

WORKING P A P E R

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.