

WORKING P A P E R

State Efforts to Improve Practice and Policy for Individuals with Co- Occurring Mental and Addictive Disorders

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WR-344-RWJ

January 2006

Funded by the Robert Wood Johnson Foundation and the John D. and
Catherine T. MacArthur Foundation

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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 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 the state level. 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 25 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 25 states were selected for the study: Alaska, Arizona, California, Connecticut, Delaware, Georgia, Illinois, Iowa, Indiana, Massachusetts, Michigan, Missouri, Montana, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Tennessee, Washington, Wisconsin, and Wyoming. (Two of these states, Michigan and North Carolina, declined to participate.)

Solicitation letters were sent to targeted respondents—state MH and SA directors (see Appendix B)--and intensive follow up communications were made for each state. Qualitative research methods were used to collect and analyze survey and secondary data. An interview protocol (see Appendix C) was 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. Content and thematic analysis techniques were used to analyze cross-cutting trends and themes according to the domains of interest for the delivery of COD services.

Findings and Implications

In brief, highlights from the analysis included the following themes and trends:

Facilitators of COD care at the state level 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 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 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.

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.

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 by the Robert Wood John and John D. and Catherine T. MacArthur Foundations 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 23 states to improve the service delivery system for their COD populations. 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.¹

¹ We also conducted a more detailed investigation of the activities to improve services for the COD population in a subset of 9 states, under a contract to the Center for Substance Abuse Treatment (CSAT) within SAMHSA. The investigation involved collecting additional data from state Medicaid officials and local service programs. The 9 states are Arizona, Connecticut, New York, Ohio, Oregon, South Carolina, Texas, Tennessee, and Wyoming. The results from this work are summarized in a separate

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 23 states (Chapters 3 through 25). Chapter 26 summarizes general findings that emerge from an assessment of information collected from all 23 states, and Chapter 27 provides recommendations for next steps.

Chapter 2. Methods

This project is a cross-sectional and exploratory survey of current activities that states are conducting (and planning) to improve care for adult persons with co-occurring (COD) mental health and substance abuse disorders. Twenty-five states were selected because we had reason to believe that they had engaged in at least some state-level efforts to develop services for persons with co-occurring disorders. Ultimately, 23 of the 25 states selected agreed to participate in the study. In each of these 23 states telephone interviews were conducted with the state mental health commissioner/director and state substance abuse commissioner/director.² 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 profiles between December 2003 and February 2004.

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

² In a subset of 9 states, we conducted additional interviews with state Medicaid officials, as part of a separate study that investigated the activities being pursued in these states to improve COD services in more detail. The state profiles and analysis in this report are informed by the data collected from these additional interviews. The 9 states in which we conducted these interviews are Arizona, Connecticut, New York, Ohio, Oregon, South Carolina, Texas, Tennessee, and Wyoming.

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 C.)

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 B.) Lists for state mental health and substance abuse commissioners/directors were obtained from the National Association of State Mental Health Program Directors, and the National Association of State Drug and Alcohol Directors. 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.)

Interviews were conducted by telephone with two RAND research staff, with one researcher conducting the interviews and the other taking detailed notes. Using these notes, written documentation of responses from all interviews was prepared. This documentation was synthesized to create state profiles for each of the 23 states. States reviewed these profiles and provided corrections or feedback, and these comments were integrated into the final profiles.

Chapters 3 through 25 in this report provide the profiles for each of the states. Chapter 26 summarizes our observations across the 23 states. Chapter 27 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. Alaska State Profile

COD Population Focus

At the time of our interview, Alaska was in the process of merging its Mental Health section of the Division of Mental Health and Developmental Disabilities with the Division of Alcoholism and Drug Abuse, and adding the Medicaid fiscal component into a new Division of Behavioral Health. The MH and SA Divisions are housed under an umbrella agency, the Department of Health and Social Services.

The state serves a broad spectrum of persons with COD, designating adults with COD, children with SED, and pregnant women as priority populations. Both the MH and SA Divisions do not promulgate an “official” definition of COD, and have “left it up to providers” to define COD in their programs. However, this will change as the infrastructure changes and the Division moves toward regionalizing services.

While the state has used the Four Quadrant Framework as a conceptual framework to help address COD issues, a state committee’s recommendation to formally adopt the Framework has been “slow”. However, the state generally perceives that providers are more aware of COD as many attended a conference on the topic last year, agency documents increasingly include “dual diagnosis” or “COD” language, and SA providers must now report the number of COD patients they treat quarterly. The state is encouraging the delivery of integrated COD care throughout the state.

Financing and Access to Services

Alaska is mostly a frontier and rural state, providing MH, SA and COD services through separate MH and SA systems. Services are delivered by the state’s grantees, or its 58 CMHCs, 20 residential SA providers, 20 SA outpatient providers, 15 dual agencies, and 15 Native American programs. Located in 15 regions, the Alaska Native American programs provide an array of health services; manage hospitals; train and work with counselors in villages; receive funding from the MH and SA Divisions; are eligible to bill Medicaid; and are delivering more and more services to non-Native American persons.

The state hopes to improve access to care, more fully develop “no wrong door” community-based systems, and further refine state Division roles by merging its MH, SA and Medicaid Divisions and regionalizing care. The MH and SA Divisions are engaged in several internal and external strategic planning activities (see Consensus Building section below) to accomplish these goals. Currently, the state’s delivery of coordinated, parallel and integrated COD services varies geographically. In larger urban areas (of which there are few) COD treatment is more parallel. In more rural areas, necessity (lack of separate MH and SA providers) often dictates that COD treatment is more integrated. Regardless of geographic area, the 15 dual agencies deliver some form of integrated COD care. The state perceives that it has made progress in moving from the delivery of “traditional to parallel to more integrated” COD care during the past few years.

The major sources of funding for MH and SA services are Medicaid, block grants, state general revenues and sliding scale fees for persons not eligible for Medicaid. There is no managed care in Alaska. With state revenues significantly decreasing, access to care for uninsured persons is also decreasing significantly. Medicaid does not cover services for persons with a primary SA diagnosis.

In addition to merging the MH and SA Divisions and engaging in strategic planning activities, the state is developing other strategies to address limitations in financing and access to MH and SA services. The state has targeted funds from a SAMHSA grant to improve services and system infrastructures, such as

new psychiatric emergency (and other) services for the COD population. The state is also reviewing statutes and regulations associated with MH and SA eligibility and coverage requirements so that limitations in Medicaid coverage for SA services, and billing problems for both MH and SA services, can begin to be addressed.

Collaboration and Consensus Building

In 2001 the MH and SA Divisions began the process of aligning activities to improve COD care by securing a SAMHSA Co-morbidity grant and bringing together stakeholders to examine service system integration issues between certain groups (e.g., planning boards and tribes). The MH Division, SA Division, planning boards and tribes wrote a document that addressed these issues and clarified priorities to improve service delivery in general and for COD. The state Medicaid agency was also involved and has been supportive of developing funding strategies for COD services. The Division merger is part of an overall reorganization set forth by an Executive Order that includes COD as one of its priorities. MH and SA staff are “excited” about moving the merger forward; they think it will improve working relationships and services.

In addition to the stakeholders mentioned above, several others are involved in the state’s “two pronged” (internal and external) strategic planning process that is supporting the merger and service system improvement activities. These stakeholders include the Alaska Mental Health Trust Authority, MH Department Steering Committee, Alaska Mental Health Board, Governor’s Advisory Board on Alcoholism and Drug Abuse, MH and SA providers, MH and SA consumers, Alaska Native representatives (from the Native American Consortium) and the University of Alaska. The Alaska Mental Health Trust Authority is a unique entity that was established (funded) by the sale of land for \$1 million when statehood was attained to oversee the care of its four beneficiary groups. Comprised of four planning groups--the Mental Health Board (or State Mental Health Planning Council), community agencies, Commission on Aging, and Governor’s Advisory Council on Education and Disabilities and Special Education—it ensures that funds exist for certain beneficiary groups and involves consumers in all activities. The Mental Health Board and the Governor’s Advisory Board on Alcoholism and Drug Abuse are developing guidelines and principles (and considering administrative or financial incentives) for delivering MH, SA and COD services.

Training and Workforce Development

The state provides both internal and external training to Alaska Native and non-Native MH and SA staff throughout the state at individual agencies and at statewide conferences. Independent consultants, such as Ken Minkoff; the University of Alaska faculty; a Train the Trainers program for COD; and SAMSHA grants are used to provide training.

The state is developing guidelines and principles for the delivery of MH, SA and COD services, and is hoping to create administrative and financial incentives to support them. While no standards or competencies for COD exist, the Division is in the process of surveying clinicians and agencies, asking them to conduct a self-assessment of their COD definitions, barriers to delivering COD services, baseline of competencies, and general readiness level for implementing COD services and integrated treatment models. This information will be used to develop future training programs.

The state is discussing how it might establish a COD certification process. Currently, it does not certify or license MH providers. Only a non-mandatory certification process exists for alcoholism counselors. “Dual” MH and SA agencies are therefore not licensed, nor are COD clinicians certified as such.

Information and Data Systems

The state is currently working on integrating its MH and SA MIS systems with some assistance from a SAMHSA grant. The new web-based MH and SA system will be called AKAIMS (Alaska Automated Information Management System). The state is also developing a new Medicaid MIS system. A common web-based standardized intake/screening instrument, which includes MH and SA domains, will be used by all providers after piloting is completed. Sharing information between providers is voluntary and not required in any formal manner. However, the state does require SA providers to refer persons who have been screened to have a MH disorder to a MH program.

Quality Assurance/Quality Improvement

As the state develops the AKAIMS MIS system it plans to develop quality assurance and quality improvement models, and COD performance and outcomes measures, to support COD care. The MH Division is surveying providers to learn more about their COD definitions so that the new Behavioral Health Division will be able to “draft language that makes sense for future contracts”.

Pilot Projects

Other than piloting the common intake instrument, the state is not involved in any COD pilot projects. However, the state would like to conduct a systematic review of potential pilots projects (e.g., testing the implementation of Scott Miller’s model of COD care) and strategically plan similar efforts. The state has also applied for a COSIG grant that if awarded will be considered a resource for infrastructure building and demonstration projects.

Chapter 4. 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.

Chapter 5. California State Profile

COD Population Focus

California has separate MH (Department of Mental Health or DMH) and SA (Department of Drug and Alcohol Programs or ADP) departments which function under the umbrella agency, the Health and Human Services Agency. While DMH and ADP serve vastly different populations with a small overlapping segment of persons with SMI and SA-related disorders, together the two departments deliver COD care to a broad spectrum of adult persons with COD. DMH is mandated to deliver services to persons with SMI, including those with COD. ADP is able to deliver COD care to persons who have both SMI and non-SMI MH disorders and a range of SA problems. While the state is familiar with the Four Quadrant Model and has targeted programs for some populations, at the time of the interview it was not focusing on particular quadrants. Instead, the MH and SA state directors are conducting activities that are designed to promote “no wrong door” and “recovery” philosophies as the basis for delivering care to MH, SA and/or COD populations.

Financing and Access to Services

California is a geographically diverse state with suburban, urban, and rural areas. Management and delivery of MH and SA services is provided at both the state and local levels. The state departments manage their own respective county plans, and conduct audits and monitor contracts to ensure that counties meet minimum requirements for allocating resources. All counties operate as separate entities and systems of care, have the authority to certify providers, and set different priorities for MH and SA services.

Only MH services are delivered through managed care and non-managed care arrangements; SA services are carved out. Counties and providers (not the state) directly contract with managed care companies to deliver services. Both MH and SA services are provided through a network of CMHCs that are part of California’s 58 counties. However, SA services can only be provided by facilities with a SA license. While parallel and sequential treatment are the most common models of COD care delivered throughout the state, coordinated and integrated models of COD care are also used. Results from the state’s own research have shown that integrated treatment for homeless and forensic populations is more effective than other approaches.

The state’s strong and diverse county-based MH and SA systems pose complex challenges in the two state directors’ quest to address service and system barriers associated with delivering MH, SA and COD care. Access to MH, SA and COD services in the state varies by geographic region, county and provider availability. Capacity to deliver SA services varies, as 20 counties provide limited drug (or medical) care, and for the most part, SA services are delivered in SA settings. Delivering services in rural areas is also problematic. Clients often need to be transported to other counties for care and many rural counties have joint residential programs that limit the ability to deliver COD treatment. Some providers are not willing to address such gaps in care because of the small number of clients to be served, and/or philosophical biases that SA providers may have against serving MH clients, and vice-versa for MH providers.

Regardless of county, MH providers have found it difficult to deliver care to Proposition 36 clients (persons who have been arrested for drug problems and are required to receive MH and/or SA treatment) because they are seen as a “SA population”. Likewise, many SA providers are concerned that they should hire part-time psychiatrists to better screen and treat clients who also have MH problems.

Such barriers have provoked the two state department directors to set three main priorities to improve the delivery of COD care: 1) to identify COD capable facilities and to develop licensing requirements that can help increase capacity; 2) to develop strategies, such as MH, SA and COD guidelines. To promote a “no wrong door” philosophy among providers; and 3) to address structural and financial barriers to providing COD care, such as the need for a COD Medicaid billing code (a state work group is addressing this).

The main sources of funding for MH, SA and COD services are Medicaid (Rehab Option), MediCal, block grants, private foundation monies, general state revenues and other sources that counties may solicit to fund services. Both departments cited the need for more funding (SA receives less funding than MH, however) and their frustrations with federal regulations that have made it difficult to blend or braid funds. One exception to this constraint has been the state’s successful blending of funds for the COD TANF population. Budget limitations and federal guidelines (e.g., third party payments cannot be applied to persons with drug histories) have made it increasingly difficult for uninsured populations to receive MH, SA and COD services in the state. While it has been hard to generate new funds to deliver services, private foundations have recently taken an interest in making monies available for service and structural changes.

The two state directors are working together to examine these financial structural barriers and to continue to address effects that a 1992 realignment process has had on local MH and SA systems (e.g., MH priorities were established over SA concerns). The state has also targeted funding to facilitate the delivery of SA and/or COD treatment. For example, SA providers have hired MH practitioners with SA funds to deliver MH services. The MH department has targeted monies to deliver COD services to the homeless population, and the SA department has used monies to service the Proposition 36 population. The state is also working on problems with reimbursement using the Drug MediCal benefit and, as mentioned, is developing a COD Medicaid billing code.

Collaboration and Consensus Building

Since 1996, the directors of the state MH and SA departments have jointly led the collaboration and consensus building efforts to create greater awareness of COD models of care and to improve COD service delivery. The two directors are committed to conducting inter-departmental projects and being visible together as much as possible. For example, they have been traveling throughout the state to discuss COD with county governments and providers. The two departments work under a Memorandum of Understanding for COD, collaborate on non-COD state issues (e.g., Governor’s Task Force on Homelessness), and are participants in each other’s advisory groups (e.g., the MH director is a member of ADP’s drug rehab Proposition 36 program advisory group). A range of stakeholders from a variety of geographic areas are involved in both COD and non-COD activities, namely MH and SA providers, consumers, county government, NAMI and other MH constituency groups.

Consensus building efforts in the state have largely focused on building trust and dialogues between the MH and SA systems and promulgating a “recovery” oriented approach to treatment. Special attention is being paid to help the SA community “see” the benefits of inter-departmental efforts “in a different light”. That is, both directors have been working hard to establish credibility in the opposite sector so that providers can reach a higher comfort level to more efficiently deliver MH, SA and parallel or integrated COD care. Because of the strong county culture throughout the state, strategies to deliver services vary by type of provider, geographic region, and county. For example, when one county formed an integrated

behavioral system and designated MH teams as primary overseers of care, many SA staff left the system. Strategies were then developed to orient SA providers differently so they felt part of the change process and a larger partner in delivering care. The state hopes that conferences on COD topics will also help to ameliorate differences between the two systems.

The state engages in other activities to address issues associated with delivering COD care. Its COD Task Force was formed several years ago to start discussions about COD. The current structure of the Task Force is smaller with a more targeted focus. The Task Force has developed guidelines and principles for COD care that includes a set of values for both clinicians and administrators, and 13 priorities that the state is committed to implement. The state hopes to develop incentives that are associated with the guidelines and principles, and to create additional task forces that can further develop treatment and funding models for COD.

Training and Workforce Development

The MH and SA departments share a similar vision for training staff and implementing strategies to increase the delivery of COD care. Training for MH, SA and other providers in California is sponsored separately and jointly by the state MH and SA departments. The two departments coordinate with the counties on training and are developing regional training programs. Despite budget constraints, the state is in the process of expanding its training activities to help implement COD treatment statewide, addressing limitations in training that MH and SA providers have experienced in the past. The state's interagency workgroup is developing training strategies that can enhance services integration. The state's COD Task Force has recommended that cross-training become a mandatory state sponsored activity. Annual conferences on COD are planned to help implement this recommendation.

DMH requires that its providers receive annual training to provide MH services, and has licensed counselors, while SA does not require that its counselors be certified. However, the SA department plans to develop "more of a demand for SA training" by establishing its own annual trainings. The SA department has also taken the lead in developing standards, competencies and credentialing, and facility licensing for COD. Both departments perceive that lack of financial support is the biggest barrier to their being able to further develop credentialing and licensing requirements for providers to become certified in MH and/or SA competencies).

Information and Data Systems

The MH and SA departments maintain separate MIS systems and do not require that providers share clinical information across sectors or use a standardized intake instrument that includes MH and SA domains. Both departments are engaged in several efforts that address these separate practices. The COD Work Group is developing strategies that address some of the difficulties that HIPAA has posed with regard to sharing information. The state is working with outside consultants to implement its federal Data Infrastructure Grant to improve data systems at the county level. The SA department is developing a new automated outcomes measurement system, in conjunction with federal performance partnerships data development efforts. The system is designed to make data collection, input and analysis easier, and include standardized instrument measures to access treatment outcomes in multiple domains of the Addiction Severity Index (ASI). The SA department has also been working under a MOU with UCLA to link data between the state's criminal justice and SA MIS systems.

Quality Assurance/Quality Improvement

The state routinely measures performance and outcomes indicators, monitors access to and quality of care, and uses quality improvement models to support the delivery of services to persons who have MH or SA

problems. The state plans to develop such supports for COD specifically after the federal government disseminates standards associated with its performance partnership measurement efforts.

Pilot Projects

Both the MH and SA departments, separately and jointly, have conducted demonstration projects and other research that has focused on COD service delivery. Overall, these efforts have shown that providing integrated COD is a “complex” endeavor; that is, while integrated care leads to better outcomes for a variety of groups, maintaining clients in such care is difficult, and involvement in integrated treatment leads to higher costs because clients begin to use other services they need. The state is not planning to conduct more COD pilots because it wants to move COD efforts “to scale” statewide.

Chapter 6. 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 DMHAS 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.

Chapter 7. Delaware State Profile

COD Population Focus

The public mental health and substance abuse systems in Delaware are integrated at the agency level in the Division of Substance Abuse and Mental Health (DSAMH), located within the Delaware Department of Health and Social Services. DSAMH defines COD broadly, and includes in this conceptual category any persons who have both a diagnosable mental health and substance abuse disorder, regardless of which diagnosis is considered “primary”. DSAMH is familiar with the Four Quadrant Model for characterizing COD, and has focused its attention mainly on Quadrants II and III (i.e., persons who present with a primary, high-intensity mental health or substance abuse problem, and a secondary, lower-intensity problem in the other domain). In addition, DSAMH also addresses Quadrant IV (i.e., persons with severe mental illness and high-intensity substance abuse) through its administrative responsibility for Delaware’s state psychiatric center.

Financing and Access to Services

Medicaid financing for COD services in Delaware is controlled by the Division of Social Services (DSS) within the Delaware Department of Health and Social Services. Medicaid behavioral health benefits are administered under a statewide, risk-based, managed care contract with a managed care organization. Although the Medicaid managed care system generates typical complaints about its coverage decisions, those complaints and related problems are not specific to COD services. Medicaid coverage for inpatient substance abuse treatment (including detox) is reportedly problematic in the current system, largely because of very restrictive eligibility criteria. The limited availability of high-intensity substance abuse care under Medicaid is problematic for the treatment of COD.

COD services for the non-Medicaid population in Delaware are administered directly by DSAMH, through contracts with community providers (both in mental health and substance abuse) across the state. DSAMH provides funding for a full continuum of public mental health and substance abuse care, ranging from outpatient to residential services. Financing for these services comes from a combination of state general revenues and federal block grants, and limitations in funding are reportedly a challenge in delivering public sector services for COD. Another barrier to COD care involves the limited knowledge of many mental health and substance abuse providers regarding the other treatment sector. Developing clinical competencies across mental health and substance abuse domains is another challenge for the improvement of COD services.

Provision of COD services through the DSAMH system occurs largely under a parallel delivery model, although DSAMH’s goal is to provide more integrated COD services across the state. Community mental health centers (CMHCs) in Delaware have recently been restructured, and are training clinicians to treat COD as a part of that process. Ultimately, DSAMH would like all of its contractual providers to be able to offer integrated mental health and substance abuse care, but at the time of our interview, there was variation in the extent to which integrated care was available. DSAMH is facilitating the move toward integrated care by providing COD training to providers with implementation assistance, and also by revising some of its current contractual arrangements to increase available funding to substance abuse providers for psychotropic medications.

Collaboration and Consensus Building

As mentioned above, government oversight of public mental health and substance abuse systems in Delaware has long been integrated into a single state agency, DSAMH. DSAMH is engaging in a

consensus-building process with substance abuse and mental health providers from across the state. In addition, DSAMH anticipates issuing a future set of COD service guidelines, based on the findings of its own internal working group. These guidelines will then be applied to future contracts with mental health and substance abuse providers. At the time of our interview, DSAMH required the provision of COD services as one element in its contracts, and the agency employed performance-based contracting with some substance abuse and mental health providers. DSAMH has plans to move further in the direction of tying the level of reimbursement for mental health and substance abuse services to providers' performance.

Training and Workforce Development

DSAMH operates a training office that offers a catalog of courses to its mental health and substance abuse providers throughout the year. At the time of our interview, there were no specific state standards for COD clinical competencies, nor for dual licensing.

Information and Data Systems

DSAMH requires the use of a standardized intake instrument across mental health and substance abuse settings to collect basic demographic data. The current IT system does not provide the capability to share this information directly among providers. However, with appropriately executed client consent, programs share clinically relevant information with each other.

Quality Assurance/Quality Improvement

Although DSAMH engages in system-wide quality assurance, data monitoring, and performance evaluation efforts, none of those efforts are currently focused on COD specifically.

Pilot Projects

Delaware is not currently engaged in sponsoring any COD demonstrations, pilot programs, or other research.

Chapter 8. Georgia State Profile

COD Population Focus

The public MH and SA systems in Georgia are integrated at the agency level in the Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD), located within the Georgia Department of Human Resources. Officials from the MH and SA sections of MHDDAD endorsed a broad definition of COD, including in this category any persons who have a simultaneous, diagnosable mental health and substance abuse disorder. Both MHDDAD officials we interviewed were familiar with the Four Quadrant Model for characterizing COD sub-populations, and the two officials acknowledged the potential utility of that model for clinical service provision, training, education, and so on. However, at the time of our interviews the Division was at an early stage in actually beginning to use the model, primarily through its educational efforts aimed at providers, staff, and regional planning boards. Reliable COD prevalence information is currently not available in Georgia across the four quadrants of the model, and refinement of the state's MIS system is a target of opportunity for trying to generate this kind of information.

The public sector MH treatment system focuses on persons with SMI and co-occurring substance abuse, with relatively few persons not so classified being served by the system. By contrast, it is not clear that the public sector SA treatment system has any specific, quadrant-based treatment focus.

Financing and Access to Services

The primary administrative responsibility for Medicaid in Georgia falls under the purview of the Division of Medical Assistance (DMA), an independent state agency within the Department of Human Resources. DMA works collaboratively with MHDDAD in formulating the state's plan for Medicaid services (i.e., as it relates to mental health and substance abuse), and MHDDAD also has collaborative involvement in managing Medicaid resources in connection with mental health and substance abuse treatment.

The public sector mental health and substance abuse treatment system in Georgia operates on a regional basis. Planning for services is done independently by region, and the state is currently implementing a consolidation of its 13 administrative regions into 7. For each region, MHDDAD enters into MH and SA services contracts with a variety of public and private service providers. "Public" providers predominantly take the form of community mental health centers (CMHCs), which in Georgia are non-profit organizations that are neither state-owned nor state-operated. CMHCs frequently include both MH and SA clinicians on their staffs, while private providers have traditionally been more likely to specialize in delivering one or the other kind of service.

Medicaid restrictions were not identified by MH and SA officials as creating a major barrier in the delivery of COD services in Georgia. However, Medicaid staffing requirements would prevent SA service organizations from billing for MH services, unless the organizations had qualified staff (i.e., possessing formal MH credentials). Historically, MH services for Medicaid-eligible persons have not left much room to serve the COD population, and SA benefits under Medicaid are narrowly defined. An effort is underway to revise Medicaid billing codes, so as to allow providers to bill for COD services, rather than forcing a billing choice between MH and SA services.

Georgia does not have separate public service systems for Medicaid and non-Medicaid populations. Federal block grant funding (i.e., CMHS and SAPT) for non-Medicaid services flows through the same

regional contracting mechanism as Medicaid funding, and the ultimate goal of MHDDAD is to provide equivalent services to consumers regardless of Medicaid eligibility.

MHDDAD generally does not engage in managed care contracting for the provision of MH or SA services, but instead contracts directly with provider organizations on a regional basis (as indicated above). However, MHDDAD and DMA do have an ASO contract with an external review organization, which provides utilization review and other administrative support in connection with public sector MH and SA services.

Provision of COD services through the MHDDAD system occurs largely under a parallel delivery model, although integrated services are offered by some provider organizations in some parts of the state. A majority of COD treatment is provided in CMHC settings, where MH, SA, and developmental disability services are all offered within one agency. Even within CMHCs, however, the parallel service delivery model is reportedly more common than the integrated model. Although MHDDAD has embraced the concept of integrated service delivery, implementation is still in the design phase, and is limited by MHDDAD's power through its contractual relationship with provider agencies. Other barriers to integrated services include philosophical differences between MH and SA providers, and substantial geographic variation in the number of provider organizations. Facilitators of integrated services have included state-sponsored training initiatives, together with the support of independent advocacy groups (e.g., the Georgia Council on Substance Abuse).

Collaboration and Consensus Building

Because state MH and SA authorities in Georgia are both housed in a single state agency (MHDDAD) within a single state department (Human Resources), there has not been a formal interagency consensus building process on COD issues. Nevertheless, informal collaboration on COD between MH and SA officials has been longstanding, and has involved some outreach to clinical providers and to community boards. COD consensus building has not directly involved the state Medicaid agency, notwithstanding the collaborative efforts of MHDDAD and DMA in developing the state's Medicaid plans. Other consensus building activities on COD have included collaboration and consultation between MHDDAD and other government entities (e.g., the State MH Planning Council, the Governor's Council on Substance Abuse) and outside advocacy organizations (e.g., the Carter Mental Health Center). MHDDAD has not issued any formal guidelines or principles for the delivery of COD services across the state.

Training and Workforce Development

MHDDAD has contracted with an outside expert (Kathleen Sciacca) to provide COD training to providers across the state. Training is offered statewide on a first-come, first-served basis, and is aimed at getting clinicians to implement more integrated services for the COD population. On the SA side, additional training resources are provided through the CSAT technical assistance center. At present, there are no specific state standards for COD clinical competencies, nor for dual licensing.

Information and Data Systems

MHDDAD does not mandate the use of a standardized intake instrument across mental health and substance abuse settings, and does not require clinical information sharing between MH and SA providers. There is a linked MIS system across the state's MH, SA, and Medicaid authorities, but that system is very limited and cannot identify or track persons with COD.

Quality Assurance/Quality Improvement

MHDDAD is currently unable to engage in systematic data monitoring and QA/QI efforts for COD, because of severe limitations in its data system. Upgrading the data system is a threshold step in the direction of QA/QI for COD services, and MHDDAD has efforts underway to obtain related infrastructure grant support from CMHS and CSAT.

Pilot Projects

MHDDAD is funding a Peer Center Pilot program that offers integrated MH and SA services using a community-based, support services team model. The program is operating in 3 sites and serves approximately 60 people. The program has no formal research or evaluation component.

In addition, there is a “COD Treatment Court” pilot, with combined funding from MHDDAD and the justice system. The pilot is intended to improve COD services in a justice system context, following the model established elsewhere by mental health courts. This pilot may include an evaluation component.

Chapter 9. Illinois State Profile

COD Population Focus

Illinois has separate MH and SA Departments, the Division of Mental Health (DMH) and Division of Alcoholism and Substance Abuse (DASA). The two agencies have been housed within the same umbrella agency, the Department of Human Services, since 1996.

Over a decade ago DMH and DASA began collaborating to address COD delivery issues in Illinois. The state noted that its focus on COD “preceded” the Four Quadrant Model and that its COD activities have proceeded in tandem with what the Model represents. Under a joint initiative, the Divisions serve a spectrum of persons with COD. Currently, DMH defines its target COD population as persons with COD and SMI. While DASA views COD on a broader continuum, and serves a broader population of persons with SA and MH disorders, the state uses the term “MISA” to refer to persons who have both mental illness and substance abuse disorders.

Financing and Access to Services

Illinois is a geographically diverse state, with major urban, suburban and rural areas. MH and SA services are provided through a network of over 150 CMHCs and over 140 SA providers. While the state has many boards and local tax levying bodies, most counties focus on providing resources to non-SMI populations. The state believes in a “multiple door” model of MH and SA care, and the availability of a comprehensive needs assessment regardless of the system accessed or primary diagnosis. DMH and DASA, therefore, “crossover” monies to provide SA and MH services. As a result, about 50% of MH providers receive some SA funding, about 20% of SA providers receive some MH funding, and 35-40% of all agencies receive funding to deliver both MH and SA services.

Currently, the state is delivering primarily parallel COD care. The Departments have been working hard to encourage increased delivery of COD services and integrated treatment models. Persons with SMI, and institutionalized populations, receive more integrated treatment through CMHCs, ACT teams or specialized residential, hospital and prison programs. Access to coordinated, parallel or integrated COD services in the state has been facilitated during the last several years by an array of research, monetary and consensus building strategies that continue to address 1) reluctance to change or believe that COD services can be reimbursed under existing rules, and 2) the need for technologies and training to deliver COD services, and to improve typical MH and SA care.

MH and SA services are delivered mainly through non-managed care arrangements in the state. However, the state Medicaid agency maintains some risk-based contracts for both medical and MH/SA services in certain regions, such as Chicago. The major sources of funding for MH and SA services are Medicaid (including the Rehab Option), block grants and local or county funds/tax revenues. Non-state Medicaid match monies (\$250 million this year) that CMHCs receive can be used to pay for services for persons who are non-Medicaid eligible, indigent, need more comprehensive care than managed care can provide, or are Medicaid eligible and need services that are not covered under Medicaid (e.g., case management, vocational counseling). During the last several years the state has targeted funds to help implement COD care by creating budget initiatives, developing and sponsoring pilot programs, providing support for a MISA Training Institute (see below), and contracting with providers to engage in activities with the Institute. Despite recent state budget crises that prevent new pilot efforts, support for COD care has been enhanced by a slight increase in the state’s Medicaid budget and general revenue funds.

Even so, there are financial and structural limitations in Medicaid coverage, and general limitations in system capacities, that prevent the state from meeting as much of the MH and SA service needs as it would like. Both Departments report that they are delivering services at maximum capacity. They are also concerned that interventions they have established (e.g., referral programs between hospitals and dual MH and SA agencies) are still not delivering an optimal level of services for certain groups, such as persons with a primary SA disorder who have SMI, or persons in need of detox outside of MH hospitals. The state's budget deficit is the main reason the Departments are not taking steps to address such limitations. However, the Departments would like to work towards expanding MH and SA service coverage under Medicaid by creating incentive rules to serve MISA clients, or by exploring ways to pay differentially for services that meet certain fidelity standards, such as those used in the Dartmouth Toolkit Models.

Collaboration and Consensus Building

DMH and DASA have been collaborating and consensus building to better serve persons with COD for over a decade. The two Departments have "jointly sponsored, funded, organized and implemented dual diagnosis programs and training activities to support clinical strategies and benefit patients and conserve state resources". The two agencies also have a formal MOU to work together, though it does not pertain specifically to COD.

The state has established several Task Forces to improve systems of care and to address COD issues throughout the state. It remains committed to implementing recommendations that the Task Forces has set, such as making available and rolling out evidence-based practices for various services, including COD, and to making available specific guidelines and principles for delivering MH, SA and COD care through targeted solicitations, and departmental websites and newsletters.

Since 1991 the state has provided funds to support specialized programs (e.g., case management, local treatment networks) and initiatives (e.g., to improve local coordination of MH and SA services) for persons with mental illness and substance abuse disorders, or "MISA" clients. The state established and continues to "jointly support, in partnership with the University of Chicago Center for Psychiatric Rehabilitation", a major training and technical assistance infrastructure for the state--the MISA Institute. In 1999 MISA initiatives were expanded to establish "five consortia that included 16 DASA funded agencies, 12 DMH funded agencies and 2 agencies funded by both Departments", and to engage the "local state mental hospital in each consortium to be an active treatment and referral partner". DASA also increased its funding commitment at this time and has continued to fund 24 SA agencies to provide MISA services. A MISA Advisory Board continues to oversee the Institute's activities and represent various stakeholders.

Other stakeholders--such as NAMI, AMI of Illinois, and the Mental Health Association-- have been involved in COD activities since the first Taskforce was created in 1990. DMH considers consumers a "must" partner for any activities it pursues and has worked hard to facilitate the consumer voice in Illinois. For example, DMH developed consumer specialists in each local network so that a range of consumer interests and issues are represented that relate to both outpatient and inpatient care. DMH and DASA are both committed to building more MH consumer involvement, and better organizing SA stakeholder involvement, throughout the state. One important step in this direction has been the recent travel by the directors of the two Departments to all regions of the state to discuss evidence-based practices and models of COD care with providers and consumers.

Training and Workforce Development

Illinois has been engaged in specific ongoing activities to build organizational capacity and to educate the workforce to implement evidence-based practices in general, and COD treatment specifically. Historically, DMH has taken the lead in training activities, with DASA working directly with DMH and overseeing all activities. Recent budget cuts have made it more difficult for the state to offer and/or sponsor as much training as they have been able to do in the past.

Training in Illinois is both decentralized and statewide. Both MH and SA providers receive cross-training from activities sponsored by the state, and from independent consultants and organizations such as the Great Lakes Addiction Technology Transfer Center, the University of Chicago Center for Psychiatric Rehabilitation (the MISA Institute) and the University of Illinois at Chicago Circle Campus. As mentioned, the MISA Institute has primary responsibility for training MH and SA clinicians--who are employed by members of the consortia--in basic skills, clinical consultation, psychopharmacology, treatment planning and evaluation. To date, the Institute has trained over 500 clinicians who work in CMHCs and a small number of state hospital employees. As part of MISA activities in 1999, DASA funded a MISA Specialist position to act as a “point of contact for collaboration with DMH, the MISA Institute and the statewide consortia” and to provide “technical assistance and training” and “overall MISA initiative management” to field sites. The Departments sponsor non-consortia training activities that include MISA and other topical conferences. The Departments have also started to create a document that outlines how to start up and maintain MISA programs.

Overseen by a unique infrastructure, the MISA Board Registration, Illinois has developed specific standards for COD provider competencies that are part of a MISA clinician certification program. While no special MISA licensing exists, providers can be evaluated to receive an “optional” MISA accreditation. The state also plans to make changes to SA continuing education requirements.

Information and Data Systems

The Departments maintain separate information systems for MH, SA and Medicaid data. While MIS links are not maintained between MH and SA systems, links are possible to the Medicaid system for billing purposes. The state would like to link systems but does not have specific plans to do so at this time. DASA is exploring how to “remake” its system to be more efficient and web-based. Both Departments would like create a MIS system that clinicians can use to input data.

At this point in time the state does not require that providers share clinical information between MH and SA sectors. However, about five years ago the state enacted legislative changes that made it easier for providers to share information within the same service area and also funded a series of pilot projects to help providers learn how to better share information. The Departments think that new HIPAA rules will make sharing information more difficult overall, but that providers will find ways to overcome the problem as they provide more integrated COD treatment. Both agencies encourage providers to adopt evidence-based practices, including the use of standardized intake instruments, for the COD population. However, neither agency requires providers to use a standardized intake instrument.

The state tracks outcomes for COD specifically from MISA providers, and other providers who receive training from and/or are part of the MISA Institute training and research, using several standardized instruments. The state is waiting to review indicators that the federal government is developing for the block grants before it develops and/or adopts additional COD measures to be tracked across the state. While the state’s “Medicaid program book” can be used to assess hours and kinds of services, specific indicators that link diagnosis and service types are not available at this time.

Quality Assurance/Quality Improvement

Currently, the Departments are assessing how to better routinely measure performance and outcomes indicators, how to monitor access to and quality of care, and how to develop quality improvement models to support COD care. The state will use their new “Medicaid program book” and determine the usefulness of the CMHS/Dartmouth Toolkit materials and fidelity measures as part of their QI development process.

Pilot Projects

Illinois has been engaged in many pilot and other research projects to study and improve COD, MH and SA care in the state. All projects have helped the state to promulgate an integrated COD treatment focus for several populations, to roll out COD activities and to become more outcomes oriented. Currently, the state’s largest pilot project is a 15-site study designed to test and implement evidence-based COD practices. In addition to this effort and others discussed above, the Departments and individual provider agencies have implemented a range of funded projects (and small research centers) that focus on needs assessment, traumatic brain injury capacity, residential treatment, recovery management, and homeless case management and outreach for persons with COD, MH and/or SA disorders. While both Departments apply for grants to improve MH and SA care and would like to do more research, state budget shortfalls have made it difficult to implement pilot and research strategies consistently.

Chapter 10. Indiana State Profile

COD Population Focus

Indiana has a combined MH and SA division, the Division of Mental Health and Addiction, which is part of an umbrella agency for state human service agencies, the Indiana Family and Social Services Administration (FSSA). At the time of the interview, leadership in the Division was in transition. The Division's Director had retired and the Assistant Director left to become an Executive Vice-President of a CMHC. The Acting Director of the Division is a long-time staff member of the Division and was a member of the 1999 COD Task Force.

At the time of the interview, the Division was focusing its attention on the delivery of COD to persons with a primary diagnosis of serious mental illness (SMI) and a secondary diagnosis of substance abuse disorders. Four years ago (1999), a COD Task Force was formed to better meet the needs of the COD population. The state and the Task Force have used the Four Quadrant Framework to guide their COD activities. Indiana is also a national Dartmouth/Center for Mental Health Services Evidence-Based Practice Toolkit state, implementing the Dual Diagnosis and ACT evidence-based practices.

Financing and Access to Services

Indiana is a geographically diverse state, with major urban, suburban and rural areas. MH and SA services are provided through a network of providers, including 31 CMHCS located in 92 counties. Most (but not all) CMHCs provide MH and SA services, and all provide services to persons with SMI. CMHCs are considered managed care entities by the state even though no managed care system operates (e.g., there are no risk-based or ASO contracts). CMHCs employ managed care principles and oversee, or manage, care statewide.

The state is encouraging increased delivery of COD services, and integrated treatment models of care. Access to parallel or integrated COD services in the state has been facilitated by monetary and consensus building (see below) strategies which are helping to address staff and managerial reluctance to change, and their desire for technology to help them learn how to provide better COD treatment. Decisions were made to implement the Dual Diagnosis Toolkit in 6 sites as one major tool to positively forge change, and integrated models of COD care, throughout the state.

Financially, the Division has provided targeted funds to help implement COD care in both Toolkit and non-Toolkit programs. The Division set aside \$1 million from the general operating fund for Dual Diagnosis (IDDT) Toolkit sites to fund enrollments of clients and to help them with transitional and start-up costs. The Division provided a one-time set-aside of \$5 million to Toolkit and non-Toolkit sites to fund dual diagnosis clients. The funding amounts awarded were based on the market share of the COD population a CMHC serves across the state. For example, if a CMHC had 10% of the COD business in the state, their receipt of \$500,000 would be written into their CMHC SMI contract.

Reimbursement for MH and SA services in Indiana is paid for primarily through a Medicaid fee-for-service system that is associated with the state's insurance plan, known as the Hoosier Assurance Plan (HAP). A case rate system, based on categories of diagnosis and functioning, has long been in place in the state to regulate reimbursement and contracts. The state maintains two separate sets of billing codes for MH and SA services. However, the state is in the process of 1) implementing a tenth SMI case rate code-- a dual diagnosis code for persons with SMI and substance abuse problems, and 2) determining ways in

which Medicaid could be used more efficiently to pay for COD services. MH and SA services are also paid for through block grant funding, county/ local tax revenues and private funds.

In order to receive MH and SA services that are supported by the state, each person must be enrolled in HAP by his/her CMHC. Persons who have incomes under 200% of the poverty level are automatically eligible for HAP. While 45-50% of the state's Hoosier Assurance Plan population is not Medicaid eligible, the Division did not perceive that any problems exist regarding eligibility and Medicaid benefits. By law, CMHCs must enroll persons non-eligible for Medicaid (or persons who are otherwise uninsured) in HAP, categorize them as "unfounded enrolled", and still serve them. Care for this population is paid for using county funds, private payments, third party payments, or other mechanisms, such as monies "left over" from their HAP contract.

Collaboration and Consensus Building

Consensus building activities to improve the delivery of COD care have been ongoing in the Division since 1999 when a COD Task Force was created. At the time of our interview, activities were continuing, yet may become delayed as the Division's leadership is in transition, and the implementation of the Dual Diagnosis Toolkit project has progressed slowly. Both informal and formal commitments exist within the Division, and with providers, to work together to continue to roll out COD treatment in both Toolkit and non-Toolkit programs. However, it is not clear how these efforts will be supported financially.

The Division works closely with Gary Bond's ACT Technical Assistance Center to implement the Toolkit project's evidence-based practices. The Division is also talking with Gary Bond about developing formal guidelines and principles for delivering MH or SA services to persons with COD. The new FSSA secretary is supportive of COD efforts in the state. The Division contributes as much as possible to educating state legislators who have an interest in MH and SA issues. The Task Force process helped to involve more stakeholders—such as the Department of Corrections, CMHCs, a provider of homeless and addicted clients, and consumers—to support COD care and conference planning. The Division is planning a conference on COD treatment for the summer of 2003.

Training and Workforce Development

Indiana has been engaged in specific ongoing activities to build organizational capacity and to educate the workforce to implement evidence-based practices and COD treatment.

Historically, the Division has paid for training through a training budget, and through technical assistance from CSAT, the Technical Assistance Center (in Reno, Nevada), and some technical assistance facilitated by the COD Task Force.

Training is both decentralized and statewide. Both MH and SA providers receive training from the state or independent consultants. As mentioned, the Division is planning a statewide COD conference for the summer of 2003. The Division is exploring the possibility of expanding training for COD care, through Gary Bond's Technical Assistance Center, for non-Toolkit sites. Other consultants, such as Charlie Rapp and others from the Dartmouth group, have provided training for the state. The Division is in the process of talking about developing standards and competencies for staff who deliver COD treatment. No special credentials or licensing for COD are in place, nor being explored (at least as of the time of our interview).

Information and Data Systems

The Division maintains separate information systems for MH and SA within its Community Services Data System. Medicaid information can be linked to MH and SA data by special request. The state is

exploring the use of outcomes measures that the federal government has promulgated through some of its efforts, such as CMHS's State Sixteen Indicator project.

The state requires that all providers use a standardized intake instrument—the HAPI-A that includes MH and SA domains for adult care—and share clinical information between MH and SA providers. CMHCs are responsible for reporting enrollment data to the state. Data on service use can be tracked using pooled provider HAP enrollment data.

Quality Assurance/Quality Improvement

The Division is assessing how to better routinely measure performance and outcomes indicators, how to monitor access to and quality of care, and how to develop quality improvement models to support COD care. Quality improvement models for COD are being tested mainly through the Toolkit pilot design and fidelity measures. When these data becomes more readily available the Division would like to assess the various impacts that the Toolkit model, and packages and units of service, have on clients. The state would like to more formally plan this type of research but is finding it difficult to do because the Division's research budget has been cut.

Pilot Projects

The Toolkit project is the state's single pilot effort for COD care. Its six sites are in the beginning stages of implementation. As mentioned, the Division is providing some start-up funding for this effort. Fidelity to the Dartmouth integrated COD model will be evaluated. The intention is that the pilot will establish a basis for rolling out the integrated treatment model, and help to continue the emphasis on improving and delivering COD care, throughout the state. The Division is not engaged in any other pilot projects or research, even though it would like to be. This is largely due to the fact that the state's research budget was recently cut and there is no designated grants writer on staff.

Chapter 11. Iowa State Profile

COD Population Focus

The mental health service system in Iowa is under the auspices of the Division of Behavioral, Developmental, and Protective Services (DBDPS) within the Department of Human Services. The Division of Health Promotion, Prevention, and Addictive Behaviors (DHPPAB), within the Department of Public Health, has primary responsibility for the substance abuse service system at the state level. Neither DHPPA nor DBDPS uses the Four Quadrant model, nor do the agencies have a working definition of “COD”.

Financing and Access to Services

Medicaid is the primary source of funding for both mental health and substance abuse services in Iowa. The state has a Medicaid managed care program under which DBDPS and DHPPAB jointly oversee a behavioral health carve out arrangement. The agencies contract jointly with a single MCO on an at-risk basis, which in turn subcontracts with providers throughout the state. In addition to Medicaid funds, all block grant and state dollars that fund treatment are passed through the MCO.

DBDPS allocates CMHS block grant funds and state dollars for non-treatment activities (e.g., training, infrastructure development, etc.) to mental health authorities in each of 99 counties. Most counties also fund mental health services. (County funds for treatment do not pass through the MCO.) The counties have considerable discretion over how they use these funds and in managing mental health providers. For example, the counties decide on their own eligibility criteria for mental health services. DHPPAB, on the other hand, contracts directly with providers throughout the state. Under these contracts, DHPPAB provides SAPT block grant funds and state general revenue funds to providers for non-treatment activities. DHPPAB therefore has more leverage over providers than DBDPS. Few counties fund substance abuse services.

Most care for the COD population is provided in either sequential or parallel fashion. A few providers offer integrated care. One example is the Mount Pleasant Mental Health Institute, an inpatient provider of mental health services that has a special COD treatment program. The Institute operates under the auspices of the Department of Human Services. In addition, the behavioral health MCO has initiated ACT teams that treat both SMI and substance use disorders on a pilot basis in a few counties.

A lack of funding for the Medicaid-ineligible population is a major barrier to accessing mental health services. Another barrier is a lack of mental health providers in the state. DHPPAB pays for most substance abuse services, though funding constraints limit access to these services as well. Furthermore, if a provider agency wishes to deliver integrated care, it must braid funding from separate sources and ensure that mental health funds are not spent on substance abuse services and vice-versa, which can be a challenge. These barriers, along with the organizational and financial split between the Medicaid managed care program and the county-controlled mental health systems, mitigate against the adoption of more closely coordinated or integrated models of care for the COD population.

Collaboration and Consensus Building

DBDPS and DHPPAB have collaborated on some initiatives that have included consideration of COD. However, they have not collaborated with regard to COD on an ongoing basis. DHPPAB has convened mental health and substance abuse providers to discuss ways to better coordinate services. A few

providers have also pursued their own efforts to better coordinate or integrate mental health and substance abuse services.

In 2002 the state legislature and the Department of Human Services convened a statewide Mental Health and Developmental Disabilities Commission, which was charged with developing recommendations to redesign the system of care for adults and children with mental illness or other disabilities (not including substance abuse). The Commission, which consists of provider agency representatives, consumers, and state and local policymakers, had not yet produced any formal recommendations at the time of our interviews. The Commission is focusing primarily on making the financing of and access to disability services more equitable across the state, but it is not addressing COD. Officials told us that any potential collaborative activities concerning COD would probably have to wait until the Commission's work is completed.

Training and Workforce Development

DHPPAB has invested much in training activities for substance abuse professionals. These include cross-training activities designed to teach them about screening, assessing, and treating people with both types of disorders. The single-state behavioral health MCO has invested in similar training activities for providers. Both organizations have involved consumer organizations in the design and planning of these activities. DBDPS allocates some funding to the counties to conduct training sessions, but few of these have addressed COD.

Information and Data Systems

Neither mental health nor substance abuse providers are required to use a standardized intake instrument. Nor are they required to share clinical information with providers in the other system, but both state agencies encourage them to do so as long as the proper release-of-information requirements have been met. While DHPPAB maintains a statewide information system that includes some data on COD, DBDPS does not have such a system. Rather, each county maintains its own data system for mental health, and these systems are generally not linked with county or state-level substance abuse systems.

Quality Assurance/Quality Improvement

Neither DBDPS nor DHPPAB has any quality assurance or improvement initiatives in place with regard to COD. However, the behavioral health MCO has begun to investigate quality improvement approaches for COD.

Pilot Projects

A few pilot COD treatment initiatives have been launched in Iowa in recent years. As mentioned above, the behavioral health MCO has overseen the creation of ACT teams in three localities. Two of these teams utilize NAMI's ACT model. A residential corrections facility in northeastern Iowa is piloting a dual diagnosis treatment program. DBDPS funds a Mental Health Consortium, housed at the University of Iowa, which conducts research and disseminates information on best practices with regard to mental health treatment. DHPPAB funds a similar Substance Abuse Consortium, also housed at the University of Iowa, which conducts the same kinds of activities with an emphasis on substance abuse issues. Both of these Consortiums' activities have addressed COD treatment.

Chapter 12. Massachusetts State Profile

COD Population Focus

Massachusetts has separate MH and SA agencies, the Department of Mental Health (DMH) and the Bureau of Substance Abuse Services (BSAS), which is housed within the Department of Public Health (DPH). A third entity, MassHealth, oversees Medicaid and the Children's Health Insurance Program (CHIP) for the Commonwealth. All three are organized under a single umbrella agency, the Executive Office of Health and Human Services (EOHHS).

Both DMH and BSAS staff are aware of the Four Quadrant Model, and both agencies are interested in serving people in all four quadrants. However, largely due to funding constraints, DMH focuses primarily on serving the SMI population. To be eligible for DMH services, a person must have suffered from a severe mental illness for at least six months and demonstrate significantly impaired functioning. Until January of 2000, an individual with a substance abuse disorder had to obtain treatment in the substance abuse system before he or she was eligible for DMH-funded mental health services. DMH recognizes that among eligible clients with serious mental illness as many as 50% may have significant substance abuse problems, and agency staff are looking carefully at ways to be more responsive to persons with COD. In contrast, BSAS has historically served the broad population of people with substance abuse disorders. BSAS also defines COD quite broadly, including not only people with both MH and SA disorders but also those with SA and other conditions, such as HIV.

Financing and Access to Services

Massachusetts uses a managed care approach to deliver Medicaid services throughout the state. The system consists of five managed care plans including the Primary Care Clinician (PCC) Plan, which is a plan administered by the state with behavioral health services carved out and delivered through a single behavioral health entity, the Massachusetts Behavioral Health Partnership. The Partnership, which contracts with MassHealth, covers emergency and acute psychiatric care for the largest group of the Medicaid-eligible population, which includes some DMH clients.

Massachusetts has a relatively generous Medicaid system, although lawmakers are in the process of enacting benefit reductions in order to reduce costs. MassHealth is a significant source of funding for mental health services in the state, but is not a major funding source for substance abuse services. The only substance abuse services covered by MassHealth are detox and 15 days of outpatient treatment. Substance abuse providers rely mainly on SAPT block grant funds, the state match for the SAPT block grant, Maternal and Child Health (Title V) block grant funds, and HIV prevention funds. To receive these funds, providers contract directly with BSAS on a FFS basis. (There is no county based or otherwise local system of behavioral health services.)

DMH receives state general revenue and CMHS block grants funds, and contracts directly with mental health providers throughout the state. The agency operates some service sites directly, such as four state hospitals, residential and community programs, homeless outreach teams, and case management. DMH has also provided targeted funds for COD care. Specifically, the agency has given detox centers and public hospitals serving the most serious cases funding to purchase 10 to 12 hours per week of psychiatric services.

Given the structure of financing in the state, MassHealth pays for much COD treatment, even if the patient's primary diagnosis is a substance abuse disorder. In most cases, Medicaid is billed under a MH code. The state does not have a billing code specifically for COD services. To the extent possible, BSAS

provides funding for the Medicaid-ineligible COD population, acting as a payer of last resort, using the funding sources mentioned above.

DPH licenses all substance abuse providers and mental health outpatient clinics in the state, while DMH licenses all mental health inpatient and adult residential providers. There are some specialized dual diagnosis providers, which have separate licenses from each agency.

Collaboration and Consensus Building

In recent years, DMH, the Department of Public Health (which includes BSAS), and MassHealth have collaborated on a number of issues, including that of providing a better-coordinated system of care for people with COD. Through a reorganization of the umbrella agency, EOHHS, DMH, DPH, and MassHealth's Office of Acute and Ambulatory Care have been placed in the Office of Health Services because they have complementary missions and therefore require systematic cross-agency planning. In 1998, the agencies received a federal grant to pursue consensus-building activities. Officials from each of the three agencies convened an interagency workgroup, which has produced interagency agreements aimed at improving coordination between the MH and SA systems. These agreements include a document outlining principles for treating those with a COD.

Because DMH and BSAS contract directly with providers, they are able to mandate that providers offer certain services or meet certain requirements. In particular, BSAS requires all substance abuse treatment providers to collaborate with mental health providers in caring for the COD population.

Training and Workforce Development

The Massachusetts mental health system benefits from the presence of several high quality medical schools. Thus, there is no shortage of well-trained psychiatrists and other mental health professionals.

DMH has given approximately \$5 million per year to the state's medical schools for the purpose of postgraduate psychiatry and psychology training. DMH uses this funding as leverage to require medical schools to provide training on COD. Cross training of professionals in both fields is a major priority for both DMH and BSAS, and the agencies have sponsored joint training sessions on COD in recent years. The agencies have pooled funds to hire a joint training coordinator and have hired Ken Minkoff to lead training sessions for providers on several occasions.

Information and Data Systems

DMH eligibility applications include a standardized intake instrument that screens for both types of disorders, whereas substance abuse treatment providers do not use such an instrument. Providers in each system are not required to share information; as a result, the extent to which they do so varies. DMH, BSAS, and the Behavioral Health Partnership maintain separate information systems, although the Executive Office of Health and Human Services is exploring options for integrating data across agencies. DMH does not employ performance or outcome measures specific to COD, but BSAS's information system tracks the delivery of mental health services to its clients.

Quality Assurance/Quality Improvement

Neither DMH nor BSAS uses any specific quality assurance or quality improvement models to support care for COD. Nonetheless, BSAS staff frequently collect and analyze data to assess the needs of their client population. This includes periodically administering a survey of behavioral risk factors and using

data to identify service gaps. MH and SA officials in Massachusetts are also eagerly awaiting the release of SAMHSA's Dual Diagnosis Toolkit.

Pilot Projects

DMH has funded six pilot project sites delivering COD treatment. These projects implemented a particular care management model involving greater collaboration between providers and payers, and have targeted the Quadrant Four population, particularly the SMI. The project included an evaluation component, funded by a grant from CSAT. The grant has ended, however, and the evaluation was not sustained.

The state has also funded two Centers of Excellence to conduct clinical research pertaining to COD. Harvard Medical School operates one center and the University of Massachusetts Medical School operates the other. Each center has received approximately \$1 million in funding. The Centers of Excellence have utilized these funds to leverage other research funding (from federal and other sources) of \$4 to \$6 million annually to investigate the causes of and treatment for persistent long-term mental illness.

Chapter 13. Missouri State Profile

COD Population

Missouri has separate MH (Division of Comprehensive Psychiatric Services) and SA (Division of Alcohol and Drug Abuse) divisions housed in the Department of Mental Health (DMH). The Divisions have been working together over the last few years to define their COD population similarly. Currently, the MH Division (CPS) focuses on persons with COD who have a primary SMI and a secondary SA diagnosis. The SA Division (ADA) defines COD more broadly, focusing on persons with a primary SA disorder and any MH diagnosis. The state has used the Four Quadrant Model as a guiding principle in their approaches to addressing COD issues.

Financing and Access to Services

Missouri is a geographically diverse state with suburban, urban and rural areas. MH and SA services in Missouri are delivered through the state's Medicaid authority, which manages the state's managed care contracts, and DMH, which manages all public MH and SA care through a carve out, the Comprehensive Psychiatric Rehabilitation Program (CPR). All CMHCs are referred to as Administrative Service Agencies since they contract with DMH to deliver CPR services. CMHCs may also contract with managed care providers to deliver non-CPR services. Providers who are not CMHCs may also deliver CPR services. Although no SA services are delivered through managed care, ADA has incorporated managed care principles into its service delivery since 1995.

Managed care contracts in Missouri are risked-based and part of a larger health plan system that is partially managed by United Behavioral Health. Clients can choose to opt out of managed care and, according to the state, most have chosen to do so. DMH estimates that approximately 60% of persons it serves have COD. Medicaid and non-Medicaid populations receive the same set of CPR services (screening, assessment, individual and group counseling, detox, residential support, childcare, and case management).

The major sources of funding for MH and SA services are Medicaid (mainly using the Medicaid Rehabilitation Option) and state general revenues, with SA services covered by fee-for-service only. General revenue funds are used to provide services to the non-Medicaid uninsured population. Only a few counties have a MH mill-levy, which is also used for this purpose.

While the state does not perceive any structural, definitional or eligibility limitations in its Medicaid coverage, it notes that more funds are needed to meet MH, SA and COD service needs. Even so, the state has targeted monies to address COD issues. For example, DMH is working with the Medicaid authority to make it possible for CPR program providers to bill for SA services. DMH does not perceive this to be a problem since it considers its Medicaid plan to be "written broadly enough" to accommodate this. The state's Employment Advisory Group is working on limitations in Medicaid coverage for vocational rehabilitation (currently only pre-employment services are covered). Some funds have been allocated for SA providers to employ psychiatrists to provide medication management and assessment. ADA has partnered with some county boards and the United Way to match revenue dollars to expand SA services. While no special COD billing codes currently exist, upgrades to the state's MIS systems will include this (see below).

Currently the state is delivering more parallel than integrated COD services. However, CPS has set the goal to make all CMHCs capable of providing integrated COD care by July 2003. This occurred after the

state's experiment to increase the delivery of parallel COD services through CPR Enhancement Teams (modified interdisciplinary intensive case management teams) achieved disappointing results. In order to achieve this goal, several steps are being taken. For example, contracts between MH providers and SA agencies are expanding so that SA services can be provided more easily. CMHCs will soon be able to bill for SA services. The state is encouraging providers to deliver COD services within the same program by expanding ADA's service menu to include trauma services and CPS's menu to include SA services. And, CPR providers are implementing another version of the CPR Enhancement Team model (multidisciplinary teams share caseloads and include a SA specialist who trains and provides SA treatment) that is specifically designed to provide integrated COD care. Limitations in licensing (e.g., SA providers who work in MH agencies currently cannot be recognized as licensed SA providers) and certification (e.g., the state will soon certify eligible programs to provide COD services) that prevent providers from delivering both MH and SA services are also being addressed.

Collaboration and Consensus Building

CPS and ADA have been collaborating on COD issues since 1995. The two Divisions have jointly convened several working groups to address service and system reforms, and to move the state toward more integrated treatment. Since the Divisions have worked together well they have not seen a need to operate under MOUs. Both Divisions have a strong commitment to implement recommendations that are generated from their consensus building processes.

The state's work groups include a variety of stakeholders, such as representatives from the state Medicaid agency, Office of Quality Management (OQM), CPS, and ADA; representatives from the CPS and ADA Division Advisory Councils and SA regional planning groups; NAMI and other consumers; MH and SA providers; and staff at the University of Missouri and the its Health Sciences Center. While local governments are not directly involved in consensus building activities, the SA regional planning groups identify MH and SA needs that are geographically specific, and strategies that can enhance working relationships between MH and SA providers (e.g., how wraparound services can be more efficiently provided in crisis situations).

Training and Workforce Development

For several years CPS and ADA have worked together to plan and fund ongoing training and cross-training activities, and technical assistance. Recently these activities have become more specific to COD populations. While the state has the overall goal for providers to become COD capable in some respect, currently no specific number of providers is targeted to reach this goal.

CPS and ADA have training budgets and a few grants (e.g., evidence-based practice grant) to support their separate and joint training activities. DMH has used some of its funds for specialty priority trainings in motivational interviewing, harm reduction and stages of change. ADA sponsors an Annual Spring Institute (a two and a half day training) and is helping agencies determine their COD capabilities and deficiencies.

The state's several work groups are currently developing and coordinating a range of standards for COD, including competencies, practice guidelines, and standards of MH, SA and COD care for MH and SA agencies. ADA has a training director who works with the provider community to identify training issues, and with CSAT to identify training consultants and pharmaceutical companies to solicit for training sponsorship.

DMH provides its own technical assistance, contracts with NATTC for this purpose, and also relies on the state's OQA for certification and licensing technical assistance (see below). DMH also works with

NATTC to plan cross-training initiatives and to implement the Train-the-Trainer model throughout the state.

Administrative rule indicates that staff who provide CPR services must attend orientation and continuing education/training on required topics every two years. The state hopes to modify administrative rules to include harm reduction, motivational interviewing and SA counseling as required topics. While there are no plans to create a COD certification, a new SA counselor certification includes cross-training topics. The state hopes that its plan to make it possible for CMHCs to bill for SA services will act as an incentive for providers to deliver more COD services.

Information and Data Systems

CPS and ADA use the same client MIS system. In the near future the system will be modified to integrate payment and client systems, and include COD billing codes, performance measures and quality improvement models (see below). ADA also has a separate web-based system that can interact with the CPS/ADA MIS and the Medicaid information system. Links to managed care data systems are difficult because managed care companies do not enter data that has CPS and ADA indicators.

Only ADA requires providers to use standardized intake instruments (e.g., ASI) that include both MH and SA domains. In the future this will also be the case for CPS. Both CPS and ADA require that providers share clinical information with providers in the other sector. A state HIPAA work group is developing agreements to this effect that can enhance such sharing between providers.

Quality Assurance/Quality Improvement

Currently, the state does not have routine COD performance indicators for COD or a quality improvement process that monitors access to and quality of care for COD. In the future the state's OQM intends to apply routine reviews of provider activities to COD. For example, OQM provides technical assistance for certification and licensure processes. Under administrative rule, OQM conducts the certification and licensing reviews for all contracts. OQM has an agreement with the Medicaid agency to annually monitor the use of Medicaid by randomly comparing billings and clinical documentation, and the alignment of progress notes and treatment plans. If discrepancies are found during the monitoring process, OQM provides technical assistance and training sessions.

As mentioned, the state is in the process of creating a computer system to include specific performance indicators for COD. Since the SA director is a member of the SAMHSA workgroup that is developing COD measures, the state plans to use this set when it is disseminated. The state is not yet developing quality assurance or quality improvement models to support care for COD.

Pilot Projects

DMH is currently not implementing pilots that focus on COD and does not have future plans for additional projects. Instead, it has decided to focus on enhancing MH and SA service delivery (described above). However, the Missouri Institute of Mental Health (a university based research center) is engaged in research that is testing the implementation of evidence-based practices, which includes COD.

Chapter 14. Montana State Profile

COD Population Focus

Montana has a combined mental health and chemical dependency division, the Addictive and Mental Disorders Division (AMDD), which is located in the umbrella agency, the Department of Public Health and Human Services (DPHHS). The AMDD was created seven years ago because the Chemical Dependency unit was considered too small a program to continue to operate independently. Management of the AMDD is provided by one overall administrator and a Chemical Dependency Bureau Chief. The AMDD works closely with the Medicaid agency, which is also a part of the DPHHS.

As a division, the AMDD delivers services to a broad spectrum of persons with COD. Before the division was created, the state focused its attention primarily on persons with serious mental illness and COD. Two years ago a COD Task Force was created to better meet the needs of the COD population. The state and the Task Force have used the Four Quadrant Framework to broaden the focus from Quadrant IV to Quadrants I and II. Even so, the chemical dependency system is focusing its attention largely on Quadrant IV to improve integration, coordination, collaboration and continuation of services.

Financing and Access to Services

Montana is mostly a frontier and rural state, providing MH, SA and COD services through separate MH and SA systems and providers. The state has four large regional MH Centers, three of which are also state chemical dependency programs, and a network of providers. Balancing a larger MH system with the needs of a smaller SA system is an ongoing challenge for the state. Montana's separate systems of care have been an obstacle to delivering integrated or coordinated COD treatment.

Currently, the state is discussing how to reorganize and better coordinate and regionalize its MH and SA systems, and using the legislative process to jumpstart the process (the legislature is considering a bill to push a plan forward in the MH system). Since the state is quite rural, access and availability of services is generally limited. Interagency agreements between agencies for referrals is typically used to address these issues. One reform plan is to create a three regional MH, and SA, system that is based on stakeholder controlled entities (service area authorities) and capitated funding. Each region would be coordinated by two organizations--MH Service Area and Chemical Dependency Authorities—and create a network of programs (e.g., some SA programs may combine and share functions) and a continuum of care. This plan would help to directly address the state's concern that integrated, parallel or coordinated COD care varies throughout the state. All SA programs would be expected to be capable, at a minimum, of delivering parallel COD services. The AMDD director and Chemical Dependency Bureau Chief have sent letters to all providers alerting them to this goal and requesting information about their COD capability.

Historically, financing for MH and SA services has made it difficult to focus on solving problems of coordination across systems. SA funding has been stable for several years, while MH has struggled through the termination of managed care (in 1999 the legislature fired the managed care company that contracted with the MH Bureau), transition to a fee-for-service system, and numerous budget cuts. Discussions are being held to settle conflicts about resurrecting MH managed care. Even though the SA system does not contract with managed care companies, provider sponsored organizations (PSOs) organize providers in each of the regions to employ managed care principles.

The major sources of funding for MH services are Medicaid, MH block grant, state general revenue and local funds, and monies from private donors. The major sources of funding for SA services are SAPT block grant (largest source) and Medicaid. Only recently has Medicaid covered adult outpatient chemical

dependency treatment. Unlike MH, some SA services are covered under the Medicaid Rehab Option. All MH centers receive contributions (which vary) from the counties they serve. While SA receives some alcohol tax revenue, the legislature has historically diverted more funds (about \$1 million) to the MH system. This has contributed to “furthering the gaps between the two systems”.

Since there is no joint Medicaid benefit for MH and SA services, the COD Task Force is exploring the possibility of developing COD billing codes. The reimbursement mechanism for integrated COD treatment is Medicaid, using two separate sets of MH and SA billing codes. While clients receive treatment for COD in whichever system they present, Medicaid covers a limited set of services, which include outpatient, semi-case management, family therapy and assessment. MH codes are used to bill for MH medication management. Detox, methadone and SA pharmacy services are covered under the Medicaid medical benefit managed by the state’s Health and Policy Services Division.

In addition to considering a COD code, the state has made recommendations to create incentives, such as enhanced rates and fees for COD providers. Thus far, the state has provided targeted funds for the development of new services for persons with COD through one pilot program, the Great Falls Project (see Pilot Projects below).

Financing and service delivery issues for the non-Medicaid uninsured population are also under consideration and mirror some of the problems in the Medicaid system. County, state general revenue funds managed by MH, some SAPT block grant monies, and some provider funds are used to pay for services delivered to this population. The AMDD pays for SA services for persons with incomes up to 200% of the poverty level in the SA system, and up to 150% of the poverty line in the MH system. The non-Medicaid MH benefit is limited, covering MH and SA outpatient and MH medication, but not inpatient MH or SA medications. One group that has been of special concern is women who have children and have been convicted of a drug felony. They are ineligible for TANF (and therefore Medicaid) and must seek services from a limited set of programs.

Collaboration and Consensus Building

Montana has been involved in state and local level consensus building activities to improve its MH and SA systems, and services for persons with COD, for several years. Consensus building and system reform have evolved within a number of strained contexts: MH and SA intend to simultaneously work together and maintain their independence; decreases in financial resources have been significant since 2001; and efforts to narrow the differences in attitudes and philosophies between MH and SA providers have been difficult.

Nevertheless, consensus building and services and system improvement has moved forward because of good working relationships within the AMDD, leadership by the Chemical Dependency Bureau, the state’s COD Task Force, legislative and other stakeholder support, and new training. The Chemical Dependency Bureau is leading the effort to improve COD care, along with MH, law enforcement and local governmental officials. Interest among legislators has been important to improving COD care and bridging gaps between the MH and SA fields. For example, at the time of our interview a bill was being considered by the legislature to permanently earmark a percentage of alcohol tax money for COD services (approximately \$500,000) for which the AMDD would have decision-making power.

Since state MH and SA are combined under the same umbrella agency, no MOUs are necessary. Division heads attend regular meetings. At the local level MOUs and interagency agreements, and encouragement from the AMDD (e.g., the division director recently sent a letter to local programs encouraging closer working relationships) are being used to create consensus around service delivery and regional system reform.

The state's COD Task Force gained momentum in the summer of 2001 after Ken Minkoff was invited to hold a seminar on COD for invited providers, policymakers, consumers, tribal officials, and state policy advisory council members. In addition to expanding the COD population focus, the Task Force supports the implementation of integrated COD treatment; has been assisting in regional system reform activities (e.g., hosted a key leader training session to develop regional action plans); has been developing plans for more COD training, guidelines for care, and a uniform assessment tool to be used by all providers; and is exploring how administrative and fiscal incentives might be used to enhance COD delivery. The Task Force continues to meet regularly and includes several stakeholders, including consumers.

Training and Workforce Development

Historically, the Chemical Dependency Bureau has taken the leadership role for cross-training. The Bureau's quality assurance review and monitoring activities ensure that local programs meet standards and requirements to have training plans and programs in place. The Bureau's annual training budget, technical assistance from CSAT, the Technical Assistance Center (in Reno, Nevada), and some technical assistance facilitated by the COD Task Force, support Montana's decentralized state and local training efforts.

State and local staff, and outside consultants (e.g., David Mee-Lee), provide training in COD and other areas to mostly chemical dependency and substance abuse staff. The state sponsored one COD conference and a workshop on ASAM criteria and COD treatment in 2001, and has conducted a spring 2003 conference that provided a broad-based approach to improving COD skills.

While the state has not developed standards or competencies for COD, staff are trained to use ASAM criteria and have been exposed to David Mee-Lee's and the Dartmouth Toolkit treatment approaches. The COD Task Force is working with a professional licensing board, and the state's Department of Labor, to expand licensing (through administrative rule) for licensed addiction counselors, and to include COD as part of continuing education training.

Information and Data Systems

Currently, the AMDD Division maintains separate information systems for mental health, chemical dependency, non-Medicaid substance abuse, Medicaid, and state mental hospital systems. Only the mental health and Medicaid systems are linked. While the state does not think it needs a single information system, it is using a MH Data Infrastructure Grant to develop ways to more efficiently access and track clients from each of the state databases.

As mentioned, the COD Task Force is developing a standardized/uniform intake tool to be used in either a MH or SA setting. The Medicaid agency is involved and will likely issue the requirement that providers use the tool to receive funding. State guidelines for sharing clinical information among mental health providers do not exist, and therefore such sharing varies by locality. However, SA contracts make it clear that information should be shared. The AMDD Division requires SA and MH providers to establish MOUs toward this end.

Quality Assurance/Quality Improvement

Currently, the COD Task Force is assessing how to routinely measure performance and outcomes indicators, how to monitor access to and quality of care, and how to develop quality improvement models to support COD services. The AMDD Division is involved in national agendas and performance partnership grant initiatives for COD. For example, the Chemical Dependency Bureau is revising its

Alcohol and Drug Information system to better comply with the Performance Partnership grant (which includes COD elements).

Pilot Projects

The state has been implementing one major pilot effort, the Great Falls Pilot, a cooperative project of a local SA agency, MH agency and hospital. The pilot was designed to better deliver services to the non-Medicaid population with severe disabling mental illness and chemical dependency disorders. A case rate system was established so that any one or all three types of providers could coordinate services and treat the target population more easily. While the state is not engaged in any other pilots or research, the Chemical Dependency Bureau would like to solicit funding from the legislature to conduct pilots in the near future, though it realizes that obtaining such funding will be difficult.

Chapter 15. New Mexico State Profile

COD Population Focus

The public MH and SA systems in New Mexico have been merged since the 1990s, and the Behavioral Health Services Division (BHSD) is the state agency with oversight responsibility for the two systems. The administrative authority of BHSD is continuing to expand. Four state behavioral health facilities were placed under BHSD purview in June 2003.

BHSD defines COD broadly, and includes any diagnostic co-morbidity that crosses DSM-IV Axis I (mental disorder), Axis II (personality disorder), and/or Axis III (physical disease or illness). This definition notwithstanding, BHSD is also familiar with the Four Quadrant Model for characterizing COD, and has used that model in formulating its systems-of-care approach for co-occurring psychiatric and substance abuse disorders. BHSD would like to focus more of its resources on consumers in Quadrant I (low severity mental health and substance abuse disorders), but currently focuses primarily on the other three quadrants. Our BHSD interview respondent noted that by definition, the agency is dedicated to providing an SPMI treatment system and a substance abuse treatment system (primarily for those in Quadrant III, who have a low severity mental health disorder and high severity substance abuse disorder).

Financing and Access to Services

Medicaid financing for COD services in New Mexico is administered through the statewide Salud Managed Care program, under contracts between the New Mexico Human Services Department and three HMO contractors. Medicaid benefits can be used to pay for some COD treatment services, provided that a psychiatric condition is identified as the “primary” disorder. A person is reportedly not eligible for Medicaid benefits in the state if he or she has a primary substance abuse diagnosis, and in any event the Medicaid benefit for substance abuse is limited to 12 outpatient sessions per year (i.e., does not include coverage for detox or substance abuse case management). BHSD has no administrative responsibility for Medicaid managed care, because a different state agency has oversight for the Medicaid system.

BHSD serves as the safety net provider for the uninsured population generally, and also for the underinsured substance abuse population. BHSD contracts with about 100 providers across the state to offer mental health and substance abuse services for indigent and underserved clients, and BHSD pays the providers a monthly, non-FFS stipend for supplying these services. The annual budget for the services is approximately \$40 million, consisting of state general revenues and federal block grant funds on a 2:1 matching ratio.

Provision of COD services through the BHSD system occurs largely under a parallel delivery model, with pockets of integrated service delivery emerging in some parts of the state (e.g., the Pathways program in Gallup). By contrast, the Medicaid HMO system has made less progress in moving providers toward parallel or integrated service delivery models. Access to COD services across the state does not differ by patient characteristics (i.e., based on the Four Quadrant Model). BHSD has pursued a state-level effort to promote integrated care, addressing barriers and challenges through the consultative work of Ken Minkoff and Chris Cline. Barriers to providing COD services have included limited funding; lack of interagency integration; recruitment, retention and training of clinicians; and licensing/credentialing issues.

One important challenge for New Mexico in providing COD services has involved the fact that Native American tribal groups have largely opted out of the state’s Medicaid program, and have instead elected to create their own treatment programs locally (using a combination of state money and federal money

through the Indian Health Service). The result is a decentralized set of treatment programs for Native Americans, one that parallels the non-tribal state system, while dividing the resources available to the state as a whole.

Collaboration and Consensus Building

Public mental health and substance abuse functions were consolidated into a single agency in 1997. Formal consensus building on COD began in 2000 with meetings of mental health providers, substance abuse providers, and community representatives, and also included participation by the state Medicaid agency. Concrete collaborative steps in the past couple of years have included submission of a COSIG grant proposal to SAMHSA (for COD pilot demonstration funding), and authorship of an interagency behavioral health white paper on COD services, outlining government transition and further consensus-building steps.

Efforts are underway to further improve collaboration between BHSD and the New Mexico Department of Corrections on areas of overlapping interest in regard to COD services. The population focus for consensus building on COD services has been on Quadrants II (high severity mental health and low severity substance abuse disorder), III (low severity mental health and high severity substance abuse disorder), and IV (high severity mental health and substance abuse disorders) because of a lack of strong linkages to the primary care system (which serves the Quadrant I population—those with low severity mental health and substance abuse disorders).

BHSD and its collaborators have generated basic COD service planning guidelines in draft form, and BHSD is presently working on common service coding and common service definitions (partly in response to HIPAA requirements). BHSD does not currently offer financial incentives to encourage providers to comply with its COD guidelines. Past efforts to implement such incentives were targeted more broadly than on COD, and the successfulness of those efforts was limited by the state's confiscation of dedicated funds to close unrelated budget gaps.

Training and Workforce Development

BHSD uses a “train-the-trainers” model, and undertakes statewide training of mental health and substance abuse providers. Training is fairly comprehensive, makes use of both in-house and external trainers, and includes a well-developed COD curriculum. As yet, there are no specific standards for COD competencies or skills, although BHSD is working with state licensing authorities to address dual credentialing issues.

Information and Data Systems

BHSD maintains a linked MIS system across mental health and substance abuse sectors (although this system is reportedly in a state of flux, and does not, in any event, link to Medicaid providers). BHSD does routinely monitor quality of care using COD performance indicators. However, BHSD does not require the use of a standardized intake instrument by all providers across mental health and substance abuse settings, nor is there any requirement for clinical information sharing by providers across mental health and substance abuse settings.

Quality Assurance/Quality Improvement

As noted above, BHSD routinely monitors quality of care using COD performance indicators, and does use this information to encourage and facilitate quality improvement efforts among its contractual providers.

Pilot Projects

New Mexico currently sponsors two pilot COD programs. One of these is Totaw, a grant-funded pilot focusing on Native American clients in the northwest region of the state. Totaw is designed to promote mental health screening, assessment, and services at the entry point to traditional substance abuse detox treatment. The second pilot is a prison-release program (administered by the Department of Corrections) for women with children in protective custody, designed to address the women's COD treatment needs.

Chapter 16. 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.

Chapter 17. 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.

Chapter 18. 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.

Chapter 19. Pennsylvania

COD Population Focus

Responsibility for the MH and SA service delivery systems in Pennsylvania rests with two agencies, the Office of Mental Health and Substance Abuse Services (OMHSAS), which is housed within the Department of Public Welfare, and the Bureau of Drug and Alcohol Programs (BDAP), a bureau within the Department of Health. Both agencies utilize the Four Quadrant Model in planning services for the COD population, serve people in all four quadrants, and define COD broadly. These agencies' primary emphasis with regard to COD is the state's Mental Illness and Substance Abuse (MISA) pilot program, which seeks to improve care for a wide range of people with COD, not just the SMI.

Financing and Access to Services

Under a Medicaid waiver, Pennsylvania has established a managed care program called Health Choices for Medicaid physical and behavioral health, with behavioral health carved out. Under the carve-out arrangement, Medicaid funding for both MH and SA is administered by OMHSAS, which contracts with each county to manage behavioral health dollars. Each county, in turn, contracts with a behavioral health MCO, though two (Allegheny County and Philadelphia Counties) have chosen to establish their own behavioral health entities. Some counties assume the risk, while others pass the risk on to the MCO. Some Medicaid beneficiaries, particularly those in rural regions, remain enrolled in the Medicaid FFS plan, which is administered by the Office of Medical Assistance Programs (also in the Department of Public Welfare). State officials plan to eventually enroll all Medicaid recipients in a Health Choices plan. In addition, some substance abuse services, such as outpatient treatment and hospital-based rehabilitation, are paid for under the state's FFS plan. OMAP is also responsible for the physical health Medicaid managed care dollars, and it contracts with regional MCOs (not with counties) to manage those dollars. Medications are covered under Medicaid physical health plans.

OMHSAS also administers the CMHS block grant and state mental health and substance abuse dollars, which it allocates to county mental health agencies and single county substance abuse authorities. BDAP receives SAPT block grant and other state general revenue funds, which it allocates to the same single county authorities. These county agencies and authorities, in turn, subcontract with providers. County governments also contribute funds for MH and SA services.

The multiple funding streams and their respective regulatory requirements, along with the organizational divisions among OHMSAS, BDAP, and OMAP, create challenges to providing a more coordinated system of care for the COD population. However, OMHSAS and BDAP have worked together on COD issues in recent years, and the behavioral health carve out under Medicaid has given providers more flexibility to deliver and receive reimbursement for COD treatment. Under Health Choices, the array of mental health and substance abuse services eligible for Medicaid reimbursement has been expanded. For example, outpatient partial hospitalization is now a covered service, whereas previously it was not. In addition, several county based behavioral health MCOs have achieved cost savings without compromising services, and they have reinvested these savings in new programs for COD and other Medicaid sub-populations.

OMHSAS and BDAP are also interested in the idea of offering higher reimbursement rates for COD services provided in an integrated fashion. To that end, they are monitoring the progress of the MISA pilot sites (see below) to identify criteria for determining whether a provider is delivering "integrated" treatment.

OMHSAS licenses all mental health providers, while the Department of Health licenses substance abuse treatment providers. If a provider seeks to offer integrated treatment, it must obtain both types of licenses, which is expensive for small-scale providers. Both agencies are investigating ways to ease this burden for providers that want to offer integrated services. The agencies are also working with the Pennsylvania Certification Board to develop a MISA credential for professionals who wish to be certified to treat people with both disorders.

Most people with a COD receiving both types of services obtain those services in a parallel system of care. A few providers offer integrated treatment, and most of them are in five counties participating in the state's Mental Illness and Substance Abuse (MISA) pilot program (see below).

Philosophical differences between the two fields can be a barrier to coordinating or integrating treatment for the COD population. State officials noted that this continues to be an issue even in the five MISA pilot counties.

Collaboration and Consensus Building

In 1997 OMHSAS and BDAP began a formal collaboration process with the goal of creating a better-coordinated system of care for people with COD. The agencies convened a MISA Consortium to develop recommendations for achieving this goal. The Consortium consisted of professionals, consumers, and other stakeholders from both the mental health and substance abuse treatment systems. In 1999 the Consortium produced a formal report that included recommendations for better coordinating or integrating COD care in the areas of assessment, credentialing and training, service standards, and adolescent services. The Departments of Public Welfare and Health then jointly announced pilot funding for counties interested in implementing these recommendations by formally coordinating or integrating COD care.

Training and Workforce Development

OMHSAS and BDAP have also collaborated on training initiatives related to COD, and both have invested significant amounts of funding to training efforts. Outside consultants assisted with the development of a detailed curriculum, which has a heavy emphasis on COD. The curriculum has been used in training sessions for providers participating in the MISA pilots, but OMHSAS and BDAP plan to eventually disseminate the curriculum beyond these sites. Anyone seeking the MISA credential described above will be required to complete this training.

Information and Data Systems

Pennsylvania is piloting a standardized intake instrument in the five MISA pilot counties; all mental health and substance abuse providers are required to use it. There is no standardized instrument for COD being used outside these counties. The state does not require providers to share information, although they can choose to do so as long as they meet federal and state confidentiality regulations. OMHSAS and BDAP also maintain separate data systems, though they have been investigating ways to link their systems or otherwise share data.

Quality Assurance/Quality Improvement

OMHSAS and BDAP are monitoring the performance and outcomes of providers delivering COD care within the MISA pilot counties, primarily through an outside evaluation team (see below). The five MISA counties are also pursuing a variety of quality improvement models to support COD services. At the state level, however, there are no quality improvement or assurance models in place that pertain specifically to

COD. Within Health Choices, OMHSAS has implemented certain quality assurance measures separately for MH and SA, and is interested in developing similar measures for COD.

Pilot Projects

The five MISA pilot sites, which were funded for a two-year period beginning in 2001, are the only pilot projects currently being pursued. The state has contracted with researchers at the University of Pennsylvania to evaluate the program. At the time of our interviews, officials were awaiting evaluation results to assess their success. Some pilot counties are pursuing coordinated or parallel approaches to treating the COD population, but most have implemented integrated care models. Participating providers are dually licensed by OMHSAS and BDAP. The project was funded by SAPT and CMHS block grant and state general revenue funds. These funds were intended to serve as seed money for developing closely coordinated or integrated systems of care. All participating providers in a county—including those providing integrated services—are expected to collaborate as part of a MISA network. Four of the pilot counties are focusing on adult care, while one is targeting care for children and adolescents. The MISA project aims to implement coordinated and integrated models of care not only for the SMI, but also for those in Quadrants II and III.

Chapter 20. 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.

Chapter 21. 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.

Chapter 22. 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.

Chapter 23. Washington State Profile

COD Population Focus

Washington has separate MH (MH Division) and SA (Division of Alcohol and Substance Abuse) Divisions which function under the Department of Social and Health Services, Health and Rehabilitation Services Administration.

Together the two Divisions deliver MH, SA and COD services to a spectrum of adult persons with serious (SMI) and non-serious mental illness and chemical addictions and substance abuse. The MH Division targets those persons with COD who have severe MH and SA problems. The SA Division serves a wider range of persons with COD, as the MH system is not funded to provide services to persons with non-serious mental illness.

Defining the state's COD populations has been a priority for the state. According to the state SA director, the state of Washington had developed a four-quadrant grid several years before the current version of the Four Quadrant Framework was disseminated nationally. The SA and MH divisions have used their four-quadrant grid (and case examples of subtypes) to define level of issues, symptoms and disorders for the COD populations. The state SA director was very involved in the development of the Four Quadrant Framework (and related reports) that was disseminated by NASADAD and NASMHPD. Even though Washington State has focused on COD issues for years, they still believe there are large numbers of individuals who are misdiagnosed, which has inflated the perceived numbers of COD clients.

Financing and Access to Services

Washington is a geographically diverse state with suburban, rural and urban areas. MH services are delivered by 150 public-funded certified CMHCs, approximately 30 of which provide some type of COD outpatient services. The state is divided into 14 regional support networks (RSNs) that vary in size and treat approximately 125,000 people (about one fourth are in Seattle). All RSNs contract with the state and, in turn, with the CMHCs. RSNs therefore fund services in their regions. Urban areas typically provide more comprehensive services than rural areas, although the latter do have some capacity to provide some COD services. The state is currently implementing its two-year plan to revamp its community crisis response system. This has particular relevance to the delivery of COD treatment because many persons with COD in state psychiatric hospitals do not have a residential program as their community-based alternative. The plan is addressing how to create more of these options.

Substance Abuse services are delivered through approximately 660 certified alcohol/drug treatment clinics of which 300 receive some public funding. Prevention, assessment, detox and outpatient treatment are contracted through counties and Tribes, while residential treatment is contracted directly from the state to the provider. While all treatment programs serve COD clients, only about 20% of the programs offer specialty COD services. Approximately 40,000 to 50,000 individuals are served each year in the public treatment system.

Parallel treatment is the most common model of COD care that is delivered throughout the state, particularly for persons in Quadrant IV (or persons with severe MH and/or SA disorders). The state MH and SA directors would like to see more integrated treatment for appropriate persons with severe mental illness and addictions. This, however, does not imply integrated organizational structures.

The main sources of funding for MH, SA and COD services are Medicaid (Rehab Option), block grants, and state funds. The state reports that funding is administered and allocated categorically. However,

Medicaid, block grant and state funds are sometimes braided for reimbursement purposes or co-mingled for special projects. The state perceives that mixing funds would make billing easier for providers who deliver COD services. Currently separate MH and SA codes are used to reimburse COD care. The state cites that the biggest barriers to providing COD and non-COD care is lack of money, and conflicts that providers have about whose responsibility it is (e.g. MH versus SA) to serve a particular type of client, such as persons with severe disorders. MH services are also funded much more heavily than SA (five times more). Consequently, SA is able to serve only 20-25% of those in need. The state reports that the IMD exclusion and minimal residential coverage are the only structural barriers associated with Medicaid for COD and non-COD services.

Risk-based managed care in Washington only exists for MH services. The state MH Division manages these risk-based contracts. The RSNs contract with the state, and in turn with either managed care entities or providers. The capitated rate for MH services is a per person, per month rate. The state is completing an actuarial study that will determine rates for the next two years. Risk-based managed care does not exist at the regional level for SA since its services do not have the “same level of penetration” as MH and therefore do not present the same potential benefit yield from a capitated system. Programs that provide managed or non-managed care services find monies in their budget to care for uninsured persons in general, and to also provide COD treatment in particular, as much as it is possible.

Collaboration and Consensus Building

The MH and SA Divisions have been collaborating and consensus-building about COD service delivery for over a decade. Working under a MOU, the Divisions have had (and continue to have) a strong willingness to work together in both top-down and bottom-up ways to build consensus around COD and other MH and SA service delivery issues.

The state has several working groups and stakeholders who have played, and continue to play, focal roles in developing strategies to implement and improve COD care, and to build consensus around standards and guidelines. These include two COD Workgroups (e.g., CODIAC Workgroup, which facilitates some communication between the MH and SA Divisions); local providers; counties; Regional Service Networks; Secretary of the Department of Social and Health Services, Health and Rehab Services Administration; legislators; consumers; a SA Citizens Advisory Council; and the MH State Planning Council. No single plan is driving COD activities at this time.

Training and Workforce Development

Training (including cross-training) for MH and SA providers is a priority in the state of Washington. Both the MH and SA Divisions have training budgets, and provide and sponsor ongoing training activities. One CSAT Technical Center (ATTC) and some of the counties also fund training sessions. Both Divisions sponsor annual MH, SA and COD conferences. Both Divisions funds Training Academies (or intensive trainings on a variety of topics) and the SA division has a workforce development committee (with state and regional representatives) that is working with ATTC on SA capacity issues (e.g., shortage of SA counselors). The Divisions use training curriculums they have developed, and those developed by particular consultants such as Rick Ries, and also hire consultants to conduct trainings.

Over the last few years the state (mainly the MH Division) has spent a great deal of time developing treatment standards, guidelines and competencies. Plans for implementation will be developed in the near future. In addition, both the MH and SA Divisions are working on special credentials and licensing that can help facilitate the delivery of COD care.

Information and Data Systems

The MH and SA Divisions maintain separate MIS systems that can be linked for research purposes. The state does not plan to permanently integrate the two systems because it perceives the financial costs and “confidentiality barriers” to be too high. The two Divisions, however, successfully link their systems to track utilization of services for certain populations, including COD. In the future the state would like to collect more extensive data on the COD population. The MH Division is moving in this direction, as it plans to revamp its data collection system and develop a consumer outcomes system that includes specific COD measures. The SA Division has already developed an outcomes-based system including COD consumers.

The MH and SA Divisions do not require that a standardized intake instrument, which includes MH and SA domains, be used by all providers. However, the state’s standardized assessment/intake form (which is also used for data reporting purposes) contains some MH, SA and disability questions. While the Divisions advocate the sharing of clinical information with the other sector within 42 CFR rules, both Divisions do not perceive that sharing information across sectors or providers is an issue.

Quality Assurance/Quality Improvement

Currently, the state is engaged in a few activities that lay the foundation for developing routine monitoring of access and quality of COD services, COD performance measures, and quality improvement models to support the delivery of COD care. As mentioned, the MH Division intends to include COD measures in its new consumer outcomes system. The SA Division is in the process of developing a system-wide continuous quality improvement process that will include a focus on COD. The state is concerned that persons with COD do not necessarily receive the comprehensive set of services they need. This is one quality assurance issue it plans to address in the future.

Pilot Projects

During the last several years the state has conducted several pilot and research studies that have focused on cost-effectiveness, utilization of services and outcomes for persons with multiple MH, SA and physical health problems. These studies have been useful in the state’s efforts to improve MH, SA and COD services. According to the state SA director, several studies of SSI clients showed that COD consumers experienced significant improvement in outcomes even though they received no specialized treatment, and received alcohol/drug treatment as usual. This is resulting in further discussions about how much, if any, specialized treatment is needed (and worth funding) among some individuals with a COD.

Chapter 24. Wisconsin State Profile

COD Population Focus

Wisconsin previously had separate Bureaus of Community Mental Health and Substance Abuse Services, both located within the Wisconsin Department of Health and Family Services. The two Bureaus were merged in March 2003 in an effort to improve the MH and SA systems, while streamlining administration and cutting costs. Both the mental health and substance abuse authorities define COD broadly and include individuals who have both a diagnosable MH and SA disorder (i.e., not limited to persons suffering from serious mental illness). However, COD definitions vary by funding stream, and CMHS block grant funding (and related reporting) is targeted to a particular SMI population.

Financing and Access to Services

COD services in the mental health system are financed partly by Medicaid (for those eligible) and partly by block grant and county government funds. Medicaid managed care penetration in Wisconsin is extensive but does not cover the entire state. Medicaid managed care contracting mostly takes place at the state level, and has been targeted at some specific groups of consumers and/or specific locations (e.g., voluntary SSI participants in Milwaukee, dual Medicaid/Medicare participants with long-term care needs). Participation in Medicaid managed care is based on voluntary enrollment in some counties but is mandatory in others.

In the MH system, one barrier to access for COD services is an insufficient number of Medicaid providers for COD services, and obtaining access to those providers may be problematic in some parts of the state. In addition, administrative coding regulations under Medicaid create some billing problems for MH providers in connection with offering both MH and SA services.

County governments have responsibility for providing MH services to the non-Medicaid eligible population, and have the authority to set rules regarding access to those services. Because of insufficient financial resources in the non-Medicaid sector, counties have had to choose how to target their funds. As a result, waiting lists exist for access to some public-sector MH services.

Provision of COD services through the MH system occurs mostly under parallel and sequential delivery models, and with relatively few COD services being provided through an integrated approach. Access to COD services does not differ by patient characteristics (i.e., based on the Four Quadrant Model).

In the substance abuse system, current Medicaid administrative codes create barriers for the provision of COD services. A SA provider must refer patients to a licensed MH professional in the event of a diagnosable MH problem. The administrative codes for SA providers are different from those that apply to MH providers, and the entire health code scheme was in the process of being revised and updated at the time of our interviews. Other identified barriers include parallel certification/licensing processes for MH and SA providers, tension between the two groups of providers over reimbursement issues, and philosophical differences between them about the nature and scope of care.

Medicaid Badgercare HMO provides MH/SA services on a statewide basis. In addition, there are other specialized programs that serve more limited regions within the state. State law imposes annual funding caps on Badgercare for different categories of medical services, with a major disparity in funding between MH services and SA services (MH services being capped at a higher level). This funding disparity is reportedly a barrier to providing COD services within the SA system.

On the non-Medicaid side, Wisconsin has a county-operated SA system, which is financed by block grant funding, with a minimum 9.8% match from county general revenues. In some instances, the state SA authority contracts with the counties to provide specific services, and in others the counties use the SA funds to provide a continuum of care. Availability of COD services in the non-Medicaid sector is a function of degree of need and availability of resources in particular counties. COD services for this population are more common in urban areas.

Provision of COD services in the SA system occurs mostly through parallel delivery models in most counties in Wisconsin. However, several counties have combined their SA and MH administrative operations. According to our interview respondents, this has improved coordination across the two systems.

Collaboration and Consensus Building

State-level collaborative activity for COD services has been ongoing for a number of years. A Blue Ribbon Commission on Mental Health was appointed by the Governor in 1986-1987, and a part of the Commission's work involved a focus on COD services. The Commission established some momentum in addressing COD services, and only recently finalized a set of guiding principles on the delivery of these services.

An administrative redesign process involving the state MH and SA bureaus began in 1996 and included some focus on COD issues. The redesign process culminated in the administrative merger of the two bureaus in March 2003.

Consensus building on COD has involved some outside parties beyond the MH and SA bureaus (e.g., the governor's advisory councils on MH and SA), but has not included the state Medicaid agency in a significant capacity. Both the MH and SA authorities are committed to implementing COD recommendations that are developed through their consensus building process, and the two authorities have signed a formal Memorandum of Understanding concerning COD.

Training and Workforce Development

Although Wisconsin does sponsor cross-training initiatives to enhance the skills of its MH and SA staff members, there is no distinct training program in connection with COD treatment, and COD issues are dealt with on an ad-hoc basis in other kinds of training programs.

Information and Data Systems

At the time of our interviews, the state had not undertaken substantial efforts to support COD services through its information and data systems. Intake instruments have not been standardized across the MH and SA systems, sharing of clinical information across systems is not required, and MIS are not linked across the two systems.

Quality Assurance/Quality Improvement

Wisconsin does not routinely monitor access to or quality of care for COD using performance indicators or outcome measures, although both MH and SA agencies indicated that they were currently working on implementing this sort of monitoring.

Pilot Projects

Wisconsin's COD pilot program, the Perseus demonstration project, aims to provide improved services to an adult COD population. The project involves an integrated services delivery model and a flexible/blended funding stream.

Chapter 25. 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.

Chapter 26. State Trends and Themes

Overview

This chapter summarizes how states are addressing service delivery for COD populations. 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 service systems. They also differ greatly in terms of funds available to deliver mental health and substance abuse care.

Our reporting of state activities related to COD service delivery is organized into 8 topic areas: consensus-building, workforce training and standards, COD population definitions and emphasis, access to integrated and parallel service models, regulations or policy to address financing barriers, regulations or policy to address provider agency capabilities, information system capacity, and quality improvement. Each of these is discussed below, followed by a summary of our findings.

Consensus-Building

Given historical divides between mental health and substance abuse service systems, and distinctive training and philosophical orientations of mental health and substance abuse providers, broad efforts to raise awareness of needs for and build consensus for collaboration and provision of COD services is one of the first steps taken by states to address COD service delivery issues.

Respondents from nearly all states (20 out of 23 states) that were included in the study told us that they had engaged in consensus-building activities intended to forge alignment between mental health and substance abuse authorities. Some states have engaged in consensus-building and aligning activities over many years. The results of Oregon's first task force, which included both SA and MH officials investigating ways to improve service delivery for the COD population, were published as early as 1986. Illinois has been engaged in collaboration and consensus building to better serve persons with COD since 1990, when the state's first task force was created, and since 1991 the state has provided funds to support specialized programs and initiatives targeted for persons with COD. In Connecticut, SA and MH officials have been regularly meeting and collaborating on COD issues since 1995, and COD has been a focus for several state-level commissions and advisory groups in the past 5 years. SA and MH authorities in Missouri have also been collaborating since 1995, and have convened several workgroups including representatives from wide variety of stakeholders, to address system and service delivery reforms.

Some states reported developing formal MOU's between MH and SA agencies (Texas, California, Washington, New York, and Wisconsin). Often, however, collaboration between MH and SA agencies (or divisions within a single umbrella agency) on COD issues has been carried out without a formal MOU. Most states, whether or not they used formal MOU's between agencies, had established cross-agency task forces, commissions, or workgroups to focus on improving COD services, and often these workgroups included a broad set of stakeholders beyond MH and SA officials, including representatives from the state Medicaid agency, providers, families, consumers, and special population groups such as Native American tribes.

State authorities have often used outside consultants to educate and forge a common vision among diverse stakeholder groups, and to guide initial work to develop state plans, goals, and strategies. The influence of Ken Minkoff, in particular, was notable. For example, in Montana, the state's COD Task Force gained momentum in 2001 following a seminar given by Ken Minkoff for providers, policymakers, consumers, tribal officials, and state policy advisory council members. The Task Force has since been assisting the

development of regional action plans, developing guidelines for delivering COD care and plans for providing more COD training, and is exploring how administrative and fiscal incentives can be used to enhance the delivery of COD services. Oregon's 1999 task force drew on Ken Minkoff's ideas to present recommendations for improving COD care at both the state system and provider levels, and developed guidelines for providing culturally competent care to the state's large Native American and Hispanic populations. Arizona also used outside consultants (including Minkoff and others) to guide their efforts to bring together a broad set of stakeholders and to develop broad principles and guidelines for COD services.

Sometimes these endeavors have resulted in development of state plans, principles, or recommendations that have or will be guiding subsequent efforts to improve services for persons with COD. In Connecticut, a state-level task force devised formal policy recommendations (which have since largely been implemented by state authorities), and state officials have, in turn, developed guidelines for delivery of clinical services to persons with COD. Similarly, in California, a state-level task force has developed guidelines and principles for COD care that include a set of values for both clinicians and administrators, and 13 priorities that the state is committed to implementing. (This is also the case in Massachusetts and Wisconsin.)

Not all states had developed active collaborations and consensus across MH and SA authorities. In Iowa and Ohio, COD system and services reforms have largely been carried out within the auspices of the MH authority, and consensus building efforts have largely been focused on MH stakeholders.

Workforce Training and Standards

We asked MH and SA officials to describe state sponsored cross-training to enhance the skills of MH and SA staff, and queried them about specific standards for individual clinician or provider agency competence to treat COD, such as clinician credentialing or facility licensing or contract requirements.

All 23 states had sponsored training on COD for MH and SA staff. In most states, this consisted of conferences or training workshops offered on an occasional basis, with no specific commitment to an ongoing training capacity. Four states, however, described state programs that made training and technical assistance resources available to providers on an ongoing basis (Arizona, Connecticut, Illinois, and Ohio). For example, in Illinois, the MH and SA agencies jointly support a program called the MISA (for mental illness and substance abuse) Institute, which is established at the University of Chicago Center for Psychiatric Rehabilitation. The MISA Institute has created a consortium of MH and SA provider agencies, and has responsibility for training and providing technical assistance to these provider agencies and their staff. In Ohio, the MH authority has created a SAMI (for substance abuse and mental illness) Coordinating Center of Excellence (CCOE). Because Ohio has regional authorities (50 local boards) with responsibility for contracting and providing oversight to local providers, the SAMI CCOE has responsibility both for marketing and disseminating information about evidence-based models of COD care to local communities. For those communities and provider agencies that wish to adopt these models of care, the CCOE provides training and technical assistance.

Although a number of states were in the process of developing clinician standards for COD care, few had implemented credentialing specific to provision of COD services. Examples of states with specific COD competency requirements and designations are Illinois and Texas. Illinois has both a clinician certification program and an optional accreditation for provider agencies. Texas has created COD specialist positions attached to MH or SA provider agencies with responsibilities for engaging persons with COD and referring them to appropriate services.

COD Population Definitions and Emphasis

Because there is much clinical diversity among persons with COD, we were interested in learning how states defined the COD population and which subgroups of the COD population their COD services tended to focus upon.

In many states (19 of 23), MH and SA officials were familiar with the SAMHSA Four Quadrant Model that distinguishes and defines different COD populations, and had adopted this framework either formally or as a working rubric in their definitions of the COD population. The model distinguishes four types of COD populations based on the severity of their mental illness and substance abuse. Quadrant I refers to those with low severity mental illness and low severity substance abuse. Quadrant II refers to those with high severity mental illness and low severity substance abuse. Quadrant III refers to those with high severity substance abuse and low severity mental illness, and Quadrant IV refers to those with high severity mental illness and high severity substance abuse. The broad familiarity with and use of the Four Quadrant Model definitions by both mental health and substance abuse officials suggests that this model has been useful in forging a common perspective and dialogue across mental health and substance abuse systems. Within the Four Quadrant framework, both systems can recognize their own distinctive population characteristics and service needs.

As might be expected, the emphasis of MH authorities in most states (16 of 23) tended to be on the COD population with severe mental illness (SMI), but in 7 states the MH authority claimed a broader emphasis that encompassed both the SMI and non-SMI populations. SA authorities often focused their efforts on the population with less severe mental illness (13 states) but had a broad emphasis on SMI and non-SMI in 10 states.

Access to Integrated and Parallel Service Models

The Four Quadrant Model that distinguishes COD populations based on the severity of their illness suggests that integrated services are appropriate for those in Quadrant IV, who suffer from high severity mental illness and high severity substance abuse. It suggests that collaborative models may be appropriate for those in Quadrants II or III (where the mental health system is likely to be the principal locus of care for those with high severity mental illness and low severity substance abuse, and the substance abuse treatment system is likely to be the principal locus of care for those with high severity substance abuse and low severity mental illness). Finally, for those in Quadrant I (low severity mental illness and/or substance abuse), primary health care is likely to be the main locus of care, and consultation may be the appropriate approach to service delivery.

We asked state authorities to describe the extent to which different COD populations had access to parallel and integrated COD services. We defined parallel services as receiving services for MH and SA problems simultaneously, but in different programs, and integrated services as receiving both SA and MH services within a single program. For the COD population with more severe mental illness who enter care through the mental health system, 8 states reported offering broad access to integrated services, and 16 states reported providing broad access to parallel services. For those with less severe mental illness who enter care through the SA treatment system, 13 states reported that they provide broad access to parallel services, and no states reported providing broad access to integrated services. Two states mentioned that their predominate model of COD care was neither integrated nor parallel, but rather a “generalist” model. These were Wyoming and Alaska, both with large rural and frontier areas where it may not be practical to maintain separate substance abuse and mental health providers.

Many states have been involved in demonstrating and evaluating different service delivery models. Most often, states reported undertaking initiatives that implemented integrated treatment services for the SMI

population in selected provider agency sites (14 states). Relatively little demonstration and evaluation of parallel service delivery models has been attempted. Missouri reported that they are now encouraging providers to deliver integrated COD services within their agencies because the state's experiment to increase the delivery of parallel COD services "didn't work". In Pennsylvania, researchers are evaluating service demonstrations in 5 counties; these include both coordinated and integrated models of care for both the SMI and non-SMI populations.

Regulations or Policy to Address Financing Barriers

Widely recognized barriers to delivering COD services are inherent in the distinct financing environments in which public mental health and substance abuse treatment services are delivered. In the mental health system, which predominately serves persons with serious mental illness and is heavily dependent on Medicaid financing and therefore subject to Medicaid regulation, provider agencies find it difficult to pay for substance abuse services that are not Medicaid reimbursable, or to extend their integrated COD service programs to non-Medicaid eligible populations. In the substance abuse system, which is heavily reliant on federal block funding and total state budgets are much smaller than those for mental health services, there are concerns that scarce substance abuse treatment resources will be further diluted if used for mental health services. Scarcity of resources often translates into relatively lower rates of reimbursement for services delivered by SA providers relative to MH providers, even when the service is similar (e.g., case management), making it more difficult for SA providers to extend their services to those with complex needs like COD.

A number of states undertook regulatory or policy changes to alleviate such barriers – largely by making Medicaid funding more flexible. Medicaid reforms that created an at-risk managed care system increased flexibility to deliver COD services in several states. Arizona created a "seamless system" of mental health and substance abuse treatment, viewed from the perspective of providers and consumers, by contracting with 5 regional authorities to provide services to the Medicaid population under an at-risk arrangement, and for the non-Medicaid population under an ASO arrangement. 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. In the Dallas, Texas area, a behavioral health carve-out plan (Northstar) serves the Medicaid population under a capitated contract, where Medicaid eligibility has been expanded to include those at or below 150 percent of the federal poverty level. State officials reported that Northstar enhanced providers' flexibility and capacity to provide COD services, including coordinated and integrated treatment, and increased access to COD services with no waiting lists. Pennsylvania also increased flexibility for providers to deliver and receive reimbursement for COD services through a behavioral health carve-out within a Medicaid managed care system.

Medicaid reforms involving managed care, however, did not always result in greater flexibility to deliver COD services. In Oregon, which has a state-wide managed Medicaid system that includes the poverty population, Medicaid managed care contracts generally carve-out mental health benefits to a managed behavioral health organization, but the substance abuse benefit remains with the general medical plan, leaving a structural divide that imposes a barrier to the delivery of COD services.

Some states with traditional FFS Medicaid systems had or were in the process of implementing other financing strategies to facilitate delivery of COD services. In Illinois, separate state mental health and substance abuse treatment authorities provide "crossover" monies to provider agencies. As a result, about 50% of mental health providers receive some substance abuse funding, about 20% of substance abuse providers receive some mental health funding, and 35-40% of all agencies receive funding to deliver both mental health and substance abuse services. Indiana reported using a case-rate form of reimbursement to provider agencies, based on categories of diagnosis, and was in the process of implementing a case-rate that would be specific for persons with SMI and substance abuse problems. Montana was exploring the

development of billing codes that would be specific to COD services and Medicaid reimbursable. Missouri was encouraging providers to offer integrated COD services by expanding definitions of reimbursable services, allowing SA provider agencies to bill for trauma services and mental health provider agencies to bill for substance abuse services.

Regulations or Policy to Address Provider Agency Capabilities

Barriers to delivering COD services have included regulation or rules that discourage integration or coordination of COD services. Separate licensing requirements for substance abuse and mental health provider agencies often preclude the delivery of any mental health care by substance abuse providers. Mental health provider agencies may not be able to employ staff with credentials to treat substance abuse, and may require that persons with COD get treatment for their SA disorder before being eligible for MH services. Even when mental health and substance abuse treatment providers are co-located within the same facility, separate regulatory and policy environments may require separate treatment planning and discourage the coordination of care.

A number of states reported on initiatives that were intended to overcome the “stovepiping” effects of regulation and rule that create barriers to the effective delivery of COD services. In New York, MH and SA authorities were collaborating in a pilot program that provided “dual recovery coordinators” to local regions to address issues of coordination and integration of COD care at the local system level. Similarly, Texas developed “co-occurring psychiatric and substance use disorders specialists” who are attached to local substance abuse or mental health provider agencies and help persons with COD navigate across the two systems.

Missouri and Connecticut state authorities were working on barriers related to provider agency licensing. In Connecticut, the state authority responsible for both mental health and substance abuse treatment systems began granting waivers to existing regulations so that mental health and substance abuse provider agencies could be cross-licensed.

In Arizona, where financing and delivery of mental health and substance abuse services are being administered by regional authorities under a managed care system, the state has established contract standards and expectations that all behavioral health provider agencies are competent to identify and address co-occurring disorders in their patient population. Providers must be either “dual diagnosis capable”, meaning that they can link patients to services outside their agency, or “dual diagnosis enhanced”, meaning that they can provide integrated COD services.

Information System Capacity

Responding to distinctions in regulatory and funding environments, states have generally maintained separate information systems for their mental health and substance abuse service systems. Lack of comparability of data elements and service definitions makes it difficult to link the systems in order to discover whether clients are getting services across systems. This lack of comparability creates a challenging problem when states wish to identify and monitor the extent to which people are receiving parallel COD services. Even within distinctive SA and MH management information systems, it is often difficult to track access to integrated COD services, as information systems have not historically captured COD diagnoses/problems at intake, and service unit definitions have not allowed for identification of integrated COD services.

Of the 23 states in this study, 16 reported that mental health and substance abuse information systems were separate and not linked. Of the 7 States who had linked or common information systems, 4 did not link to

the Medicaid agency's information system, and none included data elements that specifically identified COD services.

Most states reported that they were planning or undertaking improvements in their information systems to address these limitations and create a capability to monitor needs for, access to, and use COD services. Plans included developing standardized intake protocols that would capture co-occurring disorders at intake (2 states had developed and 8 states were in process of developing such protocols) and making systems more comparable and linkable (3 states). Five states reported that they were developing data elements that specifically identified COD services.

Quality Improvement

Because state information systems have not yet been revamped to enable routine monitoring of COD diagnoses at intake, use of COD services, and/or outcomes of COD service use, these systems cannot yet support quality improvement efforts for COD services that are directed and informed by routine reporting of performance. Quality improvement models such as Continuous Quality Improvement (CQI) or rapid Plan-Do-Study-Act (PDSA) cycles require information about clinical care process and/or outcomes that inform plans to improve quality and provide a means of evaluating whether quality improvement interventions are having their intended impact. No state reported currently employing this type of quality improvement approach.

Some states were conducting pilot studies or demonstrations that enabled them to learn how well specific programs were performing within one or several provider agency sites. Pennsylvania, for example, reported on the demonstration of COD services in 5 pilot counties, an initiative being evaluated by outside University-affiliated researchers. Connecticut reported undertaking 7 demonstration programs that targeted a range of COD populations. Arizona and Washington described previous research and demonstration programs that informed their efforts to expand services for persons with COD.

Fidelity assessment is a component in Ohio's quality improvement approach to delivering COD services within its mental health system. The state-supported Coordinating Center of Excellence that focuses on co-occurring substance abuse and mental disorders (SAMI CCOE) disseminates and supports training and implementation of the Dartmouth integrated dual diagnosis treatment model for interested mental health provider agencies. Existing measures of fidelity to the Dartmouth model have been adapted by the CCOE, and are being used at least yearly to evaluate provider adherence to the model among those provider agencies that have implemented the model. This information is compared over time and benchmarked with other programs.

Summary and Discussion

Our study of state initiatives and innovations in improving care for COD services found that much had been accomplished by these states in building awareness of COD service delivery needs, forging consensus between mental health, substance abuse and other stakeholder groups, and providing workforce training. In addition, we found that a few states had developed strategies and mechanisms for ongoing training, provision of technical assistance, and ways of recognizing practitioner and provider competencies in treating persons with COD. The step from paving the way for system change through consensus development and education to institutionalizing training, technical assistance, and incentives to maintain workforce competencies is a large one, but it is evident that some states are taking that step, and many are making plans to do so.

With respect to the SMI population with COD, we found broad acceptance of integrated approaches to treating COD, and most states in our study had experience piloting or implementing integrated service

models. In particular, many states mentioned their adoption of the Dartmouth integrated dual diagnosis treatment model, which is well-documented, and research evidence supports its effectiveness when implemented with fidelity. No state, however, reported broad statewide implementation of integrated treatment models, and few were at this time undertaking efforts at statewide implementation. The decision to broadly provide such intensive services is clearly a big decision for these public systems where dollars are already thinly stretched. Most states we spoke with were content to implement integrated treatment on a trial basis or in a few communities, or to allow provider agencies to take the initiative in deciding whether to delivery integrated COD services. Unfortunately, the research literature provides little guidance about other service delivery approaches for the SMI. Few competing models have been developed and evaluated. For example, there has been no development and evaluation of a “generalist” model that would be more feasible to implement in rural and frontier areas that would not be able to support the multi-disciplinary teams required by an integrated treatment model.

A major challenge that we identify for the future of COD services is the need for effective models of care for the non-SMI population. Neither integrated nor parallel/coordinated models of care have been carefully evaluated for treating this population. While it is a reasonable assumption that the intensive integrated treatment approach developed by the Dartmouth group may not be needed for this population, alternatives have yet to be demonstrated effective. Because many states are trying to increase access to parallel service delivery for this population, it is particularly important that these models of care be developed with more clinical and programmatic specificity and be rigorously evaluated.

A second major challenge is to address issues of financing services for the poor who are not Medicaid eligible. Those with severe substance abuse but less severe mental illness who enter the system through the door of the substance abuse treatment system are often not Medicaid eligible. Financing COD services for these individuals is a great challenge, both because of the strained budgets of the public substance abuse treatment systems, and because the public mental health system is increasingly driven by Medicaid financing and therefore focused on the SMI population, leaving little flexible funding to focus on the non-Medicaid population.

A third major challenge is improving state information systems so that they can support performance reporting and quality improvement on a broader scale and in a continuous way. Many states are undertaking such improvements, which is a very important investment in infrastructure to support accountability and improve their systems of care. At the present time, however, this capability is largely lacking, and thus states are continuing to rely on time-limited demonstration evaluations to inform their planning and policy.

Chapter 27. 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.

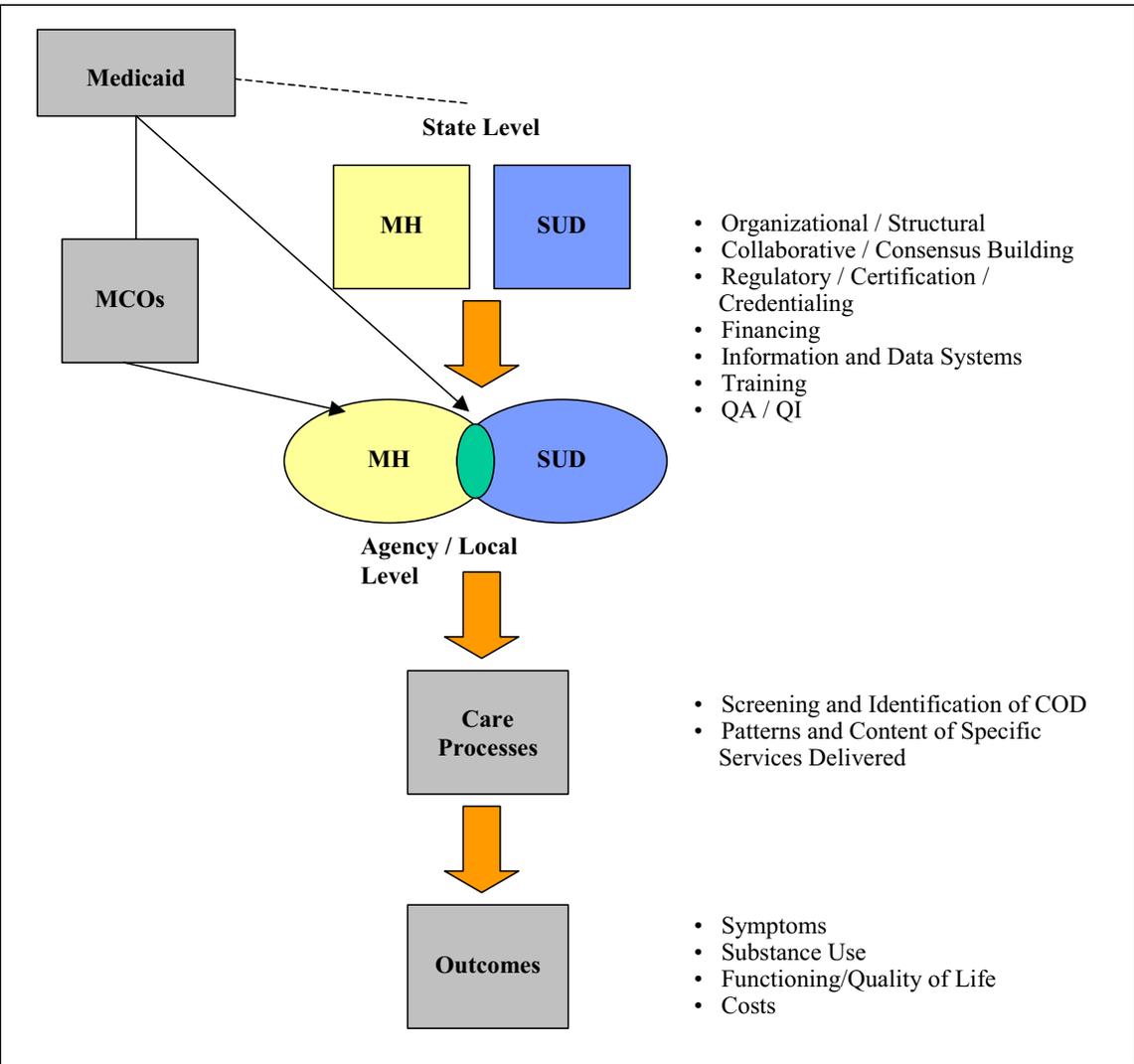
As suggested by this framework, there are two broad ways of evaluating whether state and local provider strategies and initiatives are having the intended impact on improving care for persons with COD. A first-level question that an evaluation should answer is whether processes of care are improving. 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 (IDDT) 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. Solicitation Letter

RAND

December 20, 2003

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

Dear Mr./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. We look forward to talking with you and thank you for your consideration.

Sincerely,

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Appendix C. 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

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

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				

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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,
 - 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?

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: _____
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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?

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