Administrators consider all staff to be capable of providing some kind of COD treatment. Nevertheless, most COD clients receive coordinated, parallel treatment from SADAC and the local MH agency. These clients therefore have two treatment plans, one with each agency. For each client, SADAC counselors collaborate closely with staff at the MH health agency. In particular, two alcohol and drug abuse counselors at the MH agency are in regular contact with SADAC counselors. At SADAC, individual counselors (most of whom are MSWs), rather than teams, provide COD services within the detox and intensive outpatient programs.

### **Financing Issues**

Medicaid is the agency's largest funding source. Other sources include federal block grant funds, state general revenue funds, commercial insurance, and client fees. For the past five years, the state Department of Mental Health has provided some funding for SADAC's detox program. More recently, grant funding from DMH under the SAMI initiative has enabled SADAC to add MH services to this program and to its intensive outpatient program. Specifically, SADAC has used the grant to hire three MH counselors.

Since the agency has an SA license only, staff cannot bill to Medicaid MH codes. Financing services to COD clients is a challenge because Medicaid reimbursement rates are substantially lower for SA services in South Carolina.

### **Training and Quality Assurance**

SADAC provides staff with as much COD training as possible, often by sending staff to state-sponsored COD conferences. Agency administrators hope to be able to provide some staff training sessions (most likely by hiring outside consultants) in late 2003 and in 2004 using grant funds from the state DMH.

The agency would like to create and add outcome measures for COD to its data system and hopes to develop the capability to track SMI and non-SMI cases separately. In addition, SADAC plans to implement principles for treating the COD population established by the Florida Department of Children and Families.

### **Facilitators for Providing COD Treatment and Sustainability of Services**

The local hospital has strongly urged SADAC and the local MH agency to focus more attention on the COD population, since its emergency room sees a large proportion of individuals with a COD in the county. Hospital leadership first raised the possibility of reducing ER admissions by having the two agencies provide a more coordinated system of care and by adding MH services to SADAC.

Leadership at SADAC and the local MH agency have also been crucial. The two agencies have a long history of working together. Representatives from the two agencies and the local hospital meet on a monthly basis to discuss ways to address COD and related issues. The funding that DMH has provided over the last five years, as well as the recent SAMI grant, has also been a major facilitator for addressing COD.

Agency administrators plan to continue to serve the COD population well into the future, even if doing so requires them to shift funds from other program activities.

### **Barriers to Providing COD Treatment**

At both the state and local levels, there is sometimes tension between public MH and SA agencies. These tensions have been driven in part by philosophical differences. Within the SA treatment field, some providers remain resistant to the idea that people on medication for a MH disorder can obtain SA treatment simultaneously.

## Chapter 9. Texas State Profile

### COD Population Focus

Texas has separate MH (Texas Department of Mental Health and Mental Retardation) and SA treatment authorities (Texas Commission on Alcohol and Drug Abuse). The priority COD population for the MH authority is persons with serious mental illness, including those with schizophrenia, bipolar disorder or severe depression, or those with a GAF score under 50. The SA authority defines COD more broadly and focuses on those with primary substance dependence disorders.

### Financing and Access to Services

Texas relies heavily on Medicaid and federal block grant financing streams to support public MH and SA services, with very limited general revenue from state or local government. COD services in the MH system are financed largely through the Medicaid Rehab Option, which 40 local MH provider agencies are qualified to provide. For the Medicaid-eligible population, this option allows reimbursement of Co-Occurring Psychiatric and Substance Use Disorders (COPSD) services; some community MH agencies are qualified as both MH and SA providers. The non-Medicaid indigent population has limited access to COD rehab services because of funding constraints that limit capacity to service this population; those without Medicaid often have to wait for care. For most persons receiving COD services in the MH system, the approach is a single treatment plan with support from adjunct services (COPSD Specialists specifically funded to provide this service) that specialize in engagement strategies for persons with COD (jointly funded by TCADA). Patients are also referred to SA services as needed.

COD services in the SA treatment system are financed largely through federal block grant funds. Medicaid reimburses little in the way of adult SA treatment, except for inpatient, case management, detox, pharmacy and methadone therapy. Outpatient, residential and self-help/peer support are not covered. Case management and vocational services are delivered by CMHCs and covered by Medicaid. As a result, the capacity of SA providers to provide on-site COD services to their population is limited. SA providers are expected to assess for and identify mental health problems and to utilize existing adjunct services (COPSD Specialists in specifically funded sites) that specialize in engagement services for co-occurring disorders (jointly funded by MHMR) or refer to MH services if needed. For those in residential SA treatment, COD services are typically available either through COPSD Specialists in funded sites, an on-site psychiatrist, or an agreement with local MH provider agencies. In agencies that are both MH and SA providers, MH services can be accessed down the hall. Generally, however, access to MH services, including medication, is much better for the Medicaid-eligible population, given limited resources to pay for MH services for the non-Medicaid population. Additional mental health services covered by Medicaid include inpatient, physician, outpatient, day treatment/partial hospitalization, pharmacy and vocational.

An important service delivery innovation in Texas is a Medicaid reform that created a behavioral health carve-out plan in one region of the state. The Medicaid behavioral carve-out plan, called Northstar, serves the Medicaid population in seven counties in and around Dallas. The Texas Medicaid agency contracts with the behavioral carve-out to provide MH and SA services under a capitated contract (with the behavioral carve-out vendor at risk for the costs of providing services).

Mental health services covered by Medicaid managed care include inpatient, physician, outpatient, day treatment/partial hospitalization, case management, pharmacy, residential and vocational. Substance

abuse services covered include inpatient detox, outpatient, case management, methadone therapy, pharmacy, and residential. Services not covered include mental health self-help/peer support and substance abuse vocational and self-help/peer support.

The Medicaid population eligible for Northstar includes not only the disabled (SSI) and welfare (TANF) populations, but also those at and below 150 percent of the federal poverty level. Under the Northstar contract, direct and block grant MH and SA funding is blended with Medicaid funding to provide a broad and comprehensive array of services to the Medicaid population. According to our informants from the MH, SA, and Medicaid agencies, the Northstar behavioral carve-out has enhanced the flexibility and capacity to provide COD services, including parallel and integrated treatment, and has increased access to such services such that there are no waiting lists.

Texas has also incorporated COD services into the PATH program, which provides outreach and services to homeless individuals, by including COD specialists in some PATH sites.

The state MH authority is developing a behavioral health benefit for evidence-based service models. These will be linked to Medicaid reimbursement and applied statewide. Competency standards for providers who serve the COD population are in development to correspond with the benefit. COD services would be a part of this benefit and standards.

An innovation that the MH and SA agencies have developed in the MH and SA treatment workforce is the Co-Occurring Psychiatric and Substance Use Disorders Specialists. These specialists have a defined set of skills that MH and SA treatment provider agencies could utilize to deliver COD services that are billable within the MH and SA treatment system. The specialists are attached to more than twenty local substance abuse of MH treatment organizations and help people benefit from treatment and navigate across MH and SA treatment systems. This workforce capacity was initiated using a process in which MH and SA treatment providers submitted proposals for funding to the state SA treatment authority, which serves as the fiscal agent for this collaborative effort.

### **Collaboration and Consensus Building**

Texas appears to have built strong consensus and cross-system collaboration around COD services. In the mid-1990s, the state legislature called on the MH and SA agencies to work together on COD services, and a formal MOU between the agencies was created. The pilot project and the development of COD standards and competencies for integrated treatment emerged from that collaboration. In addition, the two agencies have collaborated on education and training (see below) and jointly fund a COD coordinator that helps both systems focus on the COD population and development of COD services. Both the MH and SA authorities appear to view COD services as an important priority and have tried to increase awareness of COD among providers. Both MH and SA treatment providers are expected to assess for COD and are prohibited from turning people away from care on the basis of COD.

While MH consumers have been actively involved in the consensus and planning process, SA treatment consumers have played less of a role.

### **Training and Workforce Development**

The MH and SA treatment agencies have jointly sponsored conferences focusing on COD and COD training; these activities are overseen by the COD coordinator. These educational opportunities are made available to MH and SA treatment providers, as well as to other providers who serve criminal justice and TANF populations. Conference and training staff include local trainers (mainly from the SA system), the COD coordinator, and outside experts (Minkoff, Drake). The curriculum has been developed collaboratively by local and outside experts (Minkoff). Training activities have been implemented statewide and are ongoing. Under development is an on-line training program to which providers will have access.

As mentioned above, the MH and SA authorities have been collaborating in developing standards and competencies that providers must meet to be reimbursed for delivering integrated COD services. These competencies are not linked to licensure or certification at this time.

### **Information and Data Systems**

Northstar has capability within its data systems to examine both MH and SA service encounters; this includes identifying persons with COD or integrated COD services. For the rest of the state, however, data systems for the Texas MH, SA treatment, and Medicaid systems are separate and unlinked. Providers are sensitive about sharing any type of clinical information, particularly with the 42 CFR and new HIPAA regulations.

The MH and SA treatment systems have implemented standardized intake instruments that include COD (MH for children is implemented, while MH for adults is under development in the SA system). There have been discussions regarding standardizing the intake process and data across the two systems.

### **Quality Assurance/Quality Improvement**

The pilot project (discussed below) represents a quality improvement initiative building on evidence-based treatment approaches for COD. The sites involved in the pilot project routinely monitor quality of care for COD in addition to more intensive evaluation in the pilot project, both the MH and SA treatment agencies monitor quality of care for COD in routine monitoring efforts.

### **Pilot Projects**

A pilot project to provide integrated COD treatment services has been funded under a mix of targeted MH and SA authority block grant funds. Under the pilot project, which has existed for 6–7 years, 25 providers have implemented integrated COD treatment programs using the New Hampshire/Dartmouth approach. The state MH and SA authorities have jointly developed specific standards and competencies that must be met for services to be reimbursed at these sites. The SMI population is the focus in these integrated programs.

## **Local Program Profile**

**Local Program:** LifeNet, TX

### **Type of Agency and COD Population Focus**

LifeNet is a private, nonprofit provider of MH and SA services in the Dallas area. Part of the state's Northstar behavioral health network, the agency serves a diverse population, including people who have MH disorders only and those with a COD. LifeNet has been treating COD clients for about ten years and has employed an integrated treatment model for the past three years.

Most of LifeNet's COD clients are on Medicaid, but the agency also treats people who are ineligible for Medicaid. Roughly half of the agency's caseload consists of COD patients. Until recently, approximately 5 percent of LifeNet's COD caseload was non-SMI. However, the state legislature has eliminated non-SMI disorders from Medicaid coverage, and, as of September 2003, LifeNet and other providers can no longer bill Medicaid for MH services delivered to non-SMI patients. As a result, the only non-SMI clients the agency serves are those who can pay out-of-pocket. In contrast, the agency can treat and bill for a range of SA disorders.

Because Texas does not license providers in MH, LifeNet has only a state license to provide SA treatment.

### **Services Offered to the COD Population**

LifeNet offers a broad continuum of care for its clients. For both MH and SA, services include individual and group treatment, case management, medication management, partial hospitalization/day treatment, psychosocial rehabilitation, an ACT team, physician services, vocational rehabilitation, detox (through the ACT team only), screening, and assessments. In addition, LifeNet provides independent living and other housing services, as well as transportation services. The agency generally does not collaborate with other agencies in providing or organizing treatment, but instead tries to offer almost all services a given client needs in-house. All clients receive a biopsychosocial assessment.

Staff employ an integrated approach to care. The goal is to place clients in the least restrictive level of care possible and to maximize participation at that level of care, often with additional support from a 12-step program. COD clients typically receive a mix of individual and group treatment.

### **Treatment Implementation and Staffing**

LifeNet has had staff licensed in both fields for ten years, and currently has six dually licensed staff members who provide treatment to COD clients. Many COD clients receive treatment for both types of disorders from the same clinician or counselor, while others are served by a multidisciplinary treatment team. COD clients obtain services that are part of LifeNet's general service menu, as well as services that are part of a special COD track.

All staff are located in a single facility, and LifeNet has not had to reassign or relocate staff to provide COD services. Supervision does not typically vary according to whether services are for COD or single diagnosis clients, although COD clinicians and counselors often need more support from supervisors.

## **Financing Issues**

In the Northstar system (which is a Medicaid managed-care behavioral health carve out for the Dallas area), Medicaid and federal SAPT and CMHS block grant funds are blended, and Northstar providers are reimbursed for services from this pool of funds. Thus, providers such as LifeNet do not need to deal with separate funding streams. Although the state contracts with the Northstar system's MCO, Value Options, on an at-risk basis, Value Options apparently does not pass the risk on to providers. LifeNet bills Value Options on an FFS basis. LifeNet administrators report that they have few problems with billing for COD services, other than having to obtain pre-authorization from Value Options for services to patients, which can delay or complicate service delivery.

In addition, LifeNet receives federal Housing and Urban Development (HUD) funding to pay for housing services. The agency does not bill any insurance providers other than Medicaid, but it does accept private payments based on a sliding fee scale.

## **Training and Quality Assurance**

LifeNet conducts frequent training sessions in COD and other topics for its clinical staff. All clinical staff attend weekly, two-hour training sessions on treatment issues and changing rules within the Northstar system. Occasionally, the agency brings in outside consultants to provide training in COD. The agency also sends staff to training sessions sponsored by Value Options. In addition, Value Options trains consumers in how to educate others about COD, and some of these consumers lead peer education groups at LifeNet.

As a Northstar provider, LifeNet must use performance indicators and track outcomes for all clients, including those with COD. Its client database enables staff to identify and track COD clients, and outcomes for these and other clients are closely monitored and reported to the Texas Commission on Alcohol and Drug Abuse.

## **Facilitators for Providing COD Treatment and Sustainability of Services**

Northstar's blended funding system makes reimbursement for services simpler for providers such as LifeNet. Other facilitators have included strong and stable agency leadership. Agency Commissioner Betts Hoover has played a major role in pursuing an integrated treatment model for COD. In addition, agency management believes that having both MH and SA clinicians on staff, under one roof, enables effective COD treatment.

Agency administrators are confident that they will be able to continue to serve the COD population and are hopeful that advocacy groups will succeed in convincing the state legislature to add MH services for the non-SMI back to the Medicaid benefit package.

## **Barriers to Providing COD Treatment**

The process of obtaining pre-authorization of a service plan for each client complicates service delivery and somewhat limits the range of services that can be provided. Care managers at Value Options ultimately determine the type and frequency of services for patients. Other barriers include some patients' lack of compliance with treatment and the difficulty of treating certain psychosocial disorders.

## Chapter 10. Tennessee State Profile

### COD Population Focus

Tennessee has a separate MH department (Department of Mental Health and Developmental Disabilities) and SA bureau (Bureau of Alcohol and Drug Abuse Services), which function under the umbrella agency, the Tennessee Department of Health.

Currently, the state public MH and SA systems are focused on the delivery of COD care to a broad spectrum of adult persons with serious and non-serious MH and SA disorders. The Department of Mental Health and Disabilities is trying to increase awareness of the Four Quadrant Model framework throughout the state to encourage cross training and the implementation of coordinated or integrated treatment. The BADAS has submitted several grant applications (e.g., Co-Occurring State Incentive Grant, COSIG) to help in delivering services to Quadrant II (high severity MH and low severity SA disorders) and Quadrant III (low severity MH and high severity SA disorders) populations.

### Financing and Access to Services

Tennessee delivers MH, SA, and COD services through three distinct systems of care: (1) a joint partnership between the state's Medicaid managed-care program, TennCare, and the state's public MH system; (2) the state's "free-standing" public SA system; and (3) TennCare Partners, the state's behavioral health carve-out program for uninsured populations. Tennessee finances COD treatment through Medicaid, state general revenue, and state MH and SA block grant funds. Since the state has separate systems, forging a coordinated agenda for COD treatment and rolling out statewide improvements is challenging. The prevailing model of care in Tennessee is parallel COD treatment. A small number of MH centers deliver integrated care. Each state system considers its level of funding to be inadequate for the level of service it is providing.

The state Department of Mental Health and Disabilities primarily provides MH and COD services through TennCare. It also uses state dollars to provide services not covered under TennCare (e.g., wraparound services) and to pay for some COD services directly. Mental health services provided include inpatient, physician, outpatient, day treatment/partial hospitalization, and case management. Substance abuse services covered include inpatient detox, outpatient detox, outpatient, case management, and methadone therapy. Mental health services not covered are pharmacy, residential, vocational, and self-help/peer support. For substance abuse, inpatient detox plus services are not covered. TennCare contracts with two behavioral health organizations (BHOs) and with the Department to oversee and administer services. The statewide contract has both no-risk administrative services and risk-based arrangements. The BHOs set rates and contracts with provider organizations to deliver services. BHOs receive monies directly from the Department of Mental Health and Disabilities. The Department manages \$407 million that is appropriated by TennCare to the Department. Throughout the state, CMHC contracts with BHOs include negotiated contract rates (not risk-based arrangements).

While the state BADAS has no relationship with TennCare, providers may contract with Medicaid to deliver SA services. Perceived impacts of managed care on service delivery for COD vary among state MH and SA and TennCare staff. For example, while MH and SA staff are concerned about limitations in

managed benefits and in the definition of medical necessity, especially for SA, TennCare considers managed care a facilitator of expanded coverage for SA benefits.

The BADAS contracts with non-profit organizations to provide SA services to indigent populations who do not qualify for TennCare or who otherwise do not receive TennCare services. While providing COD services is typically encouraged and not mandated in state contracts, using the ASI and ASAM protocols is mandated. Treatment and assessment services are paid using a unit rate. Since providers are not licensed to dispense medications, clients usually pay for medications directly. Other barriers associated with providing COD services include lack of funding for SA services, limited staff capacity and training in COD, and higher demand (waiting lists) than receipt of SA services.

Uninsured populations are covered by the behavioral health care (only mental health services) carve-out program, TennCare Partners, which is overseen by the Department of Mental Health and Disabilities on a daily basis. TennCare has overall fiscal authority for services provided.

### **Collaboration and Consensus Building**

The Department of Mental Health and Disabilities and BADAS have been collaborating to address COD service delivery issues since they were separated in 1993. The thrust of their activities has been public system reform, training, consensus building among their constituents, and developing guidelines and principles of care. Prior to the change in governor and Department of Mental Health and Disabilities in 2002, decision making between the Department and Medicaid TennCare Bureau occurred in a top-down fashion on a daily basis. Shifts in relationship building included a MOU between the Department and TennCare (requiring them to work together), with usual contact occurring at all levels, e.g. weekly meetings.

In 1993, a statewide training given by an outside consultant and an initial assessment of staff training and education needs were the first major steps taken to develop consensus about the delivery of COD services. In 1996, efforts were more formalized through a COD project that launched Foundation Associates, a new program to provide COD and integrated care, and through the creation of a COD Task Force. The Medicaid Agency was involved initially (in 1997) when it was developing a new managed-care benefit package. While the Task Force's original intent was to make recommendations for training, 48 recommendations were made to address other gaps in COD care. Further discussions with stakeholders and other governmental officials resulted in seven core recommendations for implementation. Because of a change in governor and state-level MH and SA staff, such implementation was delayed. Currently, the state MH and SA commissioners have agreed to implement the seven recommendations regardless of whether additional funding has been secured and to roll out a COD initiative that involves more training.

Several stakeholders have been involved in consensus building activities for COD care: five regional Mental Health Institutes and seven SA regional organizations (see below); State Mental Health Planning Council and seven regional planning councils; the Tennessee Association of Mental Health Organizations (TAMHO); the Tennessee Association of Alcohol and Drug Abuse Agencies (TAADAS); the Tennessee Mental Health Consumer Association and National Alliance for the Mentally Ill; community mental health centers (CMHCs); the governor; a few state legislators; and the 50 agencies the Substance Abuse Bureau funds under contract.

### **Training and Workforce Development**

Tennessee's providers need much training to treat persons with COD effectively (e.g., SA providers still have biases against treating clients who are on medication, and clients are often referred out from SA agencies to CMHCs for MH assessment). While the Medicaid Bureau does not think that a specific model of COD care is necessary, the Department of Mental Health and Disability and BADAS are rolling out integrated treatment principles. Accordingly, the state considers training its main facilitator in enhancing the development of parallel and integrated treatment for persons with COD and plans to expand such efforts this year.

Traditionally, the Department of Mental Health and Disabilities and BASAS have sponsored training and other workforce initiatives separately. However, they both use available monies for training as much as possible. Some CMHCs also sponsor trainings. To address training on a broader scale, the Department is discussing the development of an educational track for COD in a few universities. While no specific standards for COD competencies or special credentials or licensing are in place, some of the 48 recommendations made by the COD Task Force address these issues. The state Commissioner of Mental Health is also exploring this.

Staff trainings are statewide and are usually implemented through the seven regional planning councils and the seven SA regional structures for CMHCs and other providers (not BHOs). Both in-house and external trainers and curricula are used in MH and SA training sessions. The BADAS uses part of its budget to pay one overall coordinator and seven regional coordinators to train providers in their regions. Regional coordinators conduct a training needs assessment to set a monthly training agenda (that may or may not include COD issues). The BADAS has developed several tools for training, including a COD training curriculum, a Best Practices Bureau of Alcohol Co-Occurring Training Guide, and Tennessee Best Practices Guidelines and Assessment Guide. The Department of Mental Health and Disabilities holds an annual conference on COD and is working on developing guidelines and principles for delivering COD care in its settings.

### **Information and Data Systems**

The Department of Mental Health and Disabilities, BADAS, and Medicaid have separate information and data systems. However, they are all working to better share encounter and other data (e.g., data from the five MH hospitals are shared routinely) and to develop performance indicators for COD. Currently, persons with COD can be identified by diagnosis and service utilization. While the Department of Mental Health and Disabilities and BADAS do not require that all providers use a standardized intake instrument that includes MH and SA domains, both issues are addressed in some fashion in the instruments that are used.

### **Quality Assurance/Quality Improvement**

Currently, Tennessee does not have performance indicators or quality improvement models to support COD care. This is a future goal.

### **Pilot Projects**

Both the Department of Mental Health and Disabilities and BADAS are open to securing grant funds to conduct pilots for COD care or to fund COD services. Recently, the BADAS targeted monies to pilot the

service delivery of COD services to clients in selected areas of the state. The state also applied for a COSIG grant to conduct service pilots and to implement the seven core Task Force recommendations.

## **Local Program Profile**

**Local Program:** Foundation Associates, TN

### **Type of Agency and COD Population Focus**

Foundation Associates is a non-profit behavioral healthcare center specializing in COD treatment for individuals and their families. The agency was founded in 1995 by the Executive Director to address the lack of COD services in the state. The agency has won many national awards, recognizing it as an exemplary program for integrated COD care.

Foundation Associates was established as an integrated MH and SA agency. It delivers services at multiple sites in two cities, Nashville and Memphis. The agency is licensed to deliver both MH and SA services and only serves clients who have COD disorders. It serves a wide spectrum of clients with COD, including SMI and non-SMI adults, Medicaid (TennCare) and non-Medicaid eligibles, elderly, homeless, and persons with HIV/AIDS and forensic histories. About one fourth of clients are covered under TennCare.

### **Services Offered to the COD Population**

The agency offers a wide variety of services for persons with COD at its Nashville facility, on its Memphis campus, and in the community. All services are designed specifically for COD; there are no specific MH and SA programs. Outpatient services include an intensive outpatient program; individual, group, and family therapy; partial hospitalization; psychiatric assessment and evaluation; aftercare; ACT; and case management and vocational counseling. All clients are screened and assessed at their initial visit with standardized instruments (including the ASI, Brief Symptom Inventory, Personality Assessment Inventory, SOCRATES scale, GIPPER, Government Performance and Results Act Report Form, Schizophrenia Subscale of the Personality Assessment Inventory, Lehman's Quality of Life Interview, Empowerment Scale and Client Satisfaction Questionnaire) and informal measures obtained through interviews. Portions of the instruments are used to evaluate client progress over time. Residential services include enhanced therapeutic community treatment, enhanced halfway house, and independent living. The agency also provides prevention and education services, crisis stabilization/respite services, sheltered workshop, permanent therapeutic community housing, and a drop-in center at the Memphis campus.

Some services are tailored to SMI and non-SMI groups. While all services are directly provided by Foundation's programs, the agency has an interagency agreement with a mobile crisis unit to exchange services. Foundation Associates refers clients who only have a MH and SA disorder to other agencies in their community.

### **Treatment Implementation and Staffing**

Foundation Associates uses a few models to deliver COD care. Agency executives and staff developed an overall model and principles of COD treatment that they consider more "complete" than the theoretical models they had assessed in the literature or were offered by consultants. This multi-dimensional model includes staff specialization, reduced caseloads, continuum of care, and adoption of integrated care philosophies. The agency also uses the ACT model to deliver COD services modified to provide tailored integrated services to individuals with COD.

COD teams, and individual therapists who can provide both MH and SA treatment, deliver COD treatment. The agency employs 150 staff in its two locations. All clinical staff are able to deliver COD treatment. In the outpatient program, approximately 50 outpatient and 15 case managers deliver COD care.

Single treatment plans are developed for each client by primary therapists and in conjunction with an interdisciplinary team, with the focus on the individual's movement through trans-theoretical stages of change. Treatment planning is multi-systemic and focuses on stage driven interventions, service matching, and incorporating evidence-based interventions. If a client is enrolled in a residence, the primary therapist works with a residence and outpatient team. Treatment plans for clients who receive individual treatments are developed by individual therapists in conjunction with smaller outpatient staff teams. Primary therapists for ACT clients work within that team to develop the plan. Supervision for staff at Foundations is consistent with their integrated treatment philosophy. For example, some of the alcohol and drug counselors have learned that it is acceptable for their clients to take psychiatric medications even though they are COD.

### **Financing Issues**

Foundation Associates' total budget is \$8 million dollars, with a goal set for \$12 million next year. The agency is supported by funding from a diverse set of sources. Over 65 percent of the agency's funding is CSAT and Medicaid funds. Other funding sources include block grants, CMS homeless grants, DHS vocational rehabilitation monies, state departments of health, mental health and human services dollars, HUD, Tennessee Housing Development, discretionary monies from SAMHSA, and local grants. The agency is committed to maintaining a diverse funding portfolio to maximize available funding opportunities, to keep the staff-to-client ratio consistent, and to expand services. The agency employs full-time grant writers to apply for 3–4 grants per month.

Currently, the agency is not experiencing any major problems with billing for COD treatment. Even though staff understand that both MH and SA diagnoses are primary, services need to be billed according to funding source (e.g., MH codes are used to bill Medicaid for mental healthcare), since no funding streams are specific to COD.

### **Training and Quality Assurance**

Foundation Associate executives and staff train other in-house staff in the agency's COD philosophy and paradigm (e.g., that both MH and SA diagnoses are primary use of motivational interviewing techniques, assertive outreach efforts, and operational integrated philosophies) and in treatment approaches. Since it is difficult to hire staff who are experienced in integrated approaches, all new staff are retrained. The agency sponsors conferences, trainings, and consultation to other providers and also provides a variety of COD resources and publications to advocates and the public. The agency maintains a list of about ten consultants it draws on for its training efforts. While certification of staff is not required, both certification and continued education is rewarded financially at the agency.

The agency has established quality assurance and improvement models, as well as specific standards and guidelines and principles to support COD care. Since much of the funding the agency secures includes an

evaluation component, over 95 percent of clients participate in research activities. Performance, quality of care, and outcomes measures result from such efforts.

### **Facilitators for Providing COD and Sustainability of Services**

Several facilitators have been key to the agency's start-up and service delivery success. Leadership provided by the Executive Director has been most instrumental in making Foundation Associates an innovative agency. His commitment to only serving COD clients and to hiring some of the best providers in the area has resulted in an agency that remains committed to delivering COD treatment. The agency's solid working relationship with the state departments of mental health and health has helped to secure the public sector funding it needs to maintain and grow services. The Chief Operating Officer's past experience as a legislator has largely helped to facilitate this. The Executive Director is also very committed to disseminating information about COD and Foundation's services and to connecting to the COD community. The agency has created an on-site library for COD and its own COD magazine, and it facilitates a network of advocates (Dual Diagnosis Recovery Network) and providers (over 140) to reduce stigma, enhance recovery opportunities, and promote change for the COD community. For example, the agency, through its Network, sponsored a statewide Task Force on barriers and solutions to COD improving services.

The agency is very optimistic about sustaining its services in the future. It plans to expand services and increase its operating budget to \$100 million dollars within five years.

### **Barriers to Providing COD Treatment**

External factors are perceived by the agency to be the main barriers to implementing or expanding COD treatment at the agency and in the field. Such factors include lack of training in educational programs for COD, unwillingness by other providers and agency leaders to make COD a priority, and separate MH and SA systems and funding.

## **Chapter 11. Wyoming State Profile**

### **COD Population Focus**

Wyoming has separate MH (Department of Health and Mental Health Division) and SA (Department of Health and Substance Abuse Division) divisions that work closely with one another, and with the Medicaid division, under a state umbrella agency, the Wyoming Department of Health. The MH and SA divisions were separated three years ago by a governor's initiative that was designed to facilitate improvements in funding, advocacy, and services for SA.

The state is currently focused on the delivery of COD care to a broad spectrum of adult persons with serious and non-serious MH and SA disorders, including criminal justice populations who have MH, SA, and COD needs. The MH division is beginning to target the needs of the Quadrant I population (low severity MH and SA disorders) by planning a conference in fall 2003 for primary care providers. The SA division is starting to focus on the needs of persons in Quadrants II (high severity MH and low severity SA) and III (low severity MH and high severity SA), and on how to better link them to MH services by integrating Minkoff's guidelines, the Four Quadrant Model framework, and the American Association of Addiction Medicine Patient Placement Criteria.

### **Financing and Access to Services**

Wyoming is mostly a frontier and rural state, providing MH, SA, and COD services through a public, county-based MH and SA agency system of 20 MH and three SA agencies. The prevailing model of COD care in the public healthcare system is integrated. All MH centers provide co-located MH and SA services. The three counties that have SA agencies, with the exception of one, provide parallel COD treatment with other organizations in each of their counties. Wyoming bases its integrated model of COD care, and the delivery of MH and SA services, on the 1970's community MH center model. Providers in MH and SA centers are considered generalists in COD service delivery.

Public MH services are primarily financed through State general funds as well as a Medicaid FFS plan and MH and SA block grants. The state does not contract, nor intend to contract, with MCOs to manage the provision of public sector MH and SA services. Since their separation, the MH division has had decision-making authority for Medicaid service and provider coverage, for targeting Medicaid funds, for approving claims, and for setting Medicaid standards. The Medicaid division has overall administrative responsibility for the Medicaid program.

Mental health services covered under Medicaid include inpatient, physician, outpatient, day treatment/partial hospitalization, case management, and pharmacy. Substance abuse services covered include inpatient detox, outpatient, case management, and pharmacy. For both mental health and substance abuse, residential, vocational, and self-help/peer support services are not covered. For substance abuse, inpatient detox plus, outpatient detox, and methadone therapy services are not covered.

Medicaid and the Medicaid Rehab Option are the main reimbursement mechanisms for MH and SA services. No direct COD reimbursement mechanism has been created. Medicaid MH service codes are used to bill integrated COD treatment, MH assessment, and medication management. MH assessment and medication management provided in SA settings are billed using MH codes, while medication associated with SA treatment is billed using SA codes.

The Mental Health and Substance Abuse Divisions have been formulating and implementing several strategies to address financing and service delivery barriers for services. SA prevention, intervention and treatment services have been infused by legislative acts and new funding, including 17 new Drug Courts, the Metamphetamine Initiative (established 2 long-term SA residential facilities), the Substance Abuse Control Plan (new plan for SA treatment delivery system, part of a Comprehensive Substance Abuse Community Initiative), and a comprehensive \$25 million bill. However, ongoing concerns to the state include SA Medicaid coverage, the shortage of providers, cross-training, and high overhead costs to delivering treatment in rural and frontier areas. Payment rates for MH and SA services have also been increased recently in the state. A Health Commission was established to review tort reform and make recommendations for how to better serve the uninsured. In the future, funds may be targeted to develop PCCMS that can assist in delivering MH and SA services, and waivers may be sought to help improve access to COD treatment.

### **Collaboration and Consensus Building**

State-level consensus building in Wyoming is valued and a matter of “pride.” Prior to the separation of the MH and SA divisions, state-level mental health and substance abuse staff had close working relationships. This largely resulted from relationship building by the state director who had overall responsibility for both divisions. When the divisions were separated, staff were supportive of the need to more evenly balance financing and increase advocacy for SA. Soon after the split, the MH director forged a close working relationship with the new SA director, and a partnership between the two divisions and the Medicaid division was established.

Currently, consensus building at the state level is driven by the two division directors and the State Mental Health Planning Council. The Medicaid division, Departments of Family Services and Corrections, two consumer groups (the Wyoming Alliance for the Mentally Ill and Uplift), a legislator, a legislative committee chair, and providers are also closely involved.

Several short- and long-term consensus-building activities are under way to continue to improve MH, SA, and COD services. A COD workgroup, Task Force, and Mental Health and Strategic Planning group are ongoing. The MH and SA directors and the Wyoming Association for Mental Health and Substance Abuse Centers meet monthly. The Medicaid and MH and SA divisions also meet regularly, along with consultants (e.g. Ken Minkoff, David Mee-Lee, Bert Pepper) who are helping them to explore how providers and systems of care might be incentivized and how to improve service delivery in general. A Medicaid Provider Manual and a value distribution contracting process (which is designed to help providers reduce costs and be able to add “quality of life” or non-clinical services to their menu) continue to be developed.

### **Training and Workforce Development**

The MH and SA divisions co-sponsor cross training and other workforce initiatives to improve the delivery of services and improve workforce capacity. Training is a statewide effort and is mostly done by providers with the help of outside consultants. One conference is scheduled for Fall 2003 that will target primary care providers and focus on how to improve COD treatment, and another is being planned for public- and private sector providers (e.g. financing strategies).

Workforce capacity (e.g., shortage of psychiatrists) and competency for COD are issues in Wyoming. The state plans to roll-out principles and standards of COD treatment, as well as a Quality Practice Initiative (see below), which include guidelines for skills training, a best practice COD treatment model, and a comprehensive plan of care (a result of legislation) for MH and SA services. The state has also developed new standards and credentialing for SA providers by contracting with the regional Technical Assistance Center (an independent agency facilitating credentialing and quality assurance for the SA provider network).

### **Information and Data Systems**

The MH, SA, and Medicaid divisions share a central information system. While encounter and other data can be entered directly into the system, the state is working to improve coordination between the three divisions and to develop COD indicators. The Division has started utilizing a series of database modifiers to designate primary diagnoses and whether a service is provided through a MH and SA agency. The Medicaid division is determining how to leverage federal contracts to improve information systems.

While MH and SA providers utilize the same type of clinical record, a common assessment instrument is not used. However, each division's assessment instrument requires collection of MH and SA information. Sharing information is not a problem in counties where MH centers are located, as long as releases of information are properly obtained and providers are satisfied they have met HIPAA requirements.

### **Quality Assurance/Quality Improvement**

Currently, a COD task committee is assessing how to routinely measure performance and outcome indicators, how to monitor access to and quality of care, and how to develop quality improvement models to support COD care. The integration of MH and SA block grant funding at the state level has set in motion a focus on accountability goals. The MH and SA divisions are also involved in national agendas and performance partnership grant initiatives for COD. Finally, the SA division is developing a Quality Practice Initiative with an outside consultant to identify and disseminate COD best practices for clinicians and administrators who are part of the state funded provider network, private providers and Departments of Family Services and Corrections.

### **Pilot Projects**

The state has not been involved in any pilot projects related to COD. However, the MH and SA divisions prepared and submitted a COSIG grant proposal, and the governor recently established a Research Center to increase the state's in-house capacity to conduct its own research.

## **Local Program Profile**

**Local Program:** Central Wyoming Counseling Center, WY

### **Type of Agency and COD Focus**

Central Wyoming Counseling Center is a 45-year old non-profit CMHC. The Center is considered a dual-service provider, since it delivers public MH and SA and COD services in one county. It operates under MH and SA certifications (not licenses) that are approved by the state MH and SA divisions.

The Center serves a wide spectrum of clients with MH and SA problems (approximately 4,000 clients annually), including SMI and non-SMI, Medicaid-eligible, non-Medicaid eligible, homeless, and forensic. No potential client is turned away. Full screenings and assessments are conducted to determine whether a client has a primary or secondary MH and SA problem and to target which Center programs are appropriate for treatment, such as COD, outpatient, psychiatric rehabilitation, comprehensive SA and residential substance abuse treatment facilities for adolescents, men and women. Since the Center serves a wide spectrum of clients, its definition of COD is broad. Approximately 40–50 percent of the Center’s psychiatric rehabilitation caseload consists of COD clients.

### **Services Offered to the COD Population**

In Wyoming, CMHCs like the Center have always offered MH, SA, and other support services to adults and children. While the Center has specialized services for its COD population, it delivers a usual menu of services to persons with COD and MH and SA disorders. This menu includes screening, assessment, individual treatment, group treatment, psychiatric rehabilitation, case management, case management (non-ACT and a modified ACT model that is blended into their programs), supported employment, pharmacy/medication management and residential services for substance abuse clients. The Center also provides several other specialized programs to address certain SMI and non-SMI population needs. These include services for persons with schizophrenia who are also substance abusers, persons with PTSD (intensive outpatient program), for persons with depression and SA problems, and for persons with MH and SA problems and a forensic history (one Center-funded case manager works in the circuit court to ensure that ASI/ASAM placement criteria process is followed); services also include a 12-step abstinence program, therapeutic family care, and school-based services in 27 schools in the Center’s district. The Center is developing a new residential program specifically for women and women with small children. As the COD population grows, the Center anticipates that their services will become even more specialized.

The Center considers its service delivery for MH and SA services to be an integrated model of care, one that they have been delivering for a long time. However, COD treatment is provided using both integrated and parallel models, with a core team model underlying each. A Center staff committee developed a homegrown COD treatment model (intensive outpatient model and cross-training model) and guidelines for care by consulting with outside consultants and assessing the literature. Clients who are served in the psychiatric rehabilitation program receive MH and SA treatment from one professional, since all staff are trained to provide both types of services. Clients in other programs may receive their COD treatment through one professional or by two therapists in two different programs within the Center. While individual therapists deliver COD treatment, an overall core team model (a modified ACT model that is employed only on-site) is associated with each client’s care. That is, each client is assigned a core team

that consists of a therapists, job coach, vocational rehabilitation counselor, nurse, and physician/psychiatrist who is geared to helping clients deal with their MH, SA, and supportive service issues (e.g., housing, employment, and self-sufficiency).

All clients are screened and assessed at intake using both standardized and homegrown instruments. The CAGE and SASSI are used to screen for MH and SA problems, respectively; a homegrown clinical assessment tool and the ASI and ASAM are used to assess MH and SA problems, respectively. All staff are able to screen and assess all clients. While three SA staff are especially skilled in screening and assessing COD clients, staff are capable of conducting whatever type of assessment is needed beyond the initial clinical assessment that all clients routinely receive. The Center provided over 700 ASIs last year. This was partially a result of new funding for SA referrals.

### **Treatment Planning and Service Delivery**

Except for residential treatment, all Center programs are located under one roof. The Center has not had to reassign staff to treat COD clients. Since the Center has been providing both MH and SA services for many years, a number of staff have been providing dual-diagnosis treatment, regardless of the Center program. Even though lack of funds has been a major reason why MH staff have provided SA treatment in the past, some staff were hired specifically to provide SA treatment when the Center expanded its specialized COD services. Across all Center programs, over 30 percent (at least 20/60) of staff deliver COD services. More MH and SA staff are dedicated to delivering COD services; three have a strong SA background. Each client is assigned a primary therapist who is responsible for his/her complete treatment plan and coordinating with the various Center program staff that are involved in a client's treatment. Supervision for staff who provide COD treatment is no different than supervision for any other diagnoses.

### **Financing Issues**

The Center finances COD services through a variety of sources. State and Medicaid monies are its two biggest funders, with the former providing major funds targeted to the SMI, substance abusers, and COD disorders (even though COD is not specified as such explicitly). The Center also receives some private donations and third-party payments. Estimating the cost of COD services is difficult at this time, since the Center is just beginning to separate its budget for the specialized COD program and other COD service that are delivered. The Center anticipates that it will pool monies to create a separate budgeting category for COD.

Billing for COD services is done separately at the Center, since a primary or secondary MH service is billed to Medicaid first and then the state MH contract, and a primary or secondary SA service is first billed to Medicaid and then the state SA contract. Billing is tracked by service not by staff level or funding source. The Center is determining how it can use some type of collaborative strategy to channel funding streams specifically for COD services, since this program area grows. Staff would like to discuss blending funds and other financial issues with the state MH and SA divisions.

### **Training and Quality Assurance**

The Center has traditionally developed its own staff trainings and also made it possible for staff to attend trainings or conferences that the state or other organization and consultants offer (e.g., International Association of Psychosocial Rehabilitation Conference). Executive management and program managers

typically identify the Center's training needs and opportunities. Consumers do not receive any training to participate in the delivery of COD services. Currently, the Center is developing trainings on ASI and COD. Training is paid for through the Center's budget.

Staff are either licensed or certified to deliver services. For example, an LCSW may only provide SA services. In the outpatient programs, there are 11 staff qualified to deliver COD services, 3 BSW staff certified addictions practitioners, 2 Ph.D. psychologists, 3 DSWs, 2 psychiatrists, 2 M.D.s and 1 physician's assistant with whom the Center contracts. Master's level staff can provide both MH and SA treatment.

Currently, the Center's utilization review staff meets twice a month and reviews cases in every program. In addition to the state's standards and practice guidelines for MH and SA programs that all clinical staff use, some of the Center's programs (e.g., intensive outpatient) also use their own guidelines and principles for training and delivering services.

The Center has started to employ standards for COD competencies in their staff trainings and in a few of their programs (e.g., intensive outpatient). However, the Center is in the beginning stages of developing quality assurance/quality improvement models and performance and outcomes indicators (e.g., who is working, how many hours working, who has housing) specific to COD and for other populations. The Manager of the Psychiatric Rehabilitation Program recently attended a training session on outcomes to assist in this effort. The Center is also working with the state SA director to determine typical measures of interest.

### **Facilitators for Providing COD Treatment and Sustainability of Services**

The Center considers the main facilitator for implementation of COD services to be the new state legislation that was passed to infuse the SA and education and family services departments with \$25 million. Leadership by the Executive Director has resulted in the Center's focus on the COD population and on the development of a SA center. He thinks that he has great flexibility to create the types of programs he sees are needed. This has also led to more recognition at the state level. Trainings offered by the state and others have helped to prepare staff to better deliver COD services. Overall, the Center has been developing more formal COD services and implementing a keener focus on this population without significant internal organizational problems.

The Center expects that COD services will be sustainable in the future, even though funding from the state legislature and federal government may not increase. Because the Center thinks that it would be a disservice to the community to discontinue COD services, it is committed to sustaining them even if it means diverting monies from other budget areas. The Center is focused on expanding COD and other services by making more training available and adding staff.

### **Barriers for Providing COD Treatment**

Historically, funding has been the biggest barrier to providing COD or other services, followed by a lack of focus on SA treatment in general. The Center also needs more space to accommodate its service and program menu and its increases in number of clients.

## Chapter 12. State and Local Program Trends and Themes

This chapter discusses current cross-cutting trends and themes for state and local program COD service delivery. For the state level, the analysis summarizes how states are pursuing consensus building and workforce training, defining the COD population, relying on the prevailing parallel service system, attempting policy and regulatory changes to better serve the COD population, planning changes to information systems, and considering quality assessment and improvement strategies to improve COD services. For the local level, the analysis highlights common activities and service delivery strategies in seven domains: type of agency and COD and population focus, services offered to the COD population, treatment implementation and staffing, financing issues, training and quality assurance, facilitators for providing COD treatment and sustainability of services, and barriers to providing COD treatment.

### *State Level Trends and Themes*

The states included in this study have all focused on the COD population as an important priority over a sustained period of time and have engaged in multiple state-level activities to promote better COD services. The states are very diverse in other respects, including the state population size, region of the country, and governance structure of their mental health and substance abuse systems. They also differ greatly in terms of funds available to deliver mental health and substance abuse care (see Table 1 in Appendix B). State expenditures controlled by the mental health authority, for example, varied from \$38 per capita for Texas to \$176 per capita for New York (in FY 2001); total substance abuse, or total state supported alcohol and other drug services per capita expenditures varied from \$6 for Tennessee to \$45 for Connecticut (in FY 1999). In spite of this diversity, we found some commonalities across the states in terms of their approaches, achievements, and ongoing challenges. In this section, we summarize those commonalities, and also note a few relatively unique system features that appear to be facilitating the development of COD services for some states.

**State efforts focus on consensus building and workforce training.** All of the states we examined have taken significant steps to improve COD services through consensus building and workforce training. All have engaged in extensive stakeholder and cross-system consensus building and have sponsored cross-disciplinary training for providers. The leadership of the state mental health authority has been central to consensus-building efforts. Sometimes, as in Arizona, specific principles and guidelines for care have emerged from consensus building activities and these are being used to drive changes at both the system and provider agency levels. State training activities have typically spanned both mental health and substance abuse systems and providers (and have sometimes included criminal justice and primary care settings and providers). In some cases, as in Connecticut, a substantial investment has been made to develop an extensive and sustained training effort based on a specific integrated care model that has demonstrated efficacy.

These consensus building and training initiatives appear to be breaking down many of the disciplinary barriers to providing COD services. They have encouraged diverse systems and providers to view COD service needs within a unitary conceptual framework that recognizes varying levels of severity of both mental health and substance abuse problems, and encourages recognition of co-occurring disorders and identification of COD service needs irrespective of the system that is the “door” into care.

**States have similar definitions of the COD population.** State mental health and substance abuse authorities are generally familiar with the Four Quadrant Model for depicting the range of severity of co-occurring disorders and settings in which individuals with these disorders are commonly found. Adoption of this common terminology appears to have mitigated conflict and misunderstanding that can arise from the different perspectives of mental health and substance abuse systems regarding the COD population, since each system can recognize distinct population characteristics and needs within the framework. States also generally seem to embrace the idea that integrated care models are needed for the COD population with more severe mental illness whose primary locus of care is the mental health system.

**Integrated program models rely on Medicaid financing and focus on SMI.** Most states have supported the implementation of integrated COD programs by selected provider organizations. The states have typically provided start-up flexible funding as incentive to development of the integrated programs. To sustain the financing of integrated care, the states are relying heavily on Medicaid financing with other funds used to cover services that are not Medicaid reimbursable or clients that are not Medicaid eligible. The integrated programs tend to largely focus on patients with severe mental illness. Most states have based their integrated care model on the approach developed by the Dartmouth group (the New Hampshire/Dartmouth model). For this integrated model a “toolkit” of implementation guidance and assessment instruments has been developed and is currently being tested in a multi-state evaluation project (see Appendix A). The broader availability of the toolkit could be useful for states undertaking wider dissemination and roll-out of integrated treatment, and some states (such as South Carolina) were hoping to have access to the toolkit soon.

While many states envision expanding the availability of integrated COD services such as that delivered in their demonstration and pilot efforts, and a few (like Connecticut) were steadily expanding integrated treatment services, most have not yet attempted state-wide roll out. This is not for lack of enthusiasm for the integrated pilot programs, which they point to with pride. Instead, it is apparent that states continue to face fiscal and organizational barriers to developing integrated services for the COD population. Integrated programs require large changes within provider agencies, and thus require initial investments to support reorganization and training, as well as organizational readiness on the part of the provider agency. Thus, access to integrated COD services is expanding slowly, even in states that have embraced integrated models of care.

In addition, the New Hampshire/Dartmouth integrated service model may not be appropriate for rural areas, where the demand for specialty COD services would not warrant a devoted COD treatment team. Wyoming, for example, is pursuing a different model of integrated COD care. In this largely rural and frontier state, most mental health and substance abuse services are co-located and provided by community mental health centers. The center providers are considered “generalists” in both mental health and substance abuse treatment.

The states included in this study had generally leveraged Medicaid (under the Medicaid rehabilitation option) to enable delivery of many COD services for their Medicaid eligible population. Medicaid benefits in the states we studied were typically expanded to include substance abuse outpatient (and sometimes residential) services. Most states were reimbursing Medicaid mental health and substance abuse services under traditional fee-for-service arrangements, but a few had implemented managed care reforms that provided flexibility for delivering integrated COD services under Medicaid. Arizona, for example, has a statewide managed care plan that encompasses both Medicaid and non-Medicaid mental

health and substance abuse services (regional managed care organizations are contracted to provide care on an at-risk basis for the Medicaid population and as an ASO for the uninsured population). The behavioral health benefits in the Arizona behavioral health plan are broad and are the same for both the Medicaid and uninsured populations, allowing for flexibility in the delivery of services. Texas has a Medicaid behavioral carve-out plan in one region of the state (in and around Dallas) that provides similar broad benefits and flexibility, and serves both the traditional Medicaid populations (SSI and TANF) as well as those at and below the 150% poverty level. Other states faced challenges to delivering COD services within Medicaid managed care arrangements, because substance abuse services were not included in the managed behavioral health benefit. In Oregon, for example, substance abuse outpatient services are managed, but are part of the main medical benefit rather than included in the mental health carve-out.

**Most people with COD, particularly the non-SMI, receive care from a parallel service system.** States appear to believe that cross-training has improved access to appropriate services for the population with COD even when they are delivered by separate mental health and substance abuse providers who are either co-located or located in separate provider agencies. All states thought that, at the current time, most of those with a co-occurring disorder in their state had access to services delivered by separate mental health and substance abuse providers rather than access to integrated care. While this “parallel” or “coordinated” model of COD service delivery appears to be the only viable option for many with COD, especially those who are not Medicaid eligible, there has been little attention by the states to these models of service delivery in order to discover if coordinated care is, in fact, occurring.

Beyond cross training, states have generally not focused on improving the coordination of care between separate mental health and substance providers. Some states pointed out the advantages that provider agencies in more rural areas provided for delivery of COD services, because substance abuse and mental health specialists were under the same roof in small organizations, and their work environments naturally encouraged more cross-professional collaboration and coordination of care. When substance abuse and mental health providers are located in separate provider agencies, coordination is hampered by concerns about confidentiality that prevents sharing of clinical information, an obstacle that Oregon’s mental health and substance abuse authority addressed by requiring sharing of clinical information when clients are being treated by separate mental health and substance abuse treatment providers.

The absence of state attention to coordination of care by separate mental health and substance abuse providers has important ramifications for the COD population whose locus of care is primarily the substance abuse system. Numerous barriers to providing COD services for this population continue to exist, even in these states that have made much progress in developing COD training and service models. Constraints in financing mental health care for this population are a significant challenge. Many substance abuse treatment clients are not Medicaid-eligible, and with public mental health resources focused mostly on the SMI and Medicaid populations, this population is not a priority for mental health providers. Relatively small and heavily strained public substance abuse treatment budgets in these states make it difficult to support mental health services for substance abuse treatment clients through this funding stream. Even so, the Texas substance abuse treatment authority has undertaken an innovative strategy to develop standards for co-psychiatric disorder specialists who would staff substance abuse treatment settings and be funded as part of the substance abuse budget.

Even when Medicaid reimbursement is available for substance abuse clients (e.g., for case management by substance abuse providers), reimbursement rates are often much lower than for mental health providers, inhibiting the development of more intensive integrated or coordinated care models. While the broad

managed care reforms in some states (for example, in Arizona, and in Dallas, Texas) appear to have created systems in which public funding pays for a flexible range of service benefits for both the Medicaid and uninsured poor populations, it is not yet clear whether these flexible systems have led to improved COD services for those in Quadrant III (low severity MH and high severity SA disorders).

**Early state efforts have involved policy and regulatory strategies to facilitate provision of COD services.** States have begun to make regulatory or policy changes to provide a more favorable environment for delivering COD services, and those that have not yet made regulatory changes are considering them. Some of the regulatory and policy changes that states have or are in the process of undertaking to support COD services include the creation of a bundled Medicaid reimbursement rate for intensive case-management services that would apply to integrated treatment services (Ohio), changing provider agency licensing requirements to require COD assessment capability for all providers (Arizona), and developing standards and competencies providers must meet to be reimbursed for COD services (Texas).

**Information systems are generally inadequate for monitoring COD services.** At the present time, many states in our study had no or very limited capability to routinely monitor the population being diagnosed with COD in their service systems, the types of services they receive, or their outcomes. When some capacity does exist, it typically does not link across mental health and substance abuse systems, nor would such links be particularly useful because the data elements within the systems are not comparable. Some states, however, have noteworthy information systems. Arizona uses a standardized intake instruments and has linked management information across mental health and substance abuse treatment, both Medicaid and non-Medicaid, and is developing indicators of COD diagnoses and services to incorporate into their system. Connecticut is routinely monitoring COD service utilization and outcomes of care. In addition, most states in our study were undertaking or planning efforts to improve their data systems, including standardizing data elements (such as standardized intake protocols), adding data elements that explicitly identified COD assessment and services, and/or creating linkable and comparable data elements across mental health, substance abuse, and Medicaid information systems.

**Ongoing strategies for quality assessment and quality improvement of COD services are not yet well developed.** Apart from a focus on improving workforce skills to deliver COD services, states have generally not developed broad strategies for improving the quality of COD services. Limitations in information systems mean that performance measurement standards or continuous quality improvement cycles cannot readily be implemented. Often, quality assessment and quality improvement responsibilities have devolved to a local authority or managed care entity, and thus a broader strategy is not part of the state agenda. Connecticut is an exception with its capability to monitor COD service use and outcomes, and a state-level quality improvement coordinator who is focusing on ways to encourage providers to improve the quality COD services. Ohio has developed and implemented an innovative state-level strategy for encouraging the adoption of best practices, in a state where funding and responsibility for quality assurance is passed to local mental health and substance abuse treatment authorities. The state has created a Coordinating Center of Excellence (linked to a University) with the goal of marketing and disseminating evidence-based treatment models into the provider community, and providing training and technical assistance to providers who wish to implement the model.

### *Local Level Trends and Themes*

In this section, we present local level trends and cross-cutting themes that emerged from our local program interviews.

**Type of Agency and COD Population Focus.** All programs that participated in this study maintain a broad COD population focus, regardless of agency type (public or private). Most agencies serve both the SMI and non-SMI, Medicaid eligible and non-eligible and forensic populations. Providing COD services does not seem to be affected if an agency holds only a mental health or substance abuse license.

**Services Offered to the COD Population.** All programs deliver a wide array of usual mental health and substance abuse services, and support services (e.g. residential, vocational rehab), to meet the needs of the COD population regardless of whether they consider their services to be a specialized program for COD. All programs provide individual, group, case management, screening and assessment services. While almost all programs provide pharmacy/medication management and vocational rehab services, only about half provide outpatient detox, physician services, partial hospitalization, psychosocial rehab and residential services. Less than half of the programs provide methadone, inpatient detox, intensive outpatient, ACT, self-help and illness management services. Almost all programs provide other types of services such as homeless outreach, crisis intervention, dialectical behavioral therapy and Spanish speaking services.

Most programs engage in more informal versus formal linkage activities with other agencies in their communities. Informal activities include referrals for services such as case management, employment, mental health and substance abuse, and informal working relationships and collaborations with organizations such as local hospitals, police departments, and residential care. Formal linkages include memorandums of understanding and inter-agency agreements with organizations such as local hospitals, health departments and mobile crisis units.

**Screening, Assessment, Treatment, and Staffing.** Almost all local programs are using both parallel and integrated treatment models to deliver COD care. Most programs have based their models of COD care on the principles that Drake and Minkoff advocate, and on other information found in the literature. All local programs have the staff capacity to deliver COD treatment through individual therapists and COD teams. Almost all programs consider the majority of their staff capable of delivering some type of COD treatment. No program had to relocate staff to begin delivering COD treatment or considers certification and licensing a barrier to delivering COD care. However, programs are addressing the need for staff to be cross-trained so that treatment can be delivered more effectively, and integrated treatment models are more the norm. In all programs a lead therapist is responsible for developing and/or coordinating treatment plans with other therapists and/or a team. All programs use a combination of standardized and homegrown instruments to routinely screen and assess clients for COD disorders. Most programs are not providing any special type of clinical supervision for staff who provide COD care.

**Financing Issues.** All local programs primarily receive funding from public sources but proactively seek out public and private dollars to maximize their ability to deliver mental health, substance abuse and COD services. Medicaid is the largest source of funding for COD services in all programs. State revenues and federal mental health and substance abuse block grants are the most common additional sources. Over half of the programs are involved in some type of risk-based contracting with managed behavioral healthcare organizations. For the most part, more flexible managed care arrangements make it easier for programs to bill and get reimbursed for MH and SA services.

Providers have learned how to provide COD care under existing billing systems. However, current reimbursement mechanisms, particularly under Medicaid, may not reflect how services actually or ideally might be provided. For example, by requiring separate billing of MH and SA services, there are no mechanisms to identify combined services.

Only a few programs can effectively estimate their total budget for COD services. Estimations are limited because COD indicators are not well established, and (as described above) funding mechanisms do not support an integrated way to bill for COD services. Although programs are concerned about the impact of declining state revenues, all programs think they need more funds to continue to provide and expand COD services.

**Training and Quality Assurance.** All local programs are highly committed to providing ongoing staff training for COD treatment and other service delivery topics. Trainings are provided by in-house agency staff and outside experts in the field of COD. Staff attend conferences on a regular basis. Most programs are in the beginning stages of developing quality improvement models and indicators to support the delivery of COD care. A few agencies have created their own COD measures and quality improvement models, or have modified their usual utilization review process to specifically include COD. All agencies plan to continue and/or expand their trainings and further develop quality improvement models and indicators for COD.

**Facilitators for Providing COD Treatment and Sustainability of Services.** The main facilitators for providing COD treatment were strong leadership by program executive directors, funding for COD services (e.g. federal grants, blending of funds), program commitment to serving the COD population, and staff training. Despite state budget cuts, all programs are confident that they will continue to maintain their menu of services to treat COD clients (even if they need to shift funds to do so), and plan to expand COD services and/or COD staff training.

**Barriers to Providing COD Treatment.** Barriers to providing COD treatment at the local level extend beyond agency-based factors. Historical philosophical differences between mental health and substance abuse providers (e.g. biases against substance abuse clients taking psychiatric medication), lack of funding for COD and substance abuse services, separate mental health and substance abuse systems, and maintaining a properly educated and trained workforce, are challenges that the local programs are addressing within their agencies and with a variety of stakeholders.

## Chapter 13. Next Steps

In this chapter we conclude with a brief discussion of next steps that might be taken to improve our understanding of the extent to which various state initiatives, policies and practices are successful in achieving their goals to improve access to and quality of COD services.

Figure 1 presents a framework for considering the links between state authorities, local provider agencies, the care that individuals receive, and the outcomes of that care for health and functioning of treated individuals, and for costs. The broad elements of this framework are taken from Donobedian's classic quality of care model (Donobedian, 1966), which posits that structural characteristics of the health care system and environment influence the processes of clinical care, which in turn influence patient outcomes. The framework makes explicit the aims and logic that underlie the specific initiatives, policies, and practices of state authorities and the leadership of local provider agencies. State authorities have adopted various strategies that are intended to influence the structural environment for provider agencies, to encourage these agencies to develop COD services. These strategies have often included the promotion of cross-system consensus and collaboration, the provision of clinical training and technical assistance, alignment of financial incentives, and institution of regulatory or administrative rules to facilitate the delivery of COD services. Provider agency directors undertake a second level of organizational initiatives that influence the structural environment of COD services at the local agency level, including the development or redistribution of financial and staff resources, and the implementation of policies and service models that are intended to improve treatment delivered to those with COD. Provider agencies may undertake strategies and activities to improve COD services directly in response to state initiatives, or may do so independently of state initiatives.

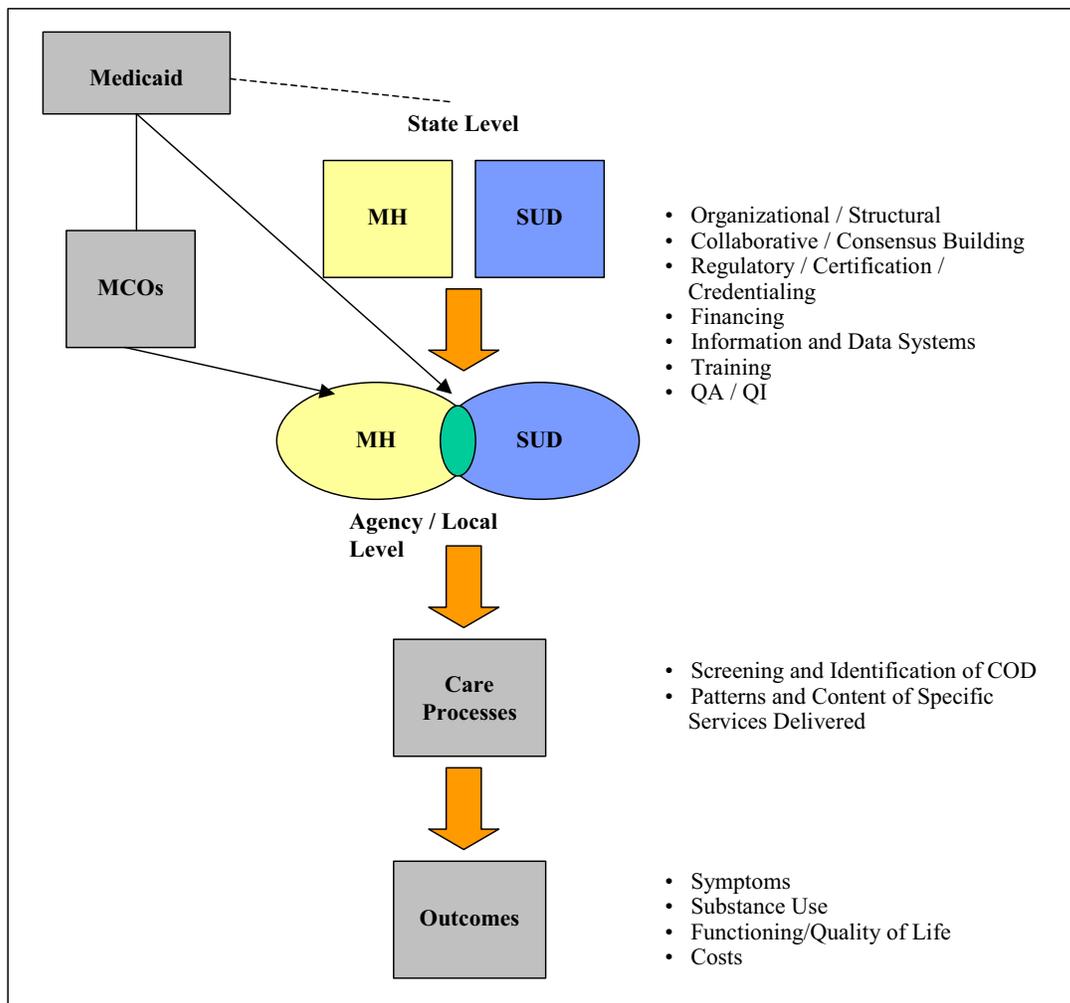
As suggested by this framework, there are two broad ways of evaluating whether state and local provider strategies and initiatives are having the intended impact on improving care for persons with COD. A first-level question that an evaluation should answer is whether processes of care are improving. That is, do more people with COD have access to treatment services, and to what extent are these services consistent with best practices (as suggested by empirical research and/or expert opinion)? If processes of care are improving, then the next level of question to address is whether these improvements in clinical processes are associated with expected improvements in outcomes. To be most informative, we would ultimately want evaluations to provide information on both effectiveness and costs of delivering COD services. Over time, the accumulation of information on costs and effectiveness could inform state and local planners in their efforts to prioritize, consider trade-offs between different types of service delivery models and intervention approaches, and work toward a more efficient system of care.

Recognizing the importance of information on processes and outcomes of care that can inform planning and quality improvement efforts, many state mental health and substance abuse authorities, as well as local provider agencies, have developed capabilities to routinely monitor some processes and outcomes of care. Usually, data that are collected for fiscal accounting purposes provide, at least crudely, information about some processes of care. In order to routinely collect outcomes information, however, or more specific information about processes of care that would map onto definitions of best practices, routine data systems have to be substantially enhanced. This is often a costly and cumbersome process, and yet some states have made substantial progress in developing information systems that have broad utility for tracking outcomes, and linking outcomes to specific types of service categories and providers.

Even for states that have invested in developing data infrastructure capability for evaluation and planning purposes, there are substantial challenges for understanding the processes and outcomes of care for individuals with COD. Separate mental health and substance abuse financing streams and regulations have typically resulted in separate and non-comparable fiscal accounting systems, neither of which can be utilized to determine which individuals have been identified to have co-occurring disorders and/or the extent to which individuals are receiving services that address both mental and addictive disorders.

As federal and state leadership continues to press for innovations and improvements in services for individuals with co-occurring disorders, the need for ongoing evaluation to learn lessons from these innovations also increases. A key aspect of these evaluation efforts should be to plan and implement improvements in data infrastructure capability to allow routine monitoring of the processes and outcomes of care for individuals with COD. Much could be learned from states and local provider agencies that have already made progress in developing these capabilities. Piloting and demonstration of specific monitoring and evaluation frameworks could be undertaken at a local level with provider agencies that have already implemented programs for individuals with COD. Controlled experimental and quasi-experimental effectiveness studies focused on specific populations and intervention approaches would complement a broader program of monitoring and continuous quality improvement.

**Figure 1. Framework for Investigating Systems-Level Changes to Better Treat COD**



## Appendix A. Definitions

Throughout this report we refer to terms such as “parallel treatment” and “integrated treatment” when discussing care for people with co-occurring disorders. Researchers and practitioners often employ varying definitions when using these terms. For the purposes of this report, we use the definitions below. Also listed are definitions for specific treatment approaches or models that are mentioned throughout the report.

*Assertive Community Treatment (ACT) Model:* “a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia” (Assertive Community Treatment Association, <http://www.actassociation.org/actModel/>).

*Comprehensive, Continuous, Integrated System of Care (CCISC) Model:* A model for organizing care for people with co-occurring disorders developed by Kenneth Minkoff. The model specifies systems-level change rather than a specific mode of treatment, with an emphasis on making efficient use of existing resources, utilizing evidence-based treatment practices, and providing care in an integrated fashion (Minkoff, <http://www.kenminkoff.com/ccisc.html>).

*Consultation:* A level of collaboration between MH and SA providers that is informal. Both MH and SA disorders in a patient are addressed through providers’ sharing of information, referral practices, and other informal means (NASMHPD and NASADAD, 1998).

*Coordination:* A level of collaboration between MH and SA providers that is formal or structured, so that both MH and SA disorders in a patient are addressed by the treatment regimen. An example would be a multidisciplinary treatment team consisting of staff from separate MH and SA provider agencies (NASMHPD and NASADAD, 1998).

*Dual Diagnosis Toolkit Project:* With support from SAMHSA and the Robert Wood Johnson Foundation, Robert Drake at the New Hampshire-Dartmouth Psychiatric Research Center and others have developed “toolkits” of implementation guidance and assessment instruments for the treatment of people with SMI, including those with co-occurring substance abuse disorders. These toolkits are being tested in a multi-state evaluation project (see Robert Wood Johnson Foundation website, <http://www.rwjf.org/reports/grr/036805.htm>).

*Four Quadrant Model:* A conceptual framework, developed by NASMHPD and NASADAD (based on a model used in New York state), which characterizes the co-occurring population by severity of mental health/substance abuse disorder and locus of care. The model assigns the co-occurring population to one of four quadrants. Quadrant I refers to individuals with a low severity mental health disorder and low severity substance abuse disorder, who are typically cared for in primary care settings. Quadrant II consists of people with a high severity mental health disorder and low severity substance abuse disorder, who are typically cared for in the mental health system. Quadrant III refers to individuals with a high severity substance abuse disorder and low severity mental health disorder, who generally receive treatment in the substance abuse system. Quadrant IV consists of people with both high severity mental health and substance abuse disorders, who typically are served by state hospitals, jails, prisons, and emergency rooms. The model also recommends the level of service coordination required among mental health, substance abuse, and primary care treatment providers, based on the quadrant in which an individual seeking care is classified. The recommended level of service coordination lies on a continuum, with

Quadrant I requiring the lowest level of coordination (consultation among providers) and Quadrant IV demanding the highest level of coordination (integrated care) (SAMHSA, 2002).

*Integrated treatment/services:* An individual receives both substance abuse and mental health treatment within the confines of a single program--regardless of whether that program is a mental health or substance abuse program. The integrated services approach has been popularized for people with severe mental illnesses (see NASMHPD and NASADAD, 1998).

*New Hampshire/Dartmouth Model:* A specific model of integrated treatment for individuals with co-occurring mental and addictive disorders developed by Robert E. Drake and colleagues. The model focuses on providing “a comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interventions; provision of help to clients in acquiring skills and supports to manage both illnesses and to pursue functional goals; and cultural sensitivity and competence” (Drake and Essock et al., 2001). This model is also known as the Integrated Dual Disorders Treatment (IDDDT) model.

*Parallel treatment/services:* Services that are not provided in an integrated fashion, but are provided in a collaborative fashion (i.e., services provided under either consultative or coordinated models of care).

*Serious Mental Illness (SMI):* In this report we use the following federal definition of SMI: An adult is considered to have a SMI if he or she “at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R *and* ... that has resulted in functional impairment which substantially interferes with or limits one or more major life activities....Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses....DSM-III-R ‘V’ codes, substance use disorders, and developmental disorders are excluded from this definition” (Federal Register, Vol. 64, No. 121, 1999).

## Appendix B. Table 1

**Table 1. State Mental Health and Substance Abuse Expenditures: Select Indicators for FY 2001 and FY 1999**

STATE	TOTAL SMHA CONTROLLED EXPENDITURES (FY 2001)	TOTAL STATE SUPPORTED ALCOHOL & OTHER DRUG SERVICES EXPENDITURES (FY 1999)	TOTAL SMHA CONTROLLED PER CAPITA EXPENDITURES (FY 2001)	TOTAL STATE SUPPORTED ALCOHOL & OTHER DRUG SERVICES PER CAPITA EXPENDITURES (FY 1999)
Arizona	\$ 472,341,291	\$ 49,743,917	\$ 89.36	\$ 9.90
Connecticut	\$ 439,519,867	\$ 151,084,202	\$128.85	\$44.61
New York	\$3,331,688,218	\$ 817,434,167	\$175.97	\$43.29
Ohio	\$ 692,287,984	\$ 357,187,274	\$ 61.12	\$31.51
Oregon	\$ 336,847,640	\$ 98,001,660	\$ 97.39	\$28.88
South Carolina	\$ 299,401,952	\$ 32,920,339	\$ 73.99	\$ 8.28
Tennessee	\$ 395,202,700	\$ 35,397,300	\$ 69.13	\$ 6.27
Texas	\$ 796,974,433	\$ 210,313,860	\$ 37.53	\$10.23
Wyoming	\$ 30,097,068	Not available	\$ 61.12	--
<b>National State Average</b>	\$ 448,518,107	\$ 96,923,897	\$ 83.51	\$ 13.98

- This Table presents the most current, standardized and aggregate national expenditure data for state mental health and substance abuse services that is comparable between states (see note below regarding Total Alcohol & Other Drug Services Per Capita Expenditures). Data for mental health expenditures is most current for FY 2001, and is based on Funding Sources and Expenditures of State Mental Health Agencies Fiscal Year 2001, the National Association of State Mental Health Program Directors Research Institute (NRI) (Lutterman et al, 2003). Data for substance abuse, or alcohol and other drug services, is most current for FY 1999, and is based on State Resources and Services Related to Alcohol and Other Drug Problems: An Analysis of State Alcohol and Drug Abuse Profiles for Fiscal Years 1998 and 1999 (SADAP) (NASADAD, 2001).
- Total SMHA Controlled Expenditures and Total SMHA Controlled Per Capita Expenditures data are based on Tables 1, 24, 27, 46 and 47 in Lutterman et al (2001), and NRI's definition of SMHA-Controlled Expenditures. For most states, SMHA-Controlled Expenditures includes the following sources: state (general state, State Medicaid), federal (Medicaid, Medicare, block grant, other SAMHSA, other federal), local and other (first and third party and other) sources. Expenditures are most typically associated with state mental hospitals funded and operated by the SMHA, community based programs directly funded (and operated) by the SMHA or contract or other state local fiscal arrangements, and SMHA support activities for research, training, prevention operated and SMHA administrative expenses.
- Total State Supported Alcohol and Other Drug Agency Expenditures data is based on Table 1 in NASADAD (2001) and includes the following sources: State Alcohol and Other State Agency, Other State Agency, SAPT Block Grant, Other Federal Government, County or Local Agencies, and Other Sources.
- Total State Supported Alcohol and Other Drug Agency Expenditures Per Capita figures were calculated for this Report. Each state's per capita figure was calculated by dividing its Total Expenditures for State Supported Alcohol and Other Drug Services by its 1999 state intercensal population estimate. Intercensal population estimates were based on the Population U.S. Division, U.S. Census Bureau, Time Series of Intercensal State Population Estimates, April 1, 1990 to April 1, 2000, Tables CO-EST 2001-12-00, 12-04, 12-09, 12-36, 12-39, 12-41, 12-45, 12-47, and 12-48. Per Capita National State Average was based on available data for 46 states only.

## Appendix C. Solicitation Letters

# RAND

December 20, 2003

[Name of Director/Commissioner]  
[Director/Commissioner Title]  
Division of Mental Health/Substance Abuse  
[Address]  
[City, State, Zip Code]

Dear Ms. \_\_\_\_\_,

We are writing to update you on the *Building Bridges* research initiative that we are undertaking to evaluate and disseminate best practices for adults with co-occurring mental and addictive disorders. *Building Bridges* is being led by Harold Pincus, M.D. and Audrey Burnam, Ph.D., senior researchers at RAND Health, with support from The Robert Wood Johnson and the John D. and Catherine T. MacArthur Foundations.

Since our last letter, we have received many valuable examples of innovations in treatment, organizational, financial and systems designs that have developed to improve care for adults with co-occurring disorders in the public and private sectors. We have reviewed these examples and other co-occurring activities that have been published and reported recently on state websites.

*At this time we are seeking to learn, in more detail, about co-occurring activities in particular states.* We would like to talk with you in order to better understand your state's activities. Our interview will take approximately 30 to 60 minutes to complete depending on the range of activities in your state. Our questions cover the following types of activities that may have been initiated in your state to improve care for adults with co-occurring disorders:

- consensus building & planning
- statutory, regulatory, financing & administrative procedural changes
- workforce training and development
- information system improvement and development
- pilot or demonstration programs and other research
- work with local mental health authorities and mental health and substance abuse providers

Our research coordinator, Jake Dembosky, will call your office in the next week to confirm your participation and to schedule an interview. One of us will conduct the interview.

Your participation will provide essential information about the most promising and broadly implementable models for co-occurring service delivery, and will help us to generate the basis for a future national research demonstration. If you have any questions about the *Building Bridges* initiative please call or email us, or visit our website at [www.rand.org/health/building.bridges](http://www.rand.org/health/building.bridges). We look forward to talking with you and thank you for your consideration.

Sincerely,

Michael Greenberg, J.D., Ph.D.  
Associate Behavioral Scientist  
Pittsburgh Office  
310-393-0411, ext. 4648  
Michael\_Greenberg@rand.org

Jennifer Magnabosco, Ph.D.  
Associate Policy Researcher  
Santa Monica Office  
310-393-0411, ext. 7589  
Jennifer\_Magnabosco-Bower@rand.org

# RAND

June 25, 2002

[Director Name]  
[Director Title]  
State Medicaid Agency  
[Address]  
[City, State, Zip Code]

Dear Mr. \_\_\_\_\_,

I am writing to request your participation in our *Building Bridges* research initiative that has been designed to evaluate and disseminate best practices for adults with co-occurring mental and addictive disorders. *Building Bridges* is being led by Harold Pincus, M.D. and Audrey Burnam, Ph.D., senior researchers at RAND Health, with support from The Robert Wood Johnson and the John D. and Catherine T. MacArthur Foundations.

We began the initiative by reviewing the research literature and state websites, convening a panel of experts, and using our project website to solicit examples of innovations in treatment, organizational, financial and system designs that have been developed to improve care for adults with co-occurring disorders in the public and private sectors.

In 2003 we launched the major data collection phase of the initiative, expert interviews with state officials. We have almost completed our interviews with state mental health and substance abuse directors in several states, including Dr. \_\_\_\_\_ and Dr. \_\_\_\_\_ in [state name]. Currently, we are scheduling interviews with state Medicaid Directors to gain their perspective on financial, policy and programming issues associated with improving care for adult persons with co-occurring disorders.

Consequently, I would like to request your participation in a telephone interview to discuss a range of activities that your state may have initiated to improve care for adults with co-occurring disorders, and the role that the Medicaid office has played in jumpstarting, implementing or maintaining them. Enclosed you will find a brief summary of the topics we would like to discuss. They are consistent with the issues covered with the state mental health and substance abuse directors.

Our research coordinator, Jake Dembosky, will call your office in the next week to confirm your participation and to schedule an interview. I will conduct the interview, which I anticipate to take about 45 minutes.

Your participation will provide essential information about the role that Medicaid plays in funding and regulating services for people with co-occurring mental and addictive disorders. If you have any questions about the *Building Bridges* initiative please call or email me, or visit our website at [www.rand.org/health/building.bridges](http://www.rand.org/health/building.bridges). I look forward to talking with you and thank you for your consideration.

Sincerely,

Jennifer L. Magnabosco, Ph.D.  
Associate Policy Researcher  
Santa Monica Office  
310-393-0411, ext. 7589  
Jennifer\_Magnabosco@rand.org

# RAND

October 10, 2003

[Director Name]  
[Director Title]  
Local Provider Agency  
[Address]  
[City, State, Zip Code]

Dear \_\_\_\_\_,

I am writing to request your participation in our *Building Bridges* research initiative that has been designed to evaluate and disseminate best practices for adults with co-occurring mental and addictive disorders. *Building Bridges* is being led by Harold Pincus, M.D. and Audrey Burnam, Ph.D., senior researchers at RAND Health, with support from The Robert Wood Johnson and the John D. and Catherine T. MacArthur Foundations.

We began the initiative by reviewing the research literature and state websites, convening a panel of experts, and using our project website to solicit examples of innovations in treatment, organizational, financial and system designs that have been developed to improve care for adults with co-occurring disorders in the public and private sectors.

In 2003 we launched the major data collection phase of the initiative, expert interviews with state officials. We have completed our interviews with state mental health, substance abuse and Medicaid directors in our pool of 23 states. In your state I have interviewed \_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_. Currently, we are scheduling interviews in 9 state states with 9 local provider agencies to gain their perspective on the delivery of treatment for adult persons with co-occurring disorders. \_\_\_\_\_ recommended your agency as one that is currently delivering integrated treatment to adults, serves a broad population of persons with co-occurring disorders (persons with and without serious mental illness) and is considered a model program for this mode of service delivery in your state.

Consequently, I would like to request your participation in a telephone interview to discuss a range of activities that your agency has initiated to deliver care to adults with co-occurring disorders. Specifically, we would like to interview your clinical director or staff person who manages services for clients with co-occurring mental and addictive disorders. Enclosed you will find a brief summary of the topics we would like to discuss.

Our research coordinator, Jake Dembosky, will call your office in the next week to confirm your participation and to schedule an interview. I will conduct the interview, which I anticipate will take about 50 minutes.

Your participation will provide essential information about how co-occurring treatment is being delivered at the local level, and complement the information we have gathered about state-level co-occurring activities. If you have any questions about the *Building Bridges* initiative please call or email me, or visit our website at [www.rand.org/health/building.bridges](http://www.rand.org/health/building.bridges). I look forward to talking with you and thank you for your consideration.

Sincerely,

Jennifer L. Magnabosco, Ph.D.  
Associate Policy Researcher  
Santa Monica Office  
310-393-0411, ext. 7589  
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## Appendix D. Mental Health/Substance Abuse Director Interview Guide

### INTERVIEW PROTOCOL FOR SAMHSA STATE CO-OCCURRING STUDY

Interview Respondent: \_\_\_\_\_  
Title: \_\_\_\_\_  
State: \_\_\_\_\_  
Interviewer: \_\_\_\_\_  
Date: \_\_\_\_\_

#### INTRODUCTION:

Thank you to respondent(s) and introductions.

The purpose of the interview is to explore state and local activities that improve care for adults with co-occurring mental and substance abuse disorders, and to place those activities within the context of the overall organization of SA and MH care in the state.

By adults with co-occurring disorders we mean any individual who has both a diagnosable MH and SA disorder. We are not limiting our inquiry to people with severe mental illnesses (such as schizophrenia or bipolar disorder) but rather are interested in the larger population of people with co-occurring disorders, including people with primary SA disorders served in the public sector.

While our interest is broad, the activities we will discuss hereafter may be focused more narrowly, for example, only for individuals with SMI.

- To begin the interview we would like to know your (SMHA or Substance Abuse Agency) definition of co-occurring disorders:

Definition: \_\_\_\_\_

The rest of the interview has 8 sections and 24 questions.

## **SECTION I: OVERVIEW OF FINANCING OF STATE AUTHORITIES**

**Introduction:** The purpose of the first section of the interview is to understand some of the ways that state MH, SA and Medicaid authorities finance MH and SA services, and the contextual basis this financing provides for how state and local activities may improve access to services for people with co-occurring disorders.

What is the name of your Agency?

What is the mission of your Agency?

1. a. Are there any structural, definitional and/or eligibility limitations in your state's Medicaid benefits that make it difficult (problematic) to deliver services for co-occurring disorders in mental health settings?

b. If yes to a/b above, are these limitations being addressed currently? If so, how (in what ways)?

**Note: For example, some state Medicaid plans do not cover outpatient SA services**

2. a. Are there any structural, definitional and/or eligibility limitations in your state's Medicaid benefits that make it difficult (problematic) to deliver services for co-occurring disorders in substance abuse settings?

b. If yes to a/b above, are these limitations being addressed currently? If so, how (in what ways)?

**Note:** For example, many SA clients are not Medicaid eligible, or SA treatment facilities may not be licensed to provide MH services.

3. a. Are there *any other* limitations in the state Medicaid program (e.g. amount, scope, duration limits, regulations for eligibility, facility licensing, etc.) that have proven problematic in providing appropriate services to people with MH/SA disorders? If so, what are they?

b. Are there (any other) barriers to financing co-occurring services for the non-Medicaid, uninsured adult population in either mental health or substance abuse service settings? If so, what are they?

4.a. Does the state directly contract with any managed care organizations to manage the provision of public sector MH/SA services?

- If so, what types of contracts do the MH, SA and Medicaid agencies have in place?

Managed Care Contracts	MH Authority	SA Authority	Medicaid
Risk-based contracts			
ASO-(admin.services)-only			
Other (specify)			

b. If the state has managed care arrangements,

- are they statewide or limited to certain regions?
- have they impacted on providing services for adults with co-occurring disorders, e.g. facilitated or limited services, proven problematic in providing appropriate services to people with MH/SA disorders? If so, what are they?

5. a. Do local entities (local MH/SA authorities, counties, cities) contract with any managed care organizations to manage the provision of public sector MH/SA services?
- If so, what types of contracts do the MH, SA and Medicaid agencies have in place?

Managed Care Contracts	MH Authority	SA Authority	Medicaid
Risk-based contracts			
ASO (admin.services) -only			
Other (specify)			

**Note: Explore to determine whether there is a consistent pattern across the state or whether there are just one or two local entities using managed care contracts. Ask for specific examples of local authorities that may be focusing attention on co-occurring disorders.**

- b. If local entities have managed care arrangements,
- are they statewide or limited to certain regions?
  - have they impacted on providing services for adults with co-occurring disorders, e.g. facilitated or limited services?

## **SECTION II: ACCESS TO SERVICES FOR CO-OCCURRING DISORDERS**

**Introduction:** Commentators describing the provision of services to people with co-occurring disorders have suggested that there are two main ways that states and localities organize services for people with co-occurring disorders.

They refer to the *parallel* services approach as one in which an individual receives services for MH problems in a MH program and services for SA problems in a SA program *simultaneously*, with linkages established between the clinicians across programs.

By contrast, the *integrated* services approach focuses on providing both SA and MH treatment within the confines of a single program – regardless of whether that program is a MH or SA program. The integrated services approach has been popularized for people with severe mental illnesses.

6. With that as background, can you tell us the extent—statewide or in certain regions—to which sub-groups/eligible populations in your state have access to parallel or integrated services within the MH and SA sectors?

**Note:** Generally, we're trying to understand the norm rather than the exception – although it would be useful to identify model programs.

- 
- Which groups have access to parallel TX in the mental health sector? Statewide or certain regions? Are there groups that do not have access (last column)?
  - Which groups have access to parallel TX in the substance abuse sector? Statewide or certain regions? Are there groups that do not have access (last column)?
  - Which groups have access to integrated TX in the mental health sector? Statewide or certain regions? Are there groups that do not have access (last column)?
  - Which groups have access to integrated TX in the substance abuse sector? Statewide or certain regions? Are there groups that do not have access (last column)?

State Specific Sub-Groups/ Eligible Populations: May match previously mentioned Groups or may name new ones	Parallel TX in MH Sector: State or region	Parallel TX in SA Sector: State or region	Integrated TX in MH Sector: State or region	Integrated TX in SA Sector: State or region	Not Available for this Sub-group: State or region

7. Does access to co-occurring disorders treatment (parallel or integrated) vary geographically, depending on the particular locale or program?

- If yes, are there areas or regions of the state that are doing a particularly good job in providing co-occurring disorder services?
- If yes, can you provide contact information on programs we might want to look at?

8. What barriers have you faced (if any) in providing services to the sub-groups/eligible populations named in the two previous questions (6 and 7)?

9. What facilitators (if any) have you observed that have enhanced the development of parallel or integrated treatment for these individuals?

10. If integrated treatment is provided in either the MH or SA sector, what financing or reimbursement mechanism are used to pay for integrated treatment?

11. If integrated treatment is provided in the SA sector, how is MH assessment and medication management paid for?

### **SECTION III: STATE-LEVEL CONSENSUS BUILDING AND PLANNING FOR CO-OCCURRING SERVICES**

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**Introduction:** We would now like to ask some specific questions about the activities going on at the state and local level to improve access to and quality of care for people with co-occurring disorders in your state.

12. Have the state MH and state SA authority entered into any consensus-building or aligning process between the two state agencies on the issue of co-occurring disorders?

- If yes, when did that process begin?
- If yes, was the state Medicaid agency involved?
- If yes, what were the target populations (i.e., people with co-occurring disorders) defined?
  - a.
  - b.
  - c.
  - d.
- Is there a commitment from the state mental health and substance abuse authorities to implement any recommendations that may have been generated from the consensus process?
- If yes, has a formal Memorandum of Understanding been signed by both state agencies? If yes, ask for a copy.

13. Has the state MH or SA authority initiated any consensus-building or planning process among other key stakeholders at the state-level (e.g., local authorities, provider agencies, consumers, family members, advocates, etc.)?

- If yes, please describe.

14. Has the state MH or SA authority issued any guidelines or principles for delivering MH/SA services to individuals with co-occurring disorders?

- If yes, ask for a copy.
- If yes, are there any administrative or financial incentives to encourage providers to implement services in keeping with the guidelines?

**Note:** We’re trying to understand if the guidelines are “just a piece of paper” or whether the state agency is aligning incentives with its stated principles. For example, does the provider agency receive special designation or enhanced reimbursement for providing services within the guidelines?

**SECTION IV: STATE-LEVEL CHANGES TO FACILITATE PROVISION OF CO-OCCURRING SERVICES**

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15. Have state agencies made any of the following changes to facilitate the provision of services to individuals with co-occurring disorders?

Has the state MH... SA...Medicaid Authority:	MH	SA	Medicaid	Briefly describe
Provided targeted funds for the development of new services for individuals with co-occurring disorders				
Made changes in benefits or reimbursement for services				
Made changes in target populations eligible for specific services				
Made changes in licensing requirements for provider agencies				
Made changes in certification requirements for professionals				
Made changes in continuing education requirements for professionals				
Other				

**SECTION V: WORKFORCE/TRAINING ISSUES FOR CO-OCCURRING SERVICES**

16. Does the state MH or SA authority sponsor any cross-training initiatives to enhance the skills of existing MH and SA staff?

- If yes, how is the state agency involved?

**Note:** We want to know whether the state agency just sponsors the training (i.e., state funds pay for the training) as opposed to actually administering the training.

- If yes,
  - Who gets trained
  - How extensive is the training (# of sessions, content)
  - Who developed the curriculum?
  - Who does the actual training (e.g., in-house versus external trainers)

- If yes, how broadly implemented are the training activities across the state/providers?

17. Are there specific standards for co-occurring competencies/skills?

18. Are there special credentials or licensing?

19. Does the state MH or SA authority sponsor any ongoing cross-training initiatives to maintain a trained workforce?

- If yes, how is the state agency involved?

**Note: We want to know whether the state agency just sponsors the training (i.e., state funds pay for the training) as opposed to actually administering the training.**

- If yes,
  - a. Who gets trained
  - b. How extensive is the training (# of sessions, content)
  - c. Who developed the curriculum?
  - d. Who does the actual training (e.g., in-house versus external trainers)
- If yes, how broadly implemented are the training activities across the state/providers?

**SECTION VI: INFORMATION SYSTEMS TO SUPPORT CO-OCCURRING SERVICES**

20. Has the state MH, SA or Medicaid authority implemented any of the following mechanisms to improve access to information across the MH and SA sectors?

Does the state MH...SA...Medicaid authority:	MH	SA	Medicaid	Briefly describe
Require that a standardized intake instrument (including MH and SA domains) be used by all providers				
Require that providers share clinical information with providers in the other sector				
Maintain a linked MIS across sectors				
Routinely monitor access to or quality of care for co-occurring disorders using performance indicators, or quality or outcomes measures				
Use quality assurance or quality improvement models to support care for co-occurring disorders				
Other				

**SECTION VII: PILOT OR DEMONSTRATION PROGRAMS & OTHER RESEARCH**

21. Has the state MH or SA authority sponsored any pilot or demonstration programs focused on services for adults with co-occurring disorders?

- If yes, please briefly describe:
  - a. service model
  - b. population targeted
  - c. financing mechanism
  - d. evaluation design (if applicable)
  - e. how this pilot relates to the overall strategy being pursued by the state
- If yes, is there someone at the local or programmatic level that we should talk to?

22. Has the state engaged in any other research efforts that are focused on adults with co-occurring disorders?

- If yes, briefly list the efforts: \_\_\_\_\_

**SECTION VIII: PLANS FOR THE FUTURE**

23. Does the state MH or SA authority have plans to pursue any of the strategies we have discussed in the near future?
- a. consensus building: Y/N? If yes, please describe.
  - b. statutory, financing, regulatory changes: Y/N? If yes, please describe.
  - c. workforce training/development: Y/N? If yes, please describe.
  - d. information systems: Y/N? If yes, please describe.
  - e. pilot/demonstration programs and/or research: Y/N? If yes, please describe.

**SECTION IX: OTHER**

24. Are there any other activities, or important information, about your state's co-occurring activities that you would like to mention at this time?

## Appendix E. State Medicaid Director Interview Guide

### MEDICAID PROTOCOL FOR SAMHSA STATE CO-OCCURRING STUDY

Interview Respondent: \_\_\_\_\_  
Title: \_\_\_\_\_  
State: \_\_\_\_\_  
Interviewer: \_\_\_\_\_  
Date: \_\_\_\_\_

**INTRODUCTION:** The purpose of this interview is to explore the role of Medicaid in financing state and local activities to improve care for adults with co-occurring mental health and substance abuse disorders. We are also interviewing state MH and SA Directors/Commissioners in your state, in order to learn more about organization and innovation in care for adults with co-occurring disorders. Ultimately, we hope to integrate our findings about Medicaid financing into a broader picture regarding the general organization of SA and MH care in your state, particularly as applied to adults with co-occurring disorders.

Please note that by “adults with co-occurring disorders,” we mean any individual who has both a diagnosable MH and SA disorder. We are not limiting our inquiry to people with severe mental illnesses (such as schizophrenia or bipolar disorder) but rather are interested in the larger population of people with co-occurring disorders, including people with primary SA disorders served in the public sector who have clinically significant but less severe mental disorders (e.g., anxiety, depression, post-traumatic stress disorder, etc.).

#### **INTRODUCTORY QUESTIONS:**

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- Does the Medicaid Agency recognize persons with co-occurring MH and SA disorders as a specific group who require services?  
*(If yes)* How does the Medicaid Agency define that group?  
*(If yes)* Are you familiar with the New York model for classifying persons with co-occurring disorders? *[Describe the 4 quadrants of New York Model.]* How does your Agency’s definition correspond to the New York model?
- Are you aware of any special financing issues that are associated with providing care for co-occurring MH and SA disorders?
- We understand that your state has been involved in \_\_\_\_\_ **[ADD BRIEF DESCRIPTION OF STATE-SPECIFIC MEDICAID POLICIES AND OTHER ACTIVITIES RE: CO-OCCURRING DISORDERS]**, in an effort to improve Medicaid financing of care for persons with co-occurring MH and SA disorders. Could you confirm/elaborate on this?

**OVERALL CONTEXT REMINDERS TO RESPONDENT:  
CURRENT FISCAL YEAR & ADULT CO-OCCURRING POPULATION ONLY**

**SECTION I: OVERVIEW OF MEDICAID'S FINANCIAL AND REGULATORY ROLE WITH REGARD TO CO-OCCURRING SERVICES**

**Introduction:** The purpose of this section of the interview is to understand the way that state Medicaid authorities organize and finance MH and SA services, in order to provide a context for understanding state and local activities to improve access to services for people with co-occurring disorders.

1. a. Does the state Medicaid agency contract with any managed care organizations to manage the provision of public sector MH/SA services?

*(If yes)* Are those contractual arrangements typically risk-based, or ASO (administrative services only)?

*(If yes)* Does your state carve out the administration of mental health or substance abuse benefits from the rest of its Medicaid managed care plan? Please describe the structure of any benefit carve-outs.

- c. If the state has managed care arrangements,

are they statewide or limited to certain regions?

Have they impacted on providing services for adults with co-occurring disorders, e.g. facilitated or limited services?

2. a. What is the range of authorities (state/local, MH/SA, county, city, providers) who have responsibility for contracting with any managed care organizations to manage the provision of public sector MH/SA services?

*(If yes)* Are those contractual arrangements generally risk-based, or ASO (administrative services only)?

**Note: Probe whether there is a consistent pattern across the state, or just one or two local entities using managed care contracts. Ask for specific examples of local authorities that may be focusing attention on co-occurring disorders.**

- b. How have those arrangements impacted on providing services for adults with co-occurring disorders, e.g., by facilitating or limiting services?

3. What sorts of managed care plan options are available under Medicaid in your state, and how do these differ (in terms of organization/operation/geographical availability, etc.) from Medicaid FFS in your state?
  
4. Which of the following MH/SA services are covered by Medicaid, both under FFS and under Medicaid managed care plans (assuming the latter are available)?

Services		Covered by the state Medicaid FFS plan	Covered by Medicaid managed care plans
Mental Health Services			
Inpatient			
Physician services			
Outpatient			
Day treatment/partial			
Case management			
Pharmacy ( <i>i.e., psychotropic meds</i> )			
Residential			
Vocational			
Self-help/Peer Support			
Substance Abuse Services			
Inpatient Detox			
Inpatient (detox plus)			
Outpatient detox			
Outpatient			
Case management			
Methadone therapy			
Pharmacy ( <i>e.g., naltrexone; antabuse</i> )			
Residential			
Vocational			
Self-help/Peer Support			

**Note:** The second column should be used only for states that contract with managed care plans. In those instances, the “covered benefit” managed by the plan may be a subset of the services (or have additional amount, scope or duration limits) than those reflected in the state Medicaid plan.

5. a. Are there limits in the state Medicaid plan or Medicaid managed care benefit plans [*e.g., in amount, scope, or duration of benefits*] that have proven problematic in providing services to people with MH/SA disorders in mental health settings? In substance abuse settings? If so, what are those limits?

**Note:** For example, some state Medicaid plans do not cover outpatient SA services, some Medicaid plans include the clinic but not rehab option, limiting the types of outpatient services that can be provided.

**[Note:** If any plan limits are reported, then probe for impact of those limits on specific groups of co-occurring patients, based on New York Model quadrants.]

b. Are there any other aspects of the state Medicaid program that are problematic in providing services to people with MH/SA disorders? [E.g., *regulations for eligibility, facility licensing, etc.*] If so, what are they?

**[Note:** If any other problems are reported, then probe for impact of those problems on specific groups of co-occurring patients, based on New York Model quadrants.]

c. Are there (any other) barriers to financing co-occurring services for the non-Medicaid, uninsured adult population? If so, what are they?

**[Note:** If any other barriers are reported, then probe for impact of those limits on specific groups of co-occurring patients, based on New York Model quadrants.]

6. Has the state Medicaid agency undertaken any revisions in structuring Medicaid benefits, reimbursement levels, or in the definition of Medicaid eligibility categories, in order to facilitate the delivery of services to adults with co-occurring disorders, such as promoting a particular clinical model of care [*e.g., parallel or integrated*]?

**[Note: If yes, probe for details. Probe also for** impact of the revisions on specific groups of co-occurring patients, based on New York Model quadrants.]

7. Has the state undertaken any other statutory, regulatory, financing, or administrative procedural changes related to Medicaid, in order to facilitate the delivery of services to adults with co-occurring disorders, such as promoting a particular clinical model of care [*e.g., parallel or integrated*]?

**[Note: If yes, probe for details, e.g.,** What facilitators have you observed that have enhanced the development of treatment for persons with co-occurring disorders? **Probe also for** impact of the revisions on specific groups of co-occurring patients, based on New York Model quadrants.]

8. Does the state MH or SA authority have any involvement in designing or overseeing the provision of MH/SA services within the state Medicaid and/or Medicaid managed care program, for the purpose of promoting a particular clinical model of care [*e.g., parallel or integrated*] or any other purpose?

**Note:** For example, does the state Medicaid agency consult with the state MH or SA authority in determining which services will be covered and at what rates? Does the MH or SA authority license facilities or set minimum staffing standards for Medicaid?

**SECTION II: STATE-LEVEL CONSENSUS BUILDING AND PLANNING FOR CO-OCCURRING SERVICES**

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9. Has the state Medicaid agency been involved in any state level consensus-building and planning for co-occurring disorders services?

***[If yes]*** When did that process begin?

***[If yes]*** How was the state Medicaid agency involved?

**SECTION III: STATE-LEVEL CHANGES TO FACILITATE PROVISION OF CO-OCCURRING SERVICES**

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10. Has the Medicaid agency provided targeted funds for the development of new services for individuals with co-occurring disorders? If so, in what ways? Has the Medicaid authority participated, sponsored, or been involved in, any pilot or demonstration programs focused on services for adults with co-occurring disorders? *[If yes, probe for contact person, brief description of pilot program, and role of Medicaid Agency pertaining thereto.]*

**SECTION IV: PLANS FOR THE FUTURE**

13. Does the state Medicaid authority anticipate making any changes in the future to improve systems of care for the co-occurring population that we haven't already discussed (statutory, financing, regulatory, consensus building, pilot/research)?

***[If yes]*** Please describe.

f.

**SECTION V: OTHER**

14. Are there any other activities, or important information, about your state's co-occurring activities that you would like to mention at this time?

## Appendix F. Local Provider Agency Interview Guide

### BUILDING BRIDGES CO-OCCURRING PROJECT CSAT LOCAL PROVIDER PROTOCOL SEPTEMBER 2003

Interview Respondent:

Titles:

State:

Organization Name:

Interviewer:

Date:

#### INTRODUCTION

Thank you to respondents and introductions.

The purpose of our study is to explore state and local activities that improve care for adults with co-occurring mental health substance abuse disorders, and to place those activities within the context of the overall organization of SA and MH care in the state. We have interviewed the MH, SA and Medicaid Directors/Commissioners in your state. Your perspective on co-occurring disorders, and information about how you deliver co-occurring services, will help to complete a profile of your state's co-occurring activities.

In this study we are mainly interested in co-occurring activities and service delivery for adults with co-occurring disorders. By adults with co-occurring disorders we mean any individual who has both a diagnosable MH and SA disorder. We are not limiting our inquiry to people with severe mental illnesses (such as schizophrenia or bipolar disorder) but rather are interested in the larger population of people with co-occurring disorders, including people with primary SA disorders served in the public sector.

#### **Q: What is your agency's definition of co-occurring disorders?**

The interview has 5 sections and 15 questions. Please keep in mind that we are primarily interested in activity that has occurred over the last few years and service delivery for adults with co-occurring disorders.

**SECTION I: ORGANIZATIONAL CHARACTERISTICS**

1. **Organization Type. What type of mental health and/or substance organization is your agency?**

- Public MH agency (e.g. CMHC)?
- Private MH agency?
- Public SA agency?
- Private SA agency?
- Other? (describe)

2. **Service Types. What types of services for persons with co-occurring disorders does your agency provide? Do you consider these services to be a specialized co-occurring service delivery program or just part of your usual menu of services?**

<b>a. Services</b>	<b>Yes</b>	<b>No</b>
• Mental health only?	___	___
• Substance abuse and alcohol treatment only?	___	___
• Both mental health and substance abuse, and a specific program for co-occurring?	___	___

b. **Service Types: Which types of mental health and substance abuse services does your agency provide?**

**ASK OPEN-ENDED QUESTION& KEEP THIS LIST HERE FOR PROBES AND OUR OWN CHECKLIST ONLY**

<u>Services</u>	<u>MH</u>	<u>SA</u>
individual treatment		
group treatment		
partial hospitalization/ day treatment		
psychosocial rehab		
case management		
ACT		
physician services		
vocational rehab		
self help/peer support		
illness management		
pharmacy/medication management		
detox		
methadone		
co-occurring		
screening		

assessment  
residential  
other

**Eligible Populations.**

- a. **What are the main population groups that your agency serves?**
- b. **What populations are eligible for co-occurring services in your agency? Do you serve both smi and non-smi populations? If so, what percentage of your clients are non-smi?**

*Probes Only*

Medicaid eligible/Non-Medicaid eligible  
TANF, CHIP, SOBRA  
Managed care clients  
Smi/Non-smi adults  
Children & Families, Elderly  
HIV/AIDS, Homeless, Forensic  
Native American tribes, Other

4. **Licenses. Under which types of licenses does your agency operate?**

- MH only
- SA only
- Dual MH and SA
- Other (describe)

## II. FINANCING FOR CO-OCCURRING SERVICES

### **5. Financing Resources.**

- a. What funding sources do you use to finance co-occurring services (e.g. block grant, Medicaid, state/local government, private pay)? Which are more important?
- b. What is the budget/cost of providing co-occurring services in your agency?

6. **Co-Occurring Billing.** How is billing for co-occurring services for adults done in your agency, e.g. using separate mental health and substance abuse codes/COD code, only certain staff can bill for mental health or substance abuse services, etc.?

7. **Problems with Financing and Billing.** Does the way you bill for/finance services create problems for delivering co-occurring services in your agency? If yes, what are main problems?

## III. FACILITATORS & BARRIERS TO DELIVERING CO-OCCURRING TREATMENT AND CO-OCCURRING TREATMENT PROGRAM CHARACTERISTICS

### **8. Overall Status of Delivering/Providing Co-Occurring Treatment**

#### **a. Model.**

What is the Model of co-occurring treatment that your agency uses to deliver co-occurring treatment—e.g. Drake integrated treatment/Toolkit, ACT, coordinated/parallel, other?

b. **Implementation Status.** What is the implementation status of delivering integrated treatment—just began, established—such as providing COD as part of ACT—or in process of expanding capacity to deliver COD treatment?

c. **Facilitators.** What are the main (top 3) facilitators that are associated with your agency's ability to deliver co-occurring services?

Probes Only:

Philosophy about co-occurring treatment?

Literature and reports in the field?

Staff commitment to implementing co-occurring services?

State Department of Mental Health, Substance Abuse, Medicaid influences?  
 Consensus building activities, e.g. task forces, local boards, regional consortium building?  
 Stakeholder involvement, e.g. consumers, State MH Planning and regional councils?  
 Involvement in pilot initiatives and/or research activities?

d. ***Barriers.*** What have been the main (top 3) barriers to implementing or expanding co-occurring services in your agency?

e. ***Changes to Achieve Implementation.*** Did implementing/adopting co-occurring treatment, e.g. integrated or other model, in your agency require shifts/changes in financial resources and organizational culture? What types of shifts/changes were necessary?:

- Probes Only
- Financial resources?
- Staff restructuring?
- Coordination between other agencies?
- Licensing?
- Certification?
- Training?
- Stakeholder involvement?
- Consumer involvement?
- External forces, e.g. federal government, county/local boards

f. ***Receipt of Co-Occurring Treatment.*** Approximately what percentage (or number per year) of the clients you serve receive co-occurring services?

9. **Screening and Assessment**

a. Do you use standardized protocols or instruments to screen and assess clients for mental health and substance abuse disorders? If yes, what are they?

Disorder	Screening Instrument	S/H*	COD	Assessment Instrument	S/H*
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COD

MH

SA

b. Which of these instruments are off-the shelf (standardized; S) or homegrown (H; developed by your agency)\*? (use above chart)

c. How routine (e.g. part of routine intake procedures, step by step process) is

screening and assessment for co-occurring disorders? At what point in the intake or continuing care process does screening and/or assessment occur?

#### **10. Treatment Planning & Service Delivery**

- a. **Staff Capacity.** How many staff are currently providing treatment for persons with co-occurring disorders in your agency? How many staff are planned to provide co-occurring treatment in the near future?
- b. **Mode of Service Delivery.** Are staff who deliver co-occurring treatment separate individual providers, or are there teams of staff who deliver co-occurring services in your agency?
- c. **Staff Placement.** Where are staff physically located who deliver co-occurring treatment—e.g. in the same building, floor, office space? Were staff relocated to deliver co-occurring treatment?
- d. **Treatment Plans.** Are treatment plans for co-occurring clients a single integrated plan, or a coordinated plan between mental health and substance abuse providers in your agency? Is treatment planning related to other support services, such as ACT, that are also provided by your agency?
- e. **Supervision.** Does supervision for staff who provide co-occurring treatment differ from the supervision staff receive who do not provide such treatment? If so, in what ways?

#### **11. Agency Training/Staff Credentials**

- a. **Type of Training.** What kind of training have your staff, and administrators, received to deliver co-occurring services?:

Who gets trained?

How extensive is training?

Is ongoing training provided/encouraged?

Who developed the curriculum?

Who does the actual training? (external experts, regional MH/SA staff, CSAT Technical Assistance Center, other champions)?

**b. Certification.**

1. What certification requirements do staff in your agency need in order to deliver co-occurring services in your agency?

Staff	Certification
MH	
SA	
Other	

**c. Consumer Involvement. Do consumers receive training to participate in the delivery of co-occurring services? If so, describe.**

**12. Information Technology and Quality Assurance**

**a. Indicators. Does your agency monitor access to or quality of care for co-occurring disorders using performance indicators, or quality or outcomes measures? If so, what are they? If yes, are they incorporated into routine information systems?**

**b. Quality Assurance. Does your agency use quality assurance or quality improvement models to support care for co-occurring disorders? If so, what are some of the strategies used to support co-occurring care?**

**c. Standards. Does your agency employ specific standards for co-occurring competencies? If so, what are they?**

**d. Principles/Guidelines. Does your agency follow particular guidelines or principles for delivering MH/SA services to adults with co-occurring disorders? If so, what are they?**

**IV. SUSTAINABILITY OF CO-OCCURRING SERVICES.**

**13. Current Sustainability. Do you expect that the co-occurring services you deliver will be easily sustainable in the foreseeable future? Why or why not?**

**14. Future Plans. Does your agency have plans for improving or expanding co-occurring services. If yes, what are the plans (e.g. credentialing, licensing, training, structural changes, information systems, Toolkit, etc.)**

**V. OTHER**

**15. Is there any other information about your agency's co-occurring activities that you would like us to know?**

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