Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders

NASMHPD-NASADAD Task Force
on Co-Occurring Mental Health and Substance Use Disorders

Final Report
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National Association of State Mental Health Program Directors (NASMHPD)

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(NASADAD)

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ACKNOWLEDGMENTS

The final report of this year's joint NASMHPD-NASADAD Project on Co-Occurring Mental Health and Substance Use Disorders comes at an opportune and unique moment in the historical development of public service systems for persons with co-occurring mental health and substance use disorders.

There is an increasing perception that the needs of individuals with co-occurring disorders are becoming ever more complex and challenging. The evidence base for effective service intervention practices is steadily growing. Provider communities are changing and seeking new knowledge, as they shift management and practice perspectives in order to deliver a more comprehensive array of services that are evolving to meet more specifically identified needs. Consumers are finding a clearer voice and demanding that services be offered in ways and in environments that are better designed to meet their needs. Policy makers and funders are increasingly considering the linkages between what and how they fund services and the consumer and program outcomes that they seek. A critical mass of key elements seems to have been reached. And all of this comes at a point of great economic uncertainty, as available resources shrink and states experience renewed financial constraints.

As the executive directors of the two national associations representing the nation's state and territorial mental health and state substance abuse agencies, we are proud of our efforts to help our constituents cope with their changing environments through this multi-year project. These contributions would not have been possible without the financial and moral support of the federal Center for Mental Health Services and the Center for Substance Abuse Treatment. Michael English, Director of the CMHS Division of Service and Systems Improvement and Jane Taylor, Chief of the CSAT Division of State and Community Assistance Co-Occurring and Homeless Activities Branch, have been instrumental in shaping the project's vision. Lawrence Rickards of CMHS and Edith Jungblut of CSAT have been knowledgeable and faithful project officers for CMHS and CSAT, respectively. We appreciate the flexible guidance that these federal agencies have provided.

The members of the joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders once again deserve thanks for their commitment to the group's work: for their review of draft documents; for attending Task Force meetings; and for their willingness to engage in the often difficult work of reconciling disparate and strongly-held points of view. The energy with which they have helped guide the project's efforts is visible throughout this document. In particular, we want to acknowledge the work of the New York State Office of Mental Health and the New York Office of Substance Abuse Services, whose directors – James Stone and Jean Somers-Miller - collaborated to produce the original conceptual

framework on which the Task Force based its work. The relationship between these two state agencies illustrates what can be accomplished through a shared vision and commitment to a common goal.

The nine service sites that participated in this study deserve both our congratulations and our thanks. These agencies and state systems have demonstrated their strong commitment to meeting the complex needs of persons with co-occurring mental health and substance abuse disorders by expanding services, retraining staff, reallocating scare resources and meeting the inevitable barriers and obstacles with creativity and confidence. This project would not have been possible without the time and energy that they devoted to participating. Their hard-won experience educates us all.

Finally, we are grateful to Bruce Emery and to Robert Anderson, who have served as co-directors of the Co-Occurring Project from its beginnings several years ago. This report was developed by Bruce Emery and James Bixler, who together have also facilitated the meetings of the Task Force for the past several years. Jim's untimely passing earlier this year left us without the expert and skilled professional we had come to rely on as we negotiated our way through to the mutually-supportive relationships on which true systems change depends. We miss Jim's intelligence, grace and good humor. We respectfully dedicate this report to his memory.

Robert W. Glover, Ph.D.
Executive Director
NASMHPD

Lewis Gallant, Ph.D.
Executive Director
NASADAD

EXECUTIVE SUMMARY

This report is the fourth in a series of publications produced under the auspices of the joint Task Force on Co-Occurring Mental Health and Substance Use Disorders of the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Created in 1998 with the support of the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse and Mental Health Services Administration (SAMHSA), the Task Force has focused its attention since its inception on creating the constructive dialogue necessary to overcoming historical barriers to treatment and strengthening services for persons with co-occurring disorders across the nation.

Together, these reports confirm the foundations for the Task Force's discussion of co-occurring mental health and substance abuse services by:

- articulating a framework that conceptualizes treatment systems for co-occurring mental health and substance use disorders in terms of the nature and severity of client symptoms and specifies the level of service coordination (i.e., consultation, collaboration and integration) needed to improve service outcomes (*National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders,* 1999);

- establishing the expectation that comprehensive, coordinated systems of care for individuals with co-occurring mental health and substance use disorders based on the conceptual framework should be developed, financed and marketed (*Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders*, 2000);

- identifying co-occurring service programs from five states as examples of successful efforts to serve persons with co-occurring mental health and substance use disorders (*Successful Programs for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders: Examples from Five States,* 2000); and

- presenting in-depth case analyses of nine service systems that deliver effective, integrated services to persons with co-occurring disorders by using funds derived from multiple sources and by documenting the specific management and program practices and methods these programs use to organize services, obtain revenue, expend resources and account for expenditures (*Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders,* 2002).

The Task Force believes that these reports make a valuable contribution to the knowledge base for public mental heath and substance abuse authorities who have identified the expansion and strengthening of co-occurring service systems as a high priority for systems improvement.

About The Problem

The needs of persons with co-occurring mental health and substance abuse disorders are varied and complex. Historically, the nation's mental health and substance abuse treatment systems have responded to these needs in a fragmented and uncoordinated fashion. Our responses have reflected significant differences in the way co-occurring disorders are understood and defined, as well as in the way that co-occurring treatment services are developed, financed and delivered. While differences of opinion and approach remain, mental health and substance abuse professionals increasingly recognize an urgent need to create more responsive systems of care. Without more effective care, individuals with co-occurring mental health and substance abuse disorders will continue to cycle repeatedly through service systems, enter jails and judicial systems and generally go without the services and supports they need to relieve and resolve their disorders.

About This Report

This report details the experience of nine service systems in developing, delivering and financing what are generally regarded as exemplary, integrated services for individuals with co-occurring mental health and substance abuse disorders by using multiple sources of funds. It provides the most complete information available nationally regarding how integrated co-occurring services are financed; synthesizes the key characteristics of successful programs; and, makes a series of fiscal and program-related recommendations to be considered by service providers, policy makers, payers, consumers and advocates in their efforts to create and expand integrated systems of mental health and substance abuse treatment.

The report contains a series of observations and conclusions that have resulted from this unique national effort, including:

- Significant improvements can be made within existing service and financial structures and mechanisms (including the Community Mental Health and Substance Abuse Prevention and Treatment Block Grants) that would increase the capacity of mental health and substance abuse service systems to deliver integrated care for persons with co-occurring disorders.

- System improvement begins with the commitment of leadership. The experience of the case study sites indicates that while service expansion and strengthening can be accomplished, it is not without risk. Leaders at state and local levels have been willing to assume that risk.

- Staff training is the key to developing a shared set of values and approaches regarding the needs and capacities of persons with co-occurring mental health and substance abuse disorders to change their lives for the better.

- State licensing, certification, financial and program rules and regulations often unnecessarily and

unintentionally impede the development of integrated co-occurring services. Whenever possible, they should be examined and reduced or eliminated.

- Each state mental health and substance abuse authority is responsible for overseeing a service system with a multitude of funding sources. Service funding reaches local service programs through diverse organizational mechanisms, including managed care frameworks, county and regional authorities and state-operated direct service systems. Being accountable for the expenditure of these funds requires that agencies balance a bewildering array of regulations, requirements and guidelines.

- State authorities share a common capacity to create and apply financial incentives that support the development and delivery of integrated co-occurring services and make the best use of limited resources.

- Mental health and substance abuse service professionals, providers, consumers and advocates – as well as their colleagues in other service systems – have unique expertise and contributions to make in the creation of more collaborative systems of care. They should be recognized and respected as essential partners in building a national consensus in support of more effective co-occurring mental health and substance abuse services.

Using The Report and Next Steps

This report is designed to provide ideas and guidance to service providers, policy makers, payers, consumers and advocates in their efforts to develop integrated mental health and substance abuse services for persons with co-occurring disorders. It employs the experience of a singular group of service agencies and state systems in order to generate further discussion and to take the next steps – whatever they may be – in strengthening state and local systems of care. The authors of this report hope it encourages their colleagues across the country to capitalize on the success of these study sites and, in doing so, move one step forward toward the shared goal of creating more effective systems of care for persons with co-occurring mental health and substance use disorders.

INTRODUCTION

Background

Co-occurring mental health and substance use disorders constitute one of the most pressing problems facing the nation's public mental health and substance abuse service systems today. As resources decline and the needs of consumers become both clearer and more complex, the estimated 7 - 10 million people in this country who experience the combination of at least one co-occurring mental health and substance use disorder present service providers, policy-makers, funding sources, consumers and advocates with a significant challenge[1]. These individuals cycle repeatedly through primary health, mental health and substance abuse treatment systems. They enter jail and judicial settings. Individuals and families alike become homeless. Many receive no treatment at all.

Beginning in 1998, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), with support from the federal Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), began a dialogue by appointing a joint NASMHPD-NASADAD Task Force on Co-Occurring Mental Health and Substance Use Disorders. The Task Force was created to explore barriers to effective treatment for persons with co-occurring disorders and to identify strategies that would bring those barriers down. Since its inception, the Task Force has sought to model the level of professional collaboration which its members believe is essential to creating more responsive systems of care.

The Task Force expanded on work that originated with the New York State Office of Mental Health and the New York State Office of Substance Abuse Services to devise a conceptual framework for considering both the needs of individuals with co-occurring mental health and substance use disorders as well as the system characteristics necessary to meet those needs. Presented in a March, 1999 report of the Task Force,[2] the conceptual framework offers a way of thinking about service delivery that

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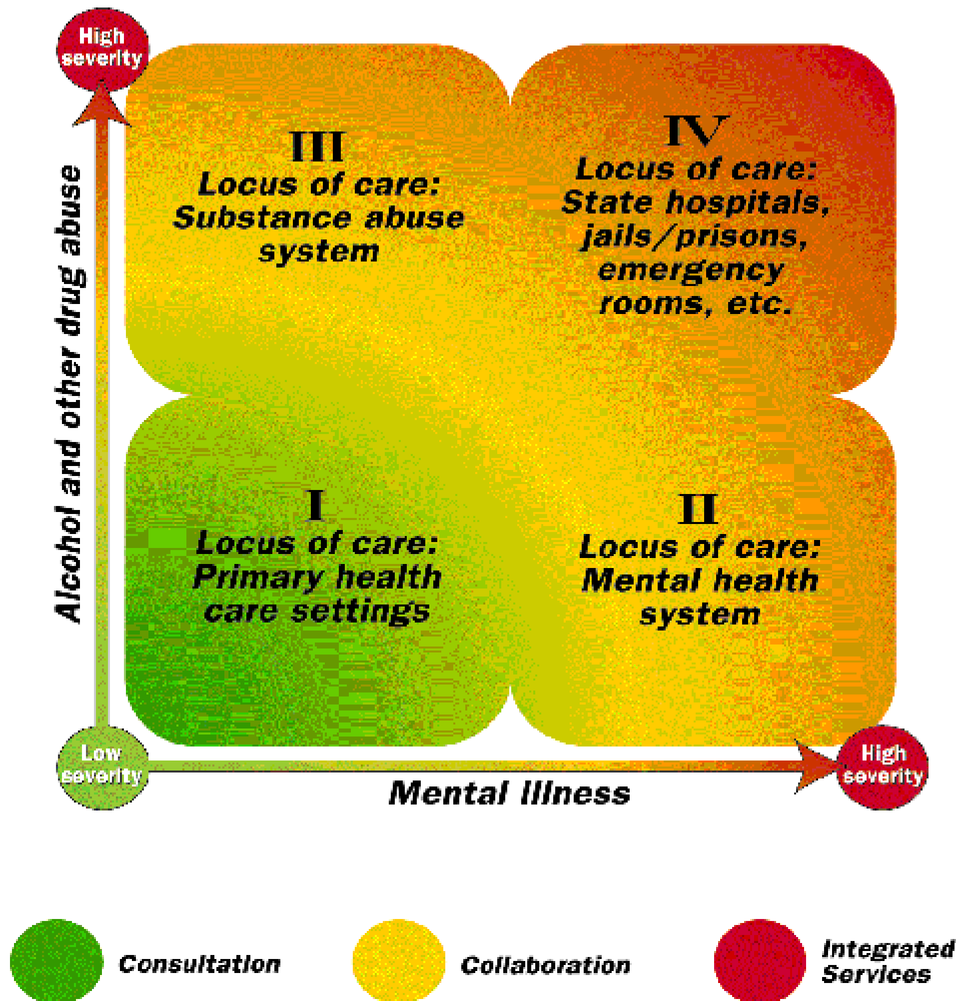
[1]U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). (1999). *A Summary of Findings from the 1998 National Household Survey on Drug Abuse.* Rockville, MD: Author.

[2]National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors. (1999). *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders.* Alexandria, VA and Washington, D.C.: Authors.

encompasses symptom multiplicity and functional severity, locus of care and degree of service coordination among various agencies – i.e., consultation, collaboration and integration. The framework provides system advocates and managers with a decision-making structure that helps illuminate their options for the best use of available resources.

FIGURE 1: CONCEPTUAL FRAMEWORK FOR DEVELOPMENT OF SYSTEMS OF CARE FOR CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

The conceptual framework considers the level of service coordination necessary for persons with co-occurring disorders based upon the nature and functional severity of their disorder and the primary location of their care. The framework recognizes that the severity of an individual's need for service is key to determining the nature and type of care provided. Moving from consultation (lower left section of framework) through collaboration (mid-range) to integrated care (upper right section of framework), increasingly serious disorders require greater and more intense levels of expertise and partnership from substance abuse and mental health professionals. Typically, mental health agencies have had responsibility for services to individuals in Quadrant II, while substance abuse service agencies have provided services



to those whose needs fall within Quadrant III. Those with the most severe need - individuals in Quadrant IV - have too often found themselves in inappropriate settings where their needs are not met at all: jails,

prisons and emergency rooms, for example.

Since its adaptation by the Task Force, the conceptual framework has been used by states to raise a number of critical questions about co-occurring mental health and substance use services: Who are our clients? What services do they need? Where and how are they being served now? In what ways can they be provided with more of what they need? Designed to frame critical questions about comprehensive service systems and catalyze discussions about systems of care, the conceptual framework has formed the basis of the Task Force's work.

At its meeting in June 1999, the Task Force continued to focus on the ways in which federal agencies, states, and communities can develop partnerships to support the development of comprehensive and coordinated systems of care for persons with co-occurring mental health and substance use disorders. Among the principles underlying the group's work was the expectation that persons with co-occurring mental health and substance use disorders will present themselves for treatment at local mental health and substance abuse programs. They are, in fact, already widely seen in service systems throughout the country. Unfortunately, as the Surgeon General stated in his Report on Mental Health (p. 413):

> [M]ost of the treatment services for mental illness and for substance abuse are separate..., as are virtually all public funds for these services. This separation causes problems for treating the substantial portion of individuals with co-occurring mental health and substance abuse disorders who benefit from an integrated approach to treatment.

Developing and financing a comprehensive, coordinated and responsive system of care requires time, creativity, resources and expertise. No single set of financing mechanisms applies to all needs, locations and organizational settings. In its April 2000 briefing paper: "Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Use Disorders"[3], the Task Force embraced a set of financing principles that provide flexible guidelines that can be adapted for use by any State or community, regardless of political structure or current funding for mental health and substance abuse services. Those principles include:

- Joint purchase by mental health and substance abuse authorities of services for a clearly defined population of persons with co-occurring disorders.

- Secure financing that can be depended upon to fully support services for co-occurring disorders, most likely in the form of multiple funding streams, including State General revenue, Substance

[3]National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors. (2000).*Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Use Disorders: A Blueprint for Systems Change* (Final Report of the Second National Dialogue of the Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders). Alexandria, VA and Washington, DC: Authors.

Abuse Prevention and Treatment and Community Mental Health Block Grants, Medicaid, and local taxes, among others.

- A mixed funding model that combines multiple, existing funding streams while continually attempting to leverage new resources.

- Purchase of services that maintain fidelity to evidence-based models and focus on desired outcomes.

- Evaluation of system performance to improve results.

The April 2000 report traced the concerns of the Task Force regarding the financing of integrated co-occurring mental health and substance abuse services by:

(1) formulating an approach to the design of comprehensive and coordinated systems of care that engages stakeholders in joint planning and creates stakeholder partnerships with concrete shared commitments, identifies barriers to systems change and then identifies potential solutions to overcoming barriers to implementation;

(2) identifying key elements of an approach to financing integrated services for persons with serious mental illness and co-occurring substance abuse disorders, including examples of how individual states have approached the challenges of financing; and

(3) developing a comprehensive marketing strategy that the Task Force and its partners can use to extend the conceptual framework to states and other stakeholders.

For those individuals who experience the most severe co-occurring mental health and substance use disorders (i.e., Quadrant IV: high mental illness/high substance abuse), the NASMHPD-NASADAD Task Force and the field at large are moving toward consensus that their effective and ethical treatment requires integrated care. Treatment agencies from both mental health and substance abuse communities increasingly recognize the value of integrated services and are developing services accordingly. While an evidence base has also been steadily building for the use of integrated service models for persons with severe mental disorders and less serious co-occurring substance use disorders (those who might be found in Quadrant II of the conceptual framework, for example)[4], the Task Force believes that it is critical to reach a better understanding of the needs, type of services received and service models that work effectively with individuals who traditionally receive care primarily from agencies located in both Quadrant II (high mental health/low substance abuse) and Quadrant III (low mental health/high substance abuse).

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[4]R.E. Drake, C. Mercer-McFadden, K.T. Mueser, G.J. McHugo and G.R. Bond. "Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders." *Schizophrenia Bulletin*: 24(4):589-608. 1998

The work of the Task Force confirms what has been widely understood for some time: state and local mental health and substance abuse agencies depend on multiple sources of revenue – including State general revenue, Community Mental Health Services (CMHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant Funds, Medicaid, and local taxes, among others – but the proportion of those funds available to both systems varies widely.

State substance abuse agencies are highly dependent on the SAPT Block Grant. According to an analysis of state alcohol and drug abuse profile data,[5] the single largest source of funding for alcohol and other drug services during FY 1999 was the SAPT Block Grant, representing 30% of the total expenditures of programs that received at least some funds administered by State AOD Agencies during the state's fiscal year. The total allocation of SAPT Block Grant funds to states during the period was $1.360 billion. In contrast, CMHS Block Grant funds make up a relatively small percentage of state mental health agency budgets. Based on the latest available data,[6] Mental Health Block Grant funds represent just 2.8 percent of total state-controlled mental health expenditures and community-based mental health expenditures during fiscal year 1997, with a total CMH Block grant allocation to states of $240.5 million.

Historically, some confusion has been evident in both the substance abuse and mental health communities with respect to the use of Mental Health Block Grant and Substance Abuse Treatment Block Grant funds to support delivery of integrated services for persons with co-occurring disorders. The question has been raised among senior mental health and substance abuse officials at state and local levels – including during a number of the interviews and site visits conducted for this project – regarding the appropriate use of the block grants to support integrated services.

Section 1956 of the Public Health Service Act provides that: "States may use funds available for treatment under the [mental health and substance abuse block grants] to treat persons with co-occurring substance abuse and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes." While a number of states utilize both the Community Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant to support the delivery of integrated services, guidelines for the use of these funds remain unclear (see Appendix A: "SAMHSA Position on Treatment for Individuals with Co-Occurring Addictive and Mental Disorders" and Appendix B: "SAMHSA Position Statement on SAPTBG and CMHSBG Funds to Treat People with Co-Occurring Disorders").

More specifically, the lack of clarity regarding accounting requirements to adequately track use of block grant funds has, in some cases, reportedly led some state agencies to avoid the use of block grants to support delivery of integrated services. In other cases (e.g., Pennsylvania), state agencies have created

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[5] L. Gallant, R. Anderson, K. Sheehan, A. Moghul, C. O'Donnell, P. Stokes and K. Nardini. (1999). *State Resources and Services Related to Alcohol and Other Drug Problems.* Washington, DC: National Association of State Alcohol and Drug Abuse Directors.

[6] T. Lutterman, A. Hirad and B. Poindexter. (1999). Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 1997. Alexandria, VA: NASMHPD Research Institute.

a complex management information (MIS) system to ensure that tracking can be rigorously accomplished. In states utilizing block grant funds to support delivery of integrated services without enhancing their MIS, they cannot be certain whether their decision to allocate block grants for this purpose will be affirmed at some future point.

Since completing the April 2002 report, NASMHPD and NASADAD have convened overlapping national membership meetings in Reno, Nevada in June, 2000. One day was dedicated solely to issues associated with co-occurring disorders; all members attended the special sessions. Members of both associations expressed their readiness to continue moving forward to accomplish their goal of improving services for persons with co-occurring disorders.

Project Description

Through the continued support of CMHS and CSAT, the NASMHPD-NASADAD Task Force has sought to focus this year on delineating specific examples of financing integrated services for persons with co-occurring mental health and substance use disorders that blend multiple funding streams at the provider level.

The project had the following original objectives:

(1) to identify provider level programs that deliver effective integrated services to persons with co-occurring disorders using funds derived from a variety of sources;

(2) using a case study approach, to document the specific management and program methods used to organize services, obtain revenue, expend resources and account to payers about program expenditures;

(3) to synthesize the "key ingredients" to successful programs that are found in the case studies;

(4) to develop a set of recommended fiscal accounting or auditing standards that could be adopted by payers to accommodate blended funding at the program level; and

(5) to develop a final report that contains the case studies, key ingredients and recommended accounting/auditing standards.

The nine program sites that participated in this project are innovators from both the mental health and substance abuse communities in providing integrated services to persons with co-occurring mental health and substance use disorders. Their case studies represent a variety of successful models of integrated services funding that can be adapted to a wide range of program locations, settings and environments. Our goal is to provide state and local managers, providers, consumers and advocates with specific and well-documented examples of how integrated services for persons with co-occurring disorders can be organized

and financed.

SECTION I

METHODS

The case study method selected for this project utilizes what is essentially a descriptive "storytelling" technique designed to explicate the nature of each site's organization, structure, development and financing and to consider the possible consequences of the actions that they have taken – in effect, to identify the lessons to be learned from a critical appraisal of their experience. The case study approach is inductive rather than deductive; the focus is on considering the details of each site's experience rather than assuming that there is one "right" or "wrong" way to develop and maintain integrated co-occurring mental health and substance abuse programs. As such, it is fundamentally a qualitative undertaking that should be differentiated from a more scientific, research-oriented approach.

Identification of Case Study Sites

In December 2000, project staff requested nominations of co-occurring programs that met the project's criteria, including (a) integrated services;[7] (b) multiple sources of funding; and (c) interested and available to participate in the project at the level required (see Appendix C for "Invitation to Nominate Exemplary Programs"). The individuals and organizations asked to make nominations included all state mental health directors; all state alcohol and drug abuse directors; selected national provider and advocacy organizations, national consumer and family advocate organizations and individuals known for their expertise in the development of co-occurring services and programs.[8]

A total of 55 nominations from the substance abuse and mental health communities were received, representing 35 states. These programs originally began as substance abuse programs, as mental health programs and/or as dual diagnosis programs. An invitation letter was mailed to all nominated sites in March 2001, explaining the project and inquiring as to each program's interest in participating in the project. All nominees who expressed interest were contacted by project staff. Questions about the project were answered and the agency's interest in participating was confirmed, as was the degree to which they met project criteria, including how feasible it appeared to be that they would be able to furnish the detailed information required to participate.

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[7]For purposes of this study, "integrated services" typically refers to treatment for both a mental illness and a substance use disorder that is delivered by a single clinician, team of clinicians or program. More specific descriptions of the integrated services model utilized by each site is included within individual case studies and summarized in the "Program Analysis" section of this report.

[8]National Mental Health Association, National Association of County Behavioral Health Directors, National Council of Community Behavioral Healthcare Providers, National Consumers Mental Health Association, National Association of State Alcohol and Drug Abuse Directors, Ken Minkoff, Bert Pepper, Bob Drake, Fred Osher.

Nine sites were selected for participation in the project, based on their meeting project criteria and the need to create a group of study sites that balanced a variety of characteristics and perspectives: budget and caseload size, geographic location, populations served, and program origins (Appendix D). A data protocol which identified the key data elements to be examined was developed and disseminated to all sites and other interested parties to allow them to provide responses to the data elements before site visits and teleconference calls (Appendix E).

Site Consultation and On-Site Visits

Logistical planning prior to all interviews and visits included developing agendas for site visits and teleconference calls, as well as determining who would participate in the visit and/or call. The majority of on-site visits lasted for one day. Each visit included participation by: Chief Executive Officer, Chief Financial Officer, Co-Occurring Program Coordinator, clinical staff, community representatives, consumers and family representatives, as available. To the extent possible, state mental health and alcohol and drug agency staff also participated in the interview process. Case study teams consisted of a program specialist and a financing specialist spanning the mental health and substance abuse fields. Federal staff also participated in selected site visits.

Subsequent to each visit and/or teleconference call, case study program staff were asked to clarify and supplement the program and fiscal information that was provided prior to the visit or on-site. Draft program descriptions were then developed and each site was asked to review its description for accuracy and clarity. Revisions were incorporated into the final report.

NASMHPD-NASADAD Task Force Meeting and Review

The Task Force convened for its third meeting in November 2001 in Washington, DC (see Appendix F for meeting participants list). The major focus of the meeting was to consider the project's findings to date and to determine the next steps in accomplishing the project's objectives. In addition to the state mental health agency directors, state substance abuse agency directors, national provider organizations and federal agency representatives that have been involved in previous meetings, this year's participants included the executive directors of two of the nine case study sites. Their "on the ground" experience and perspective contributed significantly to the discussion, as the Task Force sought to review findings and assist in identifying and synthesizing the key program and fiscal elements that crosscut the case studies. A thorough review of the audiotape and written transcript of the Task Force meeting helped to clarify the complex deliberations that the Task Force engaged in as it considered the project's draft findings. Many of the observations, conclusions and recommendations found later in this report are taken directly from those discussions.

The complete report was developed and disseminated widely for review, including to all program sites, members of the NASMHPD-NASADAD Task Force, association staff, federal agency representatives and other selected reviewers. As has been the case with previous NASMHPD-

NASADAD Co-Occurring Project reports, this final report is the product of several iterations of review and recommendation.

SECTION II

CASE STUDY PROGRAM SITES

Section II describes each of the nine programs that serve persons with co-occurring disorders that were included in this year's project effort. As was described earlier, this information derives from telephone interviews, on-site visits, background questionnaires submitted by programs prior to telephone conferences and site visits, notes from case study site team members, additional background materials provided by programs, and responses to a survey completed by programs following site visits and telephone conferences.

Each case study program description utilizes the following outline:

- Program and Organization
- History of Services and Financial Development
- Role of County and/or State Government
- Unique Features, Program Lessons and Future Plans
- Financial and Regulatory Incentives and Disincentives

ACCESS Team
Maine Medical Center
Portland Maine

"Teaching and encouraging skill development and independence to improve the quality of life"

Program and Organization

The ACCESS Team is located within the Department of Psychiatry at the Maine Medical Center. Maine Medical Center (MMC) is the largest regional medical center in New England north of Boston, and operates a range of inpatient and ambulatory services for persons with psychiatric and chemical dependency problems, in addition to typical health care services. The ACCESS Team program is located in Portland and is designed to serve fifty (50) persons with co-occurring mental health and substance abuse disorders from Cumberland County.

There are two treatment approaches for two distinct populations. The assertive community treatment (ACT) model was modified to serve persons with major mental illness and substance abuse. A

second approach was developed for the Axis II, Cluster B personality disorder and substance abuse dependent population. This second protocol integrates motivational interviewing, Dialectical Behavioral Therapy and the Trauma Recovery and Empowerment Model into an ACT team structure. The ACCESS Team program is dually licensed by the State of Maine in mental health and substance abuse.

ACCESS Team protocols guide the work of the staff. Treatment protocols are termed FACT I and FACT II, for Family-aided Assertive Community Treatment. A total of fifty (50) clients are served, with approximately half of the clients receiving FACT I services and the other half receiving FACT II services.

One hundred percent (100%) of the program's clients are diagnosed with co-occurring disorders. Admission criteria include: 1) a history of multiple mental health and substance abuse treatment episodes that have failed to result in improved function; 2) high use of crisis, emergency and hospital services; 3) marked reluctance to accept psychiatric or substance abuse treatment, and 4) frequent contact with police or other public safety officers. Priority for admission is given to persons who are or have been recently homeless or have recently resided in shelters or the county jail.

Direct service program staff include two psychiatric nurses, one social worker and three community support workers. Each team includes a team leader, a part-time psychiatrist, an employment specialist, a part-time representative payee specialist and an administrative assistant. Program staff report that while six to twelve months may be required for the treatment plan to "take hold," client successes include movement to independent living and effective personal financial management. It appears that FACT I clients (i.e, persons with major mental illness and substance abuse) are more predictable and linear in their progress toward treatment goals, while the progress of FACT II clients (i.e., the Axis II, Cluster B personality disorder and substance abuse dependent population) is more problematic and unpredictable.

History of Services and Financial Development

In 1990, a community group was convened in the belief that new services for county residents were required. The initial target populations were those persons diagnosed with schizophrenia who also abused alcohol, as well as persons with personality disorders and severe addiction. The community group was named the "Cumberland County Dual Diagnosis Collaborative" and has continued its work for more than ten years.

The Robert Wood Johnson Foundation and the Bingham Foundation provided funding for a demonstration program. The Department of Psychiatry within the Maine Medical Center led implementation of the demonstration, which began in 1993. The program has been refined since then, primarily to more effectively serve the two populations described above.

The current year's ACCESS team budget is $575,964, plus a one-year research grant. Eighty percent (80%) of operating funds come from Medicaid for individuals on Medicaid. The remaining 20%

is provided by the Maine State Department of Behavioral and Developmental Services and the Office of Substance Abuse Services to support services provided to those who are ineligible to receive Medicaid.

Role of County and/or State Government

The ACCESS Team works closely linked with the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services and their advocacy services section through the consent decree coordinator at the Augusta Mental Health Institute. The Maine Office of Substance Abuse Services is currently funding a one-year research project that is evaluating acupuncture and recovery.

Unique Features, Program Lessons and Future Plans

The ACCESS Team serves two quite different populations and uses two treatment protocols within a single program structure. The ability of the team to successfully respond to the clinical needs of both populations is perhaps the most unique feature of the program.

The team counts on the availability of in-home supports, self-help group meetings, transportation, and similar services from other organizations. The primary problem area is the lack of housing for clients, especially affordable housing just above the Section 8 income level. A related problem is the lack of residential treatment programs that will accept persons who may still be using drugs and/or alcohol.

Financial and Regulatory Incentives and Disincentives

As the "parent" organization, Maine Medical Center views the ACCESS Team as being "budget neutral" – i.e., the program is expected to break even and neither make nor lose money. The team leader believes that the case rate payment system is ideal for the program, in that it is flexible and allows comprehensive, wrap-around care and recognizes the value of integrated services for these populations.

New Directions for Families
Arapahoe House
Littleton, Colorado

"Having my kids here lets me focus on the work I have to do"

Program and Organization

New Directions for Families (NDF) is operated by Arapahoe House, Colorado's largest and most comprehensive provider of alcohol and drug abuse treatment and prevention services.

Established in 1975, Arapahoe House opened its original detoxification program in 1976 and has since grown to a budget now approaching $14 million, with approximately 350 staff delivering services at over 25 sites. Each year Arapahoe House provides over 22,000 episodes of care to more than 17,000 individual clients. The agency delivers residential, outpatient and case management services to persons with co-occurring mental health and substance use disorders in Denver area sites and has administered programs for persons with co-occurring disorders since 1989.

The New Directions for Families (NDF) program is a specialized residential and outpatient treatment program for women who have co-occurring disorders, a history of physical or sexual abuse that is causing current problems in functioning, are pregnant or have custody (or the likelihood of regaining custody) of a child ages birth to twelve years, and meet the state modified American Society of Addiction Medicine (ASAM) patient placement criteria for level 3.7 services. The residential portion of the program can serve sixteen women and their children, ages birth to twelve years. While the program's service area is Sub State Planning Area #2, the Denver Metropolitan Area, the NDF program is a Medicaid provider and Medicaid recipients residing anywhere in Colorado may be served.

The NDF program delivers substance abuse treatment, trauma treatment, case management and some mental health services through an agreement with the local mental health center, Arapahoe Douglas Mental Health Network, that facilitates referrals for mental health services for both women and children. Services may be delivered at NDF or at the mental health center. The NDF program is licensed as a substance abuse treatment facility. Arapahoe House itself is licensed as a mental health clinic.

Staff of NDF include three primary counselors who are required to be certified as addictions counselors. The program strives to hire masters level clinicians with a specialty in substance abuse, mental health or trauma treatment. The family therapist is a master level social worker. Other staff include a registered nurse, vocational specialist, team leader, milieu counselors, and child care staff. Staff are cross-trained to have at least a minimal level of understanding and skills in the areas of substance abuse, mental health and trauma.

The theoretical foundation of the NDF program model integrates a stages of change model; motivational interviewing; cognitive-behavioral and solution-focused approaches; and an integrated intervention treating substance abuse, mental illness and trauma simultaneously. There are three phases to treatment, which lasts an average of eight months.

Phase I, lasting about two months, is residential and focuses on intensive treatment for substance abuse and mental health disorders; treatment related to current or past trauma; and parenting skills. Phase II involves a further two months of residential treatment. However, the focus changes as participants develop a long-term self-sufficiency plan and find a job and a place to live in the community. The emphasis shifts to development of employment skills, job placement and relapse prevention. Phase III is the continuing care portion of treatment, and includes three discrete areas of support: continuing care treatment group; alumni groups for social support; and linkage with needed community services.

History of Services and Financial Development

Colorado state government first supported services for persons with co-occurring disorders at Arapahoe House in the late 1980's, when the State Alcohol and Drug Abuse Division funded psychiatric services within the residential substance abuse services program. The NDF residential treatment program for women and children began in 1995, funded by a grant from the federal Center for Substance Abuse Treatment (CSAT). The clinical direction changed somewhat in 1998 with funding by the Substance Abuse and Mental Health Administration (SAMHSA) of the Women, Co-occurring Disorders and Violence Study. The NDF program continues its involvement in the evaluation phase of the SAMHSA project.

A short-term grant from the Department of Housing and Urban Development (HUD) was instrumental in assisting Arapahoe House to access the current funding base for the NDF program. This $1,000,000 award was accomplished through the Colorado Congressional delegation. The largest current purchasers of service are several county Departments of Social Services, which provided $525,000 in revenue during FY 00-01. The second largest source of funding is Medicaid, under a benefit that is limited to pregnant women with substance abuse problems. This source provided $96,000 in revenue last year. The third largest source of revenue is support from SAMHSA for evaluation, totaling $82,000 last year. The fourth largest source in FY 00-01 was $44,000 from the State's Alcohol and Drug Abuse Division to serve families of children at risk of out-of-home placement. Other sources of revenue included client fees and food stamps ($25,000) and donations from private foundations ($35,000). The NDF program receives no state mental health general revenue or federal mental health block grant funds.

Role of County and/or State Government

In addition to the regional county governments' role as the largest single source of program revenue through Denver area Departments of Social Services, Colorado's Division of Mental Health Services and Division of Alcohol and Drug Abuse Services signed an interagency agreement in 1998 that addresses collaboration in supporting co-occurring mental health and substance use disorders. The agreement recognizes that, "... individuals with co-occurring disorders typically require treatment for both disorders in order to address either effectively." The agreement defines the respective responsibilities of each system, stating:

> "It is intended to place treatment responsibility for some individuals who have certain combinations of disorders with the mental health system, and persons with other combinations within the alcohol and drug abuse system. In addition, some individuals who have co-occurring disorders will need services from both systems."

Administrative staff from Arapahoe House identified several significant problems that, in their view, call into question the depth of the state's commitment to adequately finance services for persons with co-occurring mental health and substance use disorders and adversely impacts the relationship between State government agencies and the Arapahoe House/NDF program.

- The design of the state's substance abuse system is an acute care model, with state purchasers seeking to serve new consumers, while the design of the mental health system is a disease management model that provides lifetime care.

- The mental health system is based on the development of community mental health centers, while substance abuse services grew more slowly and without a clear organizational model.
- The substance abuse services system is "impoverished" – e.g., Medicaid is limited to pregnant addicts and there is no ability to pay for ACT teams or similar expensive services. The mental health service system is also financially limited, maintaining waiting lists for indigent non-Medicaid eligible persons.

- There appears to be limited appreciation by the state of the importance of developing a clinical capacity to serve persons with co-occurring disorders. For example, since Arapahoe House is currently licensed as a substance abuse service provider, the program has been discouraged from also seeking mental health licensure.

Unique Features, Program Lessons and Future Plans

New Directions for Families is unique in that it is gender specific, it includes trauma as a major program focus, and its design is quite comprehensive. Participation in two major federally funded projects has either resulted from or resulted in a program that appears unusually sophisticated in its clinical delivery.

According to the NDF program, among the more important lessons learned to date are:

- The need for staff to model healthy lifestyles;

- The importance of providing clinical services to the children of parents with co-occurring disorders and a history of trauma;

- The need to recognize and respond to important life transitions (e.g., the transition out of residential treatment, changes in employment, the inception of school or training programs);

- Connecting consumers with the larger community is essential;

- The importance of involving consumers in all aspects of the treatment program;

- Service integration within and among all provider agencies serves client needs.

The NDF program is currently searching for ways to fund a transitional housing component in order to ease the transition from residential treatment to independent housing for some consumers.

Financial and Regulatory Incentives and Disincentives

As already mentioned, Arapahoe House expresses significant concerns about the state climate for providing services to this population.

> "There are no incentives to treat co-occurring disorders in the state system. Payment does not vary based on the type or complexity of diagnoses encountered. Unfortunately, no additional funding has been provided to either system to address these co-occurring disorders as (consumers) enter treatment, and therefore providers have few resources to address these issues."

The need to juggle various sources of funding to deliver services to women affected by substance abuse, mental illness and trauma is noted as a key difficulty by program staff, who identify a series of problems created by categorical funding streams and multiple organizations. Since the NDF program focuses on families involved in the child welfare system, TANF program, mental health system, domestic violence programs and the substance abuse system, it has been difficult for the program to look to any one system for financial support. Another example is the administrative time involved in establishing relationships and contracting with various purchasers, which includes child welfare allocations and TANF funds to 64 counties, eight mental health Mental Health Administration and Services Authorities that manage Medicaid, and five substance abuse Managed Service Organizations that manage Medicaid, state and federal funds.

Arapahoe House summarizes their financing experience:

> In spite of the best of intentions of the people leading these organizations, it is difficult to convince any one system or portion of the system to invest in a comprehensive and costly intervention like NDF when the positive outcomes are felt in other systems. Community based providers in many cases face the greatest challenges of integration not in developing service delivery models but instead in bending the categorical funding and reporting mechanisms to meet bureaucratic requirements in order to work collaboratively.

Dual Diagnosis Services
Arlington County Mental Health & Substance Abuse Division
Arlington, Virginia

"Whatever door you come through, specialized services are there waiting for you."

Program and Organization

The Dual Diagnosis Program is operated by the Mental Health and Substance Abuse Division, a unit of county government in Arlington County, Virginia. Arlington County is an urban area of about 26 square miles located directly across the Potomac River from Washington, DC. Among the most densely populated jurisdictions in the country, with 7,326 persons per square mile in 2000, Arlington County has become increasingly diverse. One in five residents is foreign born, and one in four speak a language other than English at home. No incorporated towns or cities lie within Arlington's boundaries.

The Mental Health and Substance Abuse Division (MHSAD) is a unit within the Arlington County Department of Human Services. Other divisions include aging and disability services, child and family services, public health, and economic independence and assistance. Services to persons with co-occurring mental health and substance use services, termed dual diagnosis by the MHSAD, began in 1982 after a facility expansion located substance abuse staff in the same building as the mental health staff.

The program has grown in capability over the years, and now has three major components:

- Persons with dual diagnosis are served within the mental health service when they are psychiatrically high – substance abuse low (substance abusing mentally ill persons);

- Persons with dual diagnosis are served within the substance abuse service when they are substance abuse high – psychiatrically low (complicated chemical dependency, or psychiatrically complicated substance dependence);

- Persons are served using shared resources when they are psychiatrically high – substance abuse high (the substance dependent mentally ill).

Shared services for the dually diagnosed consumer are the focus of this description. The MHSAD refers to these services as the "dual diagnosis component" of its operations. These specialized services operate five days a week and include dual diagnosis education; dual diagnosis groups, with specialized groups for women, Hispanics, and persons with Global Assessment of Functioning (GAF) scores above and below 55; a dual diagnosis art group; an advanced dual diagnosis group; and a dual recovery anonymous group which meets weekly.

The frequency of specialized sessions allows MHSAD to organize a "virtual day treatment" service when needed. A dual diagnosis consultation group meets weekly. This group performs case staffing for persons with complex treatment plans, which may include psycho-educational and self-help groups, family treatment and medication. Specialized services are in addition to the standard list of services available to persons enrolled in the MHSAD, which include individual and case management services, psycho-social

services (club house), the Program for Assertive Community Treatment (PACT) team, emergency services, job avenue (supportive employment), psychological testing and psychiatric assessments and drug testing. The MHSAD contracts for detoxification and residential substance abuse treatment, homeless case management, safe haven, and homeless shelters.

Staffing of the dual diagnosis component involves clinicians from both the mental health and substance abuse units and includes an individual who conducts groups in Spanish. Staff of both units hold master's degrees and have two or more years of experience. Cross-training is common. All staff work with several psychiatrists who also specialize in co-occurring mental health and substance use disorders.

History of Services and Financial Development

The dual diagnosis component was initiated by the substance abuse unit with a specialized treatment group in 1982. According to staff, "No one said we had to, but no one said we couldn't – as long as [we didn't] stop doing the other services." In 1987, a staff member from the mental health unit was funded with substance abuse money, and the specialized program was expanded to include groups five days per week. The new groups included relapse prevention, family support and evening groups. Services in the Spanish began in 1992. Consumers are screened for participation in the dual diagnosis program component by both the mental health and substance abuse units, who use the same intake forms.

Current financing devoted to the dual diagnosis component reflects the revenue generally available to the MHSAD, including state general revenue, federal substance abuse and mental health block grant funds, county funds, and client fees. Medicaid is limited to mental health services, as Virginia does not have a Medicaid benefit for substance abuse services that can be used for this program.

Role of County and/or State Government

The specialized dual diagnosis services were developed and are operated by a unit of county government. Funds for mental health and substance abuse service flow, in part, through a county Community Services Board that acts as a planning and funding agent of the State of Virginia. None of these funds are specifically targeted for persons with co-occurring disorders.

Unique Features, Program Lessons and Future Plans

The primary features of the MHSAD specialized dual diagnosis services program is that it has been operating since the early 1980's, and that significant innovation in clinical program design and delivery has occurred within the framework of county government. Staff offer a number of key factors that contribute to the success of the specialized dual diagnosis component:

- Retention is critical; consumers shouldn't be "scared" away;

- Consumer progress should be viewed in small steps;
- The more options provided, the more empowered the consumer;
- Staff competence to work with persons with dual diagnosis consumers should be the expectation;
- Staff must be cross-trained in both fields.

Financial and Regulatory Incentives and Disincentives

Within the County Department of Human Services, there appear to be no outstanding incentives or disincentives that either created the dual diagnosis program or limit its current operation. Leadership from a long-term senior manager in the substance abuse unit and collaboration between staff of the substance abuse and mental health units appear to be the critical factors in developing and sustaining the program.

Local and state disincentives do not appear to create insurmountable barriers to effective program delivery, although staff report that it can take up to five weeks for a new consumer to see a psychiatrist. Virginia's Medicaid benefit for substance abuse does not cover specialized dual diagnosis services.

CAM
Consumer Advocacy Model
Wright State University
Dayton, Ohio

"Services to persons with any co-occurring disability."

Program and Organization

The Consumer Advocacy Model (CAM) is the clinical component of Substance Abuse Resources and Disability Issues (SARDI), a research and demonstration project located within the Center for Intervention, Treatment and Addictions Research at Wright State University. CAM operates under the auspices of the University Medical Services Administration (UMSA), a unit established to assist with billing and financial issues associated with clinical practices of medical school faculty.

The target population for the Consumer Advocacy Model are persons with any severe disability that co-occurs with substance abuse, a more expansive definition than for most co-occurring programs. In practice, CAM serves persons who are not accepted by other service providers and who are diagnosed with substance use disorders, mental illness and other co-existing disabilities. The other disabilities may include traumatic brain injury, mobility impairment such as spinal cord injury, legal blindness, mental retardation, etc. The mean number of qualifying disabilities for CAM participants is four, based upon ADA or vocational rehabilitation standards. Criteria for enrollment are quite flexible. Assessments are comprehensive, and include measures of functionality in several cognitive and life areas. There is no limit to the time spent in treatment – one consumer has been in the program for over five years, including two re-admissions. Average length of stay is approximately five months and approximately 40% of clients

successfully graduate with their goals met. Intensity of services tends to decrease the longer someone is enrolled in the program.

Approximately 50% of CAM consumers experience significant mental health issues. When State of Ohio criteria for substance abuse and mental illness (SAMI) are applied, 20-40% of CAM consumers qualify. The CAM program serves residents of Montgomery County and the surrounding area. The current census is more than 130 individuals.

The CAM program is based on the philosophy that persons with multiple and severe disabilities require support for "long duration – less intensity" services that lead to recovery. Other philosophical values include the community teams approach developed by Dr. Corrigan at Ohio State University for persons with chemical dependency and traumatic brain injury, and CAM also espouses approaches to treatment intensity and engagement described in the Dartmouth-New Hampshire model for dually diagnosed persons. CAM is certified as a mental health agency and as a substance abuse treatment agency. Services include comprehensive diagnostic assessments; case management; individual and group therapy for substance abuse and mental health issues and psycho-educational and vocational issues; toxicology testing; vocational rehabilitation planning, assessment, and support. Aftercare groups and disability-friendly AA meetings are also held at the facility in the evening.

The current multidisciplinary staff include bachelor's and master's level clinicians, as well as clinical doctoral psychology students. These individuals serve as case managers, individual therapists, intake workers, a vocational counselor, and a psycho-educational specialist. A team approach is utilized and staff meet weekly. Case management services continue when consumers are referred to other organizations for specific services, such as residential treatment. Caseloads are established at 25 to 1, although there is some fluctuation, and current funding constraints have extended the caseloads to over 40 to one (a situation that CAM is attempting to change as soon as possible).

A women's program was begun in February 2001. This focus adds a number of complex issues to be considered by the program, such as child custody, TANF, welfare to work, maintaining a household, domestic violence, child care, transportation, and issues of safety and security. More recent funding has extended into AOD prevention services for women who are homeless, disadvantaged or victimized.

<u>History of Services and Financial Development</u>

The CAM program began in 1994 as a cooperative program with Miami Valley Hospital in Dayton for persons with traumatic brain injury. The funder was the National Institute on Disability and Rehabilitation Research. In 1995 the program expanded to target persons with substance use disorders and any other severe disability. CAM's administrators estimated that the program would not be able to continue based solely on fee-for-service reimbursement, and that about 20% of the program's revenue should be other income such as grants. SARDI and CAM subsequently sought additional sources of financing. Other forms of income have now been realized.

The Ohio Rehabilitation Services Commission provided a 4-year grant to integrate vocational rehabilitation services into CAM. The Montgomery County Alcohol, Drug Abuse and Mental Health Services Board provided three months of funding for capitalization and operations. Recently the Board provided $100,000 for the new women's program. CAM is now a Medicaid service provider and the total agency budget is $625,000 per year. The overall budget has been increasing at approximately 20% per year in line with increased referrals to the program.

The research component of SARDI continues to support the CAM program with free personnel assistance in computer support, database management, record keeping, evaluation, computers, audiovisual equipment, and training. The recent certification of the program as a mental health provider may open additional opportunities for funding.

Current funding includes state general revenue, the federal Substance Abuse Prevention and Treatment block grant, TANF Maintenance of Effort (MOE) funds through the state agency, Medicaid, County funds, Client fees, charitable contributions, and a foundation award.

Role of County and/or State Government

Although initiated locally, the CAM program has been supported by Ohio's Rehabilitation Services Commission and the Montgomery County ADAMHS Board. In Ohio, County Boards act as agents for Ohio's mental health and substance abuse departments. CAM staff report that the ADAMHS Board has assisted with gaining exceptions to rules that help with financing. The minimum group size for unit reimbursement was halved, additional hours were permitted for a comprehensive assessment, and CAM is now allowed to invoice for case management services when consumers are concomitantly enrolled in other treatment programs. The ADAMHS Board has also assisted CAM with accessing state funds, such as TANF funds and substance abuse prevention support.

Unique Features, Program Lessons, and Future Plans

The primary uniqueness of the CAM program lies in its focus on consumers with severe disabilities. As a result, the CAM program inevitably treats a considerable number of persons with co-occurring mental health and substance use disorders who also experience additional disabilities. CAM emphasizes the importance of flexibility in service delivery and has a strong commitment to serving consumers that other providers cannot or will not serve. They suggest it is important to create a "learning community" that can address the specific needs of individuals with multiple and differing problems, and recommend that persons who are "system thinkers" be selected as staff. More intensive individual case planning and provision of case management services are viewed as critical components for client success.

The CAM program intends to use its new mental health certification to seek additional funds. The program believes it is too small to achieve an economy of scale, and that it must grow in size and geographic scope to remain financially viable.

Financial and Regulatory Incentives and Disincentives

CAM has identified a number of regulatory and financial barriers that have made it more difficult to establish and manage the program, including:

- The need to comply with two separate and diverse sets of regulations and standards from the state departments of mental health and substance abuse;
- Low Medicaid rates, that do not take into consideration the complex and costly services required by the CAM population, as rates of payment are often less than CAM's costs for service delivery;
- The adoption by the County ADAMHS Board of the Medicaid rates for reimbursement using county funds, for the reason described above;
- Cash flow problems when reimbursement payments take months to arrive, specifically for Medicaid payments;
- The problems of paying for program start up and initial expansion when purchasers prefer to pay primarily on a reimbursement basis;
- Current funding levels (the Medicaid rate was lowered for the current year) mandate that staff productivity exceed 50% direct service. The nature of this program, and the paperwork requirements, make this very difficult. This is especially true when considering the extensive training program necessary for staff.

Two key factors have allowed the CAM program to expand successfully, in addition to the actions that CAM leadership has taken to locate additional sources of revenue. The University Medical Services Administration has acted as a "buffer" for cash flow, permitting the CAM program to continue to operate while waiting for reimbursement checks for fee for service invoices. The local ADAMHS Board has also permitted regulatory flexibility in key clinical and financial areas: (1) the minimum group size for unit reimbursement has been halved; (2) CAM has been allowed to bill for additional hours under individual counseling in order to complete a comprehensive assessment and to bill for clients already enrolled in other treatment programs in order to address disability issues.

Foundations Associates
Nashville, Tennessee

"Money drives program development. The trick is to make sure that financial incentives are supporting current, ahead of the curve interventions."

Program and Organization

Foundations Associates was established in 1995 as an eight bed transitional living facility for men with co-occurring mental health and substance use disorders. The organization maintains its original focus on services to persons with co-occurring disorders, and grown considerably since its founding. In the fiscal year ending June 30, 2000, Foundations Associates revenue was $2,612,750. It operates programs in Nashville and Memphis, TN.

Current services include crisis stabilization, managed in conjunction with a local ACT team; a dual diagnosis enhanced therapeutic community; a dual diagnosis-enhanced halfway house; dual diagnosis independent living; and outpatient treatment services. In addition to these treatment services, Foundations Associates operates a variety of dual diagnosis prevention and education services, including sponsorship of national conferences and the Dual Diagnosis Network. Treatment services are the focus of this summary.

Crisis stabilization services typically result in a 72-hour stay to stabilize psychiatric and/or substance abuse symptoms and medication adjustments for persons at risk of admission to psychiatric inpatient care. In this nine-bed facility, services include 24-hour supervision, monitoring by a psychiatric nurse, psychiatric evaluation, and 24-hour on-call response by medical and clinical staff. Consumers are linked at discharge to community services, or placed in one of Foundations Associates programs. The inpatient crisis stabilization program is not intended to serve solely dually diagnosed consumers; however, in excess of 60% of consumers are dually diagnosed.

All remaining Foundations programs serve only dually diagnosed consumers, with the majority diagnosed with Axis I mood or thought disorders with co-morbid substance dependency. Foundations developed an assessment protocol that is designed to operationalize ASAM placement criteria, and to provide depth to the psychiatric portion of the evaluation in order to create a platform for integrated treatment. The assessment process includes pre-screening, an intake assessment, psychiatric and medical evaluation, and other specialized assessments as required for the individual consumer. Assessment is seen as an ongoing process, critical to the development and implementation of individualized treatment plans.

The dual diagnosis-enhanced therapeutic community is the most intensive of Foundations residential treatment programs. Length of stay ranges from six weeks to three months. Staffing consists of 24-hour resident counselors, the majority of whom are mentors in recovery and program graduates; a master's level therapist on-site during business hours; and a family therapist/educator on-site each Sunday. A psychiatrist provides evaluations and pharmacological interventions. Case management begins at admission and is conducted through collaboration with a local case management agency. The therapy program is conducted five days per week, three hours per day, and provides psycho-education, addictions treatment, relapse prevention, and coping strategies. In addition to formal therapy, each consumer is assigned a peer mentor, and contributes to the life of the community through chores and assignments.

The dual diagnosis-enhanced halfway house service is delivered in five-bed houses and lasts two to four months. Clinical staff are available eight hours per day, with 24-hour crisis service availability. This service is bundled with a range of outpatient services including individual, group and family therapy. In addition, a master's level independent living housing coordinator works with consumers to develop and address goals concerning personal responsibility and independence, and a vocational specialist works with consumers to address a range of work related needs. There is no charge for treatment at this level of care, and consumers are required to be competitively employed and pay market rate rent that includes food costs.

Supervised independent living is the final phase of Foundations residential continuum. As with the halfway house, consumers are required to be competitively employed and pay rent that includes food costs. Therapy sessions are reduced to monthly or bi-monthly contacts, and the consumer becomes responsible for coordinating psychiatric visits, medications, community services, and other needs. Length of stay ranges from two to four months.

History of Services and Financial Development

The founder of Foundations Associates is Michael Cartwright. Mr. Cartwright is a self-identified consumer who has received treatment for both mental illness and substance abuse. In 1995, he purchased a house with a friend that became a dual diagnosis recovery home. This pattern of out of pocket private purchases characterizes the start of Foundation Associates.

In 1996, a corporation was established, and in 1997, the Tennessee Department of Mental Health agreed to provide funding through a co-occurring initiative. The source of the first DMH grant was federal mental health block grant funds, which have since transitioned to state general revenue. Operating funds during the 1995-97 period were primarily out-of-pocket from the program founders. In 1997 the Dual Diagnosis Recovery Network was established with an initial grant of $125,000. In 1998 Foundations signed a contract with TennCare, the state's Medicaid managed care program, for outpatient services. Also in 1998, the Center for Substance Abuse Treatment (CSAT) funded Foundations for residential services through the Targeted Capacity Expansion Initiative. These funds were arranged for Foundations through the state Department of Mental Health with the assistance of the Bureau of Alcohol and Drug Abuse, and served to financially stabilize the residential services. A local provider subcontracted with Foundations for crisis intervention and respite services that year as well.

In 1999 Foundations received a grant from the Center for Substance Abuse Prevention (CSAP) for the "Strengthening Families" program. Once again, Foundations collaborated with the state Department of Mental Health, which supplied the program's principal investigator. The year 2000 saw Foundations adding evening intensive outpatient services and stabilizing existing services. In addition, the Department of Mental Health and Tennessee's Housing Development Authority provided funds to replicate Foundations' residential services array in Memphis.

This rapid growth is a result of Foundations' writing a number of successful proposals to the federal Substance Abuse and Mental Health Services Administration and continually pursuing state funds. Revenue for the year ending June 30, 2000, included $1,130,361 in state general revenue; $460, 200 from the Center for Substance Abuse Treatment; $444,949 in federal mental health and/or substance abuse block grant funds; $327,240 from the Center for Substance Abuse Prevention; $160,000 in Medicaid reimbursement through TennCare; and almost $100,000 in client fees, insurance payment, charitable contributions, foundation grants, and funds from the State's vocational rehabilitation agency.

Role of County and/or State Government

The Department of Mental Health has been a critical partner for Foundations. DMH has assisted Foundations with funding, staff and access to other purchasers.

Unique Features, Program Lessons, and Next Steps

One unique feature is that this organization was founded and continues to be led by a consumer. Another is that the treatment services of the organization focus almost exclusively on persons with co-occurring mental health and substance use disorders. A third unique characteristic is based on the organization's clinical focus. The organization is committed to implementing a state of the art continuum of treatment services for this population. A fourth is that Foundations has been unusually successful in securing start-up funds, and grants to establish new services, from both the state and federal governments.

Foundations' integrated services program manual contains a section on lessons learned. They report that a key insight is, "... that philosophical tenets typical of traditional service programs can be greatly incongruent with the mission of an integrated program. Agency efforts ... must continuously strive to develop a new culture that reinforces the strengths of multiple disciplines and encourages "out of the box" treatment paradigms." The Foundations' staff training program emphasizes non-confrontational motivational treatment that minimizes negative consequences to the individual; methods for theory integration; aspects of psychopharmacology; and Dual Recovery Anonymous.

Ongoing challenges include the need for continuous staff cross-training that emphasizes emerging treatment practices; development of integrated treatment methods and educational materials, based on motivational treatment practices; and implementation of Dual Recovery Anonymous 12-step programs.

Future Foundations activities will extend well beyond service delivery. The organization intends to sponsor national conferences on dual diagnosis service design and delivery; expand its advocacy efforts to establish dual diagnosis recovery chapters across Tennessee; provide consultation services to other service providers that focus on assessment skills and treatment improvements; and conduct research on outcomes and service delivery models on services to this population. The agency is especially interested in documenting integrated services and program models for persons with a dual diagnosis.

Financial and Regulatory Incentives and Disincentives

Foundations reports that, "(state) ...grant funding streams ... remain separate and divided" and that Tennessee, "... continues to struggle with methods for blending funds for mental health and substance abuse services." One key factor appears to be the state's historical commitment to a limited number of service providers. Foundations' reports that there has not been a new alcohol and drug provider funded in Tennessee for a number of years, and concludes that the state is maintaining a "closed system."

One regulatory example may be instructive. Foundations requested that the Bureau of Alcohol and Drug Abuse Service fund a limited number of residential treatment beds that had previous been paid for through a federal grant. The Bureau agreed, requiring that Foundations become a licensed residential treatment provider for alcohol and drug services. Foundations was in the process of completing the licensure application process when it was told by the Department of Mental Health that – should Foundations receive a residential alcohol and drug treatment license – the DMH license that permits the existing TennCare contract would be revoked. There is apparently no precedent in Tennessee for a residential program to hold both licenses.

ACCESS Program
Mental Health Association of Southeastern Pennsylvania
Philadelphia, Pennsylvania

"Everyone's my caseworker here."

Program and Organization

The ACCESS program in "West Philly" is operated by the Mental Health Association of Southeastern Pennsylvania, a consumer-run agency that celebrated its 50th anniversary during 2001. Originally an advocacy organization, the Association began to deliver services that responded to unmet needs in the mid-1980's. The agency currently has 36 programs, 290 employees, and an annual budget of approximately $13 million dollars. Its service area is the five counties in southeast Pennsylvania, of which the City and County of Philadelphia is the largest.

The ACCESS program serves persons in the Philadelphia area who have co-occurring mental health and substance use disorders and who are homeless. About 95% of consumers have a co-occurring disorder. Consumers can fall anywhere on the "high-low continuum", but primarily are in the high mental health and high drug & alcohol, or high mental health and low drug & alcohol categories. The service area is the City of Philadelphia, especially the Center City and West Philly areas. ACCESS is a targeted case management program that delivers services primarily through staff members identified as intensive case managers and resource coordinators. A modified Program for Assertive Community Treatment (PACT) is used. The primary modifications are the long-term, street-based outreach component, combined with

requested consumer services such as showers, laundry, and access to telephones and personal computers.

ACCESS provides outreach, engagement and case management services. Specific services include basic needs such as food, shelter and clothing; access to psychiatric and substance abuse treatment services; access to a nurse and physician for health care services; housing; access to job training and job readiness programs; family reunification services; help with activities of daily living; and other services that consumers need to reclaim their place in the community. Case managers deliver mental health services through the team or broker mental health services from other programs within the Association. Substance abuse treatment services can be accessed through Philadelphia's Community Behavioral Health, the organization responsible for administering HealthChoices, the Medicaid managed care program in Pennsylvania.

The ACCESS staff is composed of a director, an intensive case management supervisor, a resource coordinator supervisor, nine intensive case managers with different specialties, four resource coordinators, one nurse, two case aides, an outreach specialist, a part-time psychiatrist and a part-time psychologist. Support staff include an office manager, a receptionist, a billing clerk, a half-time clerical assistant and a half-time time maintenance staff member. A physician is assigned one-half day per week from the Department of Public Health, and an employment specialist is assigned one day per week from the Office of Vocational Rehabilitation. One drug & alcohol specialist is a member of the ACCESS staff and provides training to team members, although staff report, "...after working here for six months, almost everybody becomes an expert on drug & alcohol issues".

Caseload ratios for intensive case managers are 12 consumers per case manager, while the caseload ratio for resource coordinators is 18 consumers per coordinator. ACCESS staff are diverse in terms of age, race and ethnicity. Program administrators report they prefer to hire case managers and specialty staff directly out of college, and train them as ACCESS team members, since in their view young persons have the high energy levels needed to work effectively in the ACCESS program.

History of Services and Financial Development

The ACCESS program was conceptualized prior to 1993 when the first double trouble self help groups were being formed in New Jersey, Dr. Bert Pepper was describing young adults with schizophrenia and drug use, and the Robert Wood Johnson demonstration showed that persons with mental illness had a host of problems related to substance abuse as well. The organization created a case management program, located in a drop-in center and was designed to serve persons labeled as "non-compliant."

The Association advocated with the federal government in favor of a research and development project that would address homelessness, mental illness and substance abuse. When the request for proposal was released, the City of Philadelphia convened a group that became the Center City Project. The project agreed to conduct integrated services in a demonstration site, and monitor a control site that delivered non-integrated services. The Association became the demonstration site for a five-year project

funded by the federal Center for Mental Health Services. The project evaluation found significant progress with treatment compliance and housing retention among participants.

Subsequent service delivery and funding has been strongly influenced by Pennsylvania's Medicaid managed care program, HealthChoices. The majority of the current year's budget, $1,073,885, flows through Community Behavioral Health to reimburse ACCESS on a fee for service basis for case management services to Medicaid recipients. The other major source of revenue, $253,550, is from the County Office of Mental Health for non-Medicaid eligible consumers. Medicaid regulations require a diagnosis of major mental illness for a person to be enrolled in targeted case management.

Role of County and/or State Government

As described above, the City and County of Philadelphia has been instrumental in the initiation of the ACCESS demonstration, and the county's Community Behavioral Health (CBH) unit provides the largest source of current revenue as Medicaid reimbursement. HealthChoices, the state's managed Medicaid program, is the source of capitated funding for CBH. In addition, the county Office of Mental Health pays for ACCESS services delivered to non-Medicaid recipients using county funds as well as state and federal allocation funds provided by the State of Pennsylvania.

Unique Features, Program Lessons and Future Plans

The unique features of the ACCESS program are its strong consumer orientation, and its focus on persons who are homeless. The sponsoring organization describes itself as a consumer run agency. Intensive case managers and resource coordinators staff meet state requirements for reimbursement purposes. However, other staff of the agency do not qualify to deliver Medicaid services, and the Association is not a licensed treatment agency.

The ACCESS team emphasizes the importance of asking consumers what they want, rather than trying to deal with their clinical needs first. Staff point out that treatment planning comes only after consumers are engaged. A continuum of housing arrangements is considered critical, with staff describing a range that begins with safe havens, then progressive demand residences, moving to community rehabilitation residences (with minimum, moderate and maximum care levels), through supported independent living and independent housing with case management. Staff characterize the qualities for success as respect for consumers and "not giving up" – consumers know that staff will stay engaged with them.

Challenges that the ACCESS program is now working to resolve include: 1) the need for more residential programs and housing services for their population; 2) greater community understanding that "consumers will be consumers" – i.e., acceptance of occasional alcohol or drug use; and 3) high turnover among case managers.

Financial and Regulatory Incentives and Disincentives

The primary financial incentive experienced by the ACCESS program is the requirement that all consumers have a major mental illness in order to be eligible for targeted case management services. This criterion makes it difficult to serve persons who are addicted to or dependent upon substances but whose mental illness is an Axis II diagnosis. Association staff describe this limitation as a "stupid rule".

Harris County Mental Health & Mental Retardation Authority
Texas Dual Diagnosis Project
Houston and Austin, Texas

"The way to integrate is to start at the top."

Program and Organization

This section addresses services for persons with co-occurring mental health and substance use disorders delivered by the Harris County Mental Health and Mental Retardation Authority (MHMRA) in Houston, Texas. MHMRA dual diagnosis services were implemented as part of the Texas Dual Diagnosis Project involving multiple sites. Both the county program and the state initiative are described.

The Harris County Mental Health and Mental Retardation Authority is the largest community mental health center in Texas, with an annual budget for FY2002 of $7,191,948 for mental health services and $3,832,499 for substance abuse services, not including mental retardation and administration. The Authority delivers direct services to clients and also contracts with community based organizations for care. The Texas Dual Diagnosis Project award to the Authority was $1,017,858 for SFY2001.

The Dual Diagnosis Project in Harris County received its award as the result of a competitive proposal submitted in the Spring of 1998. It is one of 15 awards made by the Texas Commission on Alcohol and Drug Abuse (TCADA) and the Texas Department of Mental Health and Mental Retardation (TDMHMR), the two state sponsors of the state's Dual Diagnosis Project. Each local project differs somewhat from each other, and the Harris County project is unique in a number of ways. Most of the other projects established new dual diagnosis programs, while the Harris County project augmented the existing services already being delivered by contracted residential substance abuse treatment providers and by mental health clinics operated by the Authority.

The target population for Dual Diagnosis Specialized Services for SFY2000 is persons with co-occurring substance use and severe mental illness disorders which meet the DSM IV criteria for substance abuse or substance dependence and schizophrenia, major depression, bipolar disorder, or other severe mental illness that requires crisis resolution and/or specialized support and treatment due to noncompliance

with mainstream substance abuse or mental health services (Quadrants II and IV in the conceptual framework).

The Harris County Dual Diagnosis Project includes the following staff components funded by project funds and/or existing resources:

- A program administrator that works within the Authority (project funds);
- Six residential substance abuse treatment providers (existing resources);
- A mobile mental health team that visits the residential substance abuse programs once a week (project funds);
- Six licensed chemical dependency counselors (LCDC), each employed as case coordinators at the six residential treatment programs and who work one day per week at a mental health clinic (project funds);
- Six case managers that are employed by the the Council on Alcohol and Drug Abuse of Houston (project funds);
- MHMRSA mental health clinics (existing resources).

The program administrator is responsible for overall coordination of the project across the various sites, and links the Harris County project to the Texas Commission on Alcohol and Drug Abuse, the state agency that administers the Texas Dual Diagnosis Project.

Residential substance abuse treatment providers identify consumers of service who may be in need of dual diagnosis care, provide space for the mobile mental health team, hire and supervise the LCDC, and deliver all of the usual treatment activities that are appropriate for the populations that they serve. During the site visit, the consultant team visited two of these programs. Door to Recovery is a gender specific women's treatment program that is operated by a non-profit corporation. The Houston Recovery Campus is an affiliate of the University of Texas (UT), Houston Health Science Center. The Recovery Campus provides residential and outpatient treatment to adult and adolescent residents of Region VI, with UT and Riverside General Hospital as the providers. A cognitive-behavioral treatment approach is used by UT, and a Minnesota Model approach is used by Riverside.

The mobile mental health team spends one day per week at four of the residential treatment programs, and visits the two smallest residential programs one-half day per week. The team includes a psychiatrist, and two Licensed Physician Assistants (LPC's). The physician and physician assistants are joined by the LCDC working at each site and the case manager assigned to each residential location.

This team delivers a full range of services including:

- Psychological assessment and individual psychotherapy by the LPC;
- Referral to the psychiatrist by the LPC, as necessary;
- Psychiatric assessment and medication prescription and follow-up by the physician;

- Specialized group counseling twice weekly that deals with both mental illness and substance use problems, by the case coordinator;
- Individual counseling as needed by the case coordinator;
- Case coordination (making appointments, interceding with authorities, managing documents, etc.) by the case coordinator;
- Case management for consumers screened into these services, half of which are delivered at the residential treatment program;
- Staffing when the appropriate referral is difficult to find or coordination is needed between organizations.

Licensed substance abuse counselors deliver group counseling at residential facilities, act as members of the mobile mental health team when the team is on-site, and spend one day a week at the MHMRSA outpatient mental health clinic. The day at the clinic permits delivery of substance abuse continuing care treatment sessions when a consumer who has graduated from the Dual Diagnosis Project comes to the clinic for mental health medication or services.

Case managers are assigned to follow consumers once they leave the residential treatment facility. Standards for assignment to case management, in addition to a co-occurring mental health and substance use disorder, include : 1) an initial Global Assessment of Functioning score of less than 40 and a Brief Psychiatric Rating Scale score of more than 39; 2) active symptoms of mental illness and a history of symptoms for five years or longer; 3) active substance dependence (not abuse) with the most recent use within 5 days prior to admission; 4) a history of repeated unsuccessful efforts at abstinence, including repeatedtreatment and/or hospitalization for mental illness and/or substance abuse; 5) significant social problems that interfere with treatment success, and 6) a willingness to accept case management and benefit from the services.

MHMRSA outpatient mental health clinics provide mental health and medication management services. Well located throughout the Houston area, these clinics are accessible to most Dual Diagnosis Project consumers.

History of Services and Financial Development

The Texas Dual Diagnosis Project was developed as the result of senate Concurrent Resolution 88 as passed by the Texas Legislature in June of 1995. SCR88 mandated that the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Commission on Alcohol and Drug Abuse (TCADA) develop, fund and evaluate programs to meet the needs of dually diagnosed clients in an integrated manner, and make recommendations regarding the delivery of services to these clients.

TCADA and TDMHMR established as project's goals to:

- Implement effective methods of engagement, assessment and treatment through dual diagnosis pilot

programs;

- Create partnerships – particularly between publicly funded mental health and substance abuse systems – to establish community based treatment;

- Identify and evaluate key elements for program replication.

The first phase of the pilot projects began in the Spring of 1997. Common program elements have included:

1. Training of service providers and community referral sources with knowledge concerning the nature and treatment of dual disorders;

2. Development of patient recruitment and referral networks in the pilot communities;

3. Changes to TCADA's administrative codes intended to reduce traditional barriers in substance abuse treatment agencies that make it difficult for persons with co-occurring disorders to receive appropriate services;

4. Screening protocols to identify co-morbid conditions.

Several system wide changes have been implemented. In September 1996, TDMHMR included the Clinician Rating Scales for Drug and Alcohol Use as part of its statewide uniform assessment initiative. TCADA similarly added questions about psychological problems, diagnoses and medication use to its statewide client data system.

TCADA also modified its administrative rules in a number of fundamental ways designed to support delivery of effective and integrated dual diagnosis services by programs funded through the state's alcohol and drug abuse system:

- Funded substance abuse treatment providers are required to develop and implement procedures that identify behavior or conditions that suggest unmet mental health needs;
- Providers are prohibited from excluding persons from service based on mental health history, diagnosis, medications, or assumptions of ability to benefit from treatment;
- Providers may not deny admission based on a perceived threat of harm to self or others;
- Program assessment and intake staff must receive training on mental health issues and on recognizing unmet mental health needs;
- Funded programs must refer clients to mental health services to meet treatment goals, and to provide follow up services;
- Clients in residential services must have access to appropriate mental health services; and

- Programs must adopt medication procedures in every residential program to allow continued use of prescribed medication.

Within Harris County, a group of substance abuse and mental heath treatment providers formed the Dual Diagnosis Council in 1995. Although their initial effort to secure a grant failed, the attempt raised the level of awareness of the need for integrated services in the county.

The current Harris County Dual Diagnosis Pilot Project began in the Spring of 1988 when TCADA announced a second phase of the state pilot project. The MHMRSAS state medical director for Dual Diagnosis Programs was assigned to write the proposal, with 16 community and governmental agencies participating with the medical director. Funded effective July 1, 1998, initial project activities included a city-wide education and training program, a conference on case management and service delivery, and hiring of new staff members.

Several important changes have occurred since the project's beginnings. Harris County and TCADA negotiated an agreement that uses the mobile mental health team to augment services for persons with a dual diagnosis within existing residential substance abuse providers. The first year emphasis on education and training was redirected to clinical services for consumers, at the state's direction. The three-year pilot period has now been extended to a fourth year.

Funding for the Dual Diagnosis Special Project has come primarily from federal Substance Abuse Prevention and Treatment block grant funds through TCADA, and from federal mental health block grant funds through TDMHMR. State sponsors anticipate that Medicaid and state general revenue will become additional sources of revenue for these services as local projects mature. Local funding – e.g., for medications and residential treatment in Harris County – has been provided by MHMRSA through a number of existing revenue sources.

Role of County and/or State Government

TCADA and the TDMHMR jointly sponsor the Dual Diagnosis Project, with TCADA as the administering agency. The majority of funds for the state level project come from TCADA, as federal SAPT block grant funds, and from TDMHMR as federal mental health block grant funds. TCADA and TDMHMR have a shared staff position, the Texas Dual Diagnosis Coordinator, with offices for this single individual located at both state agencies. The Coordinator directs the Dual Diagnosis Project.

The Harris County MHMR Authority is a quasi-public authority that acts as the agent for the TDMHMR, and as the local sponsor and coordinator of the Dual Diagnosis Project. A number of project expenses, such as medications and the MHMRSA outpatient clinic services, are provided on an in-kind basis.

Unique Features, Program Lessons, and Future Plans

A unique feature of the Texas dual diagnosis service development effort is the joint leadership of TCADA and TDMHMR. The project was conceived at the state level and has been funded primarily through appropriations from the two state agencies. Another unique factor is that Texas state government is using the pilot program as the testing grounds for a statewide program for persons with co-occurring mental health and substance use disorders. Texas' implementation plans extend well beyond delivering services through 16 pilot programs, and include regulatory changes, statewide training events, competitive bidding for providers for these services, among other changes. A fourth unique feature is the state's use of the Coordinator position to act as a "linchpin", integrating the interests and activities of the two state agencies and directing the specialized pilot program.

At the Harris County level, the mobile mental health team is an exciting and innovative method for sharing scarce resources across six traditional substance abuse service providers. The team integrates the expert abilities of its staff members to assess co-occurring disorders, bring medication management for psychiatric problems into local programs, assist these local programs to strengthen their capacity to deliver ongoing services to the population, and provide crisis back-up for psychiatric emergencies. The out-posting of substance abuse counselors at MHMRSA outpatient clinics has the potential to revitalize continuing care services, and to assist clinic physicians and mental health staff to better address co-occurring disorders. However, it remains to be seen how well consumers will do following discharge from residential substance abuse care and after the specialized expertise of the mobile team is no longer available to them on a weekly basis.

One state participant pointed out that there has been a major change in the nature of the conversation about persons who have both a substance abuse and mental illness diagnosis. While it formerly was important to say that addicts "aren't crazy", it has now become obvious that when addicts have untreated mental health problems these problems frequently contribute to treatment failure. In similar fashion, untreated substance abuse problems among persons with mental illness complicate recovery from mental illness.

At the state level, next steps include:

- Development and implementation of clinical standards for treating persons with co-occurring disorders;
- Development of reimbursement rates for co-occurring services;
- Delivery of technical assistance on service standards and on methods of engagement, assessment and treatment for this population;
- Requiring and monitoring local training and case consultation activities;
- Bidding out services to persons with co-occurring disorders on a competitive basis, with award winners beginning service delivery in September, 2002.

At the local level in Harris County, the pilot project continues to be refined. Two project

evaluations have been completed, including structured interviews of case managed consumers and case managers (April, 2001), and a statistical analysis of service utilization by consumer type. The major focus of the dual diagnosis teams is now to support mainstream mental health and substance abuse providers, and to serve only those persons that can't be served in the mainstream system, as an "adjunct" service. The MHMRSA project administrator has begun discussions with local pilot project participants (including staff and consumers, among others) regarding the best ways to organize a competitive application next year.

Financial and Regulatory Incentives and Disincentives

All participants at the state and local levels report that specialized funding for the pilot projects was a major financial incentive, as the contract requires that funds be used exclusively for services to dual diagnosis consumers. In addition, TCADA now requires, by administrative rule, that all funded substance abuse treatment providers be capable of providing services to persons with co-occurring disorders.

Funding limitations are the primary disincentive to the growth of services for persons with co-occurring mental health and substance use disorders. Other disincentives include turf issues, accountability issues such as the design of management information systems and contract reporting procedures, bias against a difficult to serve population, and licensure issues. One participant said there are no real disincentives, and that practitioner ideas about how services should be provided are the greatest barrier to improved and expanded services. The state is committed to modifying practitioner attitudes, values, beliefs and skill levels through training over time.

Human Service Center
Peoria, Illinois

"We are going west..."

Program and Organization

The Human Service Center (HSC) is located in Peoria, in central Illinois. The agency was founded in 1976 as the result of a consolidation of two mental health organizations, an alcohol treatment agency, and a drug treatment agency. There are 39 "programs" or cost centers for services and an annual budget of $15,152,000 that is evenly split between substance abuse services and mental health services. This amount includes administrative costs allocated from the HSC management firm, Fayette Companies, as well as costs for residential substance abuse treatment services delivered by White Oaks Companies of Illinois. All of these organizations are 501(c)(3) non-profit organizations.

HSC delivers what can be regarded as a comprehensive range of primary substance abuse and primary mental health services that includes:

- 24/7 mobile crisis intervention;
- Medical detoxification (10 beds);
- Supervised mental health residential programs (32 beds);
- Four gender-specific residential substance abuse programs (93 beds);
- Substance abuse intensive outpatient and day treatment programs;
- Psychiatric services
- Assertive Community Treatment team and five other mental health treatment teams;
- Case management;
- Psychosocial rehabilitation program;
- Individual and group outpatient services;
- A recovery home;
- An internal medicine clinic for SMI clients; and
- Contractual vocational services

The service area of the agency varies by program. Most mental health services focus on persons with severe and persistent mental illness, with the primary service area in Peoria County. The array of substance abuse services includes several specialized residential treatment programs that serve the central Illinois region, or that have expanded to serve a statewide population.

The configuration of services for persons with co-occurring mental health and substance use disorders is significantly different at HSC than at most community mental health centers or substance abuse organizations. Since 1998, HSC has been implementing a policy that ALL of the services and programs delivered by the agency will be enhanced to effectively treat persons with both disorders.

History of Services and Financial Development

Human Service Center had for some years maintained an "enlightened categorical" approach to service delivery. Programs were designed for persons with mental illness, or for persons with substance abuse diagnoses. However, HSC made considerable efforts to not exclude a person from the services they needed when that person's problems included additional difficulties. Persons enrolled in the outpatient mental health program, for example, would not be discharged if they were intoxicated. In similar fashion, the specialized residential substance abuse treatment program for pregnant and parenting women would admit persons with a mental health diagnosis.

This clinical and organizational approach worked poorly for consumers. Staff at the outpatient mental health program were not well prepared to address the substance abuse needs of their consumers. The specialized women's treatment program discovered, as the result of an evaluation at six months following discharge, that former consumers were employed, caring for their children, and not drinking or using drugs, but that they frequently were anxious and depressed. Leadership at the HSC, aware of research findings about co-morbidity among the populations served by the agency, searched for a better approach.

In May, 1998, Michael Boyle, Executive Vice President of the HSC distributed a paper to staff that proposed a "revolutionary rather than evolutionary" solution. The lead paragraph states:

> "Dr. Ken Minkoff, a leading expert in the treatment of co-occurring mental health and substance abuse problems, states that dually diagnoses clients are the 'expectation and not the exception'. The mental health and substance abuse fields must adapt their treatment approaches to this reality. Current research demonstrates that the most effective approach for treating persons with dual behavioral health diagnoses is integrated treatment rather than the more standard practice of sequential or concurrent treatment."

The paper further defined the agency's initial plan as making the substance abuse and mental health program areas at the HSC each capable of serving the dual diagnosis needs of the population for which they are responsible, stating that "...while integrated services are characterized by one-stop shopping, there are still two "shops"; the primary chemical dependency system and the primary mental health system. Each will serve a distinct population of dually diagnosed individuals."

The implementation plan was described as training both staff groups to be dually competent, using an "in-house residency" approach, a plan that was anticipated to require a minimum of two years. To support the "Dual Diagnosis/Mentally Ill Substance Abuser (MISA) Project", HSC took the following steps:

- A full-day clinical workshop was delivered to all staff by Dr. Minkoff in October, 1998;
- A performance improvement project that would lead to changes in the culture of programs and the belief systems of staff was begun;
- A MISA performance improvement committee, chaired by the Executive VP, began meeting weekly in December, 1998;
- As its first task, the performance improvement committee developed a vision of the desired staff competencies, including a list beliefs, values, knowledge and skills.

The committee chose three areas for immediate action: 1) development of a single request for service (intake) form, that would capture consumer information in a comprehensive and integrated manner; 2) training of clinical supervisors, leading to training of clinical teams, and 3) addressing the cultural differences that exist between the agency's mental health and substance abuse systems. Topics selected for supervisor training were the diagnostic assessment of substance abuse and mental health problems, psychotropic medications, and utilization of motivational enhancement techniques. Cultural differences were identified in a series of discussion groups, based on a list of "fire starters" to promote exchange.

One example of a "fire starter" statement is:

> “All clients should be retained in service and treated with great respect in spite of non-compliance with treatment plan recommendations, including not taking prescribed medications or a return to use of the drug of choice.”

The organization used a simple metaphor to communicate to staff the enormity of the anticipated change:

> “We are going west. We are going on this journey and everyone has to decide if you are coming. This is not a choice. The wagon is leaving. We don’t know for sure where the journey will end or the trails to be taken, but we are going.”

HSC has determined that staff training is a major issue in implementing dual diagnosis recovery services. Ongoing training, teaching and supervision are required. The design of staff training services has led to a commitment to evidence-based treatment. However “user friendly” information on evidence-based treatment is frequently not available. In addition, HSC found that not all supervisors are natural teachers, and formed a committee of senior clinicians to develop and implement a model of supervision and training.

The state Office of Alcoholism and Substance Abuse funded a Behavioral Health Recovery Management Project, led by HSC and a sister agency in Bloomington, IL, that has financially supported the development of targeted training materials (available on the project website at www.bhrm.org), such as:

- Squires, Daniel D. and Moyers, Theresa B. (2001). “Motivational Enhancement for Dually Diagnosed Consumers: A Guideline Developed for the Behavioral Health Recovery Management Project.”
- Minkoff. K. (March 2001) “ Treatment Matching Paradigm: Subtype of Dual Disorder by Phase of Treatment.”
- Minkoff, K. (April 2000). “Behavioral Health Recovery Management Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders”.

For the most part, HSC has used existing resources to implement their enhanced dual diagnosis services. Some new resources were needed for training and consultation, the materials described above, and additional staff. These additional expenses were $50,688 in SFY2000.

HSC has estimated the costs of required shifts in the service delivery system to enhance existing programs to be more capable of serving dual diagnosed consumers. For purposes of this report, we focused on three programs. The Central Illinois Center for the Treatment of Addictions (CICTA) is a 28-bed long-term residential addiction treatment program for women with severe addiction and other significant life problems. The New Leaf program has two 15-bed residential substance abuse treatment components: New Leaf Retreat is an intensive short-term (30 days or less) program and New Leaf Lodge

delivers intermediate (30 to 90 days) services. The out patient mental health service is delivered by teams of counselors, and also includes psychiatric, nursing and pharmacist services. The following chart shows the estimated dollars (in thousands) and percentage of expenditures in each of these programs for staff time spent on mental health and substance abuse service activities for the last 3 years and the current budget year.

Program	1999	2000	2001	2002 (current)
CICTA				
SA treatment $'s	1,169	1,227	1,249	1,239
MH treatment $'s	22	28	37	42
SA %	98%	98%	97%	97%
MH %	2%	2%	3%	3%
New Leaf				
SA treatment $'s	1,349	1,282	1,381	1,341
MH treatment $'s	59	78	124	108
SA %	96%	94%	92%	93%
MH %	4%	6%	8%	7%
OPMH Service				
MH treatment $'s	1,432	1,289	1,363	1,480
SA treatment $'s	92	138	184	230
MH %	94%	90%	88%	87%
SA %	6%	10%	12%	13%

It is apparent from these figures that the proportion of staff time devoted to the "other" disability has steadily increased, in general. This shift is taking place without new resources for dual diagnosis treatment, and without the transfer of categorical funds from other traditional program cost centers. *These data may be the sole information available that estimates the financial impact on community based organizations of enhancing the capacity of traditional substance abuse and mental health programs to more effectively serve persons with co-occurring disorders over time.*

HSC has also prepared summary projections and an application to state agencies for funding consideration, that identify the costs required to accelerate the ability of the agency to fully serve dual diagnosis clients in each of its programs. The HSC summary shows an annual cost of $452,467, including administration and indirect services. The primary additions are 3 clinicians with the residential substance abuse programs, PRN positions at the medical detoxification program, a part time physician and nurse time, an additional mental health team, and two highly experienced Ph.D. level clinicians, one for substance abuse and one for mental health, each to serve as supervisors, mentors and consultants.

This total of $452,567 represents 3% of HSC's current budget of $15, 152,000. Put another way, the organization calculates that dedicated revenue equivalent to only three percent of the agency's current budget, combined with staff training, culture changes and infrastructure development, would be

sufficient to make all service programs fully capable of serving persons with co-occurring disorders.

Role of County and/or State Government

The Office of Mental Health (OMH), Illinois Department of Human Services (DHS) and the Office of Alcoholism and Substance Abuse (OASA)/DHS have been major purchasers of services from HSC since the organization was formed. OMH and OASA collaborated in the formation of a Task Force on Mentally Ill Substance Abusers in the early 1980's. Each agency has since offered the state's community service organizations competitive opportunities to apply for limited funds for special services to persons with co-occurring disorders.

HSC is the recipient of an award from OASA for the Behavioral Health Recovery Management Project. The project seeks to integrate substance abuse, mental health and primary healthcare services through the development of evidence-based clinical guidelines.

Unique Features, Program Lessons, and Future Plans

One major feature that is unique at HSC is the organization's decision to enhance all agency services and programs to serve persons with co-occurring disorders. A related feature is the emphasis upon staff training and organizational change. Staff education and performance improvement is a continuing process.

Among the more important lessons learned, according to the Dual Diagnosis Performance Improvement Committee are:

- The critical nature of leadership vision and commitment;
- Making these system changes is something like "Changing the fan belt while the car is running";
- Staff must complete an internal re-conceptualization of who they are and what they are supposed to do;
- It's important to teach and support staff throughout the process of systems change;
- Much system's change of this nature can be made within the existing resource base;
- Differences may exist in how quickly degreed staff and certified staff accept and make change;
- Staff may hold a tacit acceptance of hopelessness for the "other" condition, and become so tolerant that treatment becomes difficult;
- A better dual diagnosis approach creates additional clinical complexity for short-term addiction treatment;
- Consumer acceptance of a dual diagnosis has moved from a rare exception to its being "perfectly all right".

Next steps for this program include more work and training on clinical guidelines, identification of the longitudinal supports needed for recovery for persons with a dual diagnosis, improving access to medication within substance abuse treatment programs, and continued emphasis on the adoption of

evidence-based treatment practices within a disease management approach. In addition, HSC will implement a dual diagnosis jail diversion program in Peoria County.

According to Executive Vice President Boyle:

> "I know the focus of this study is on multiple funding sources, but I have come to believe separate funding streams are not the major barrier to the development of effective dual diagnosis programs. The major barrier is internal to each organization. It's inertia, resistance to change, staff fears, prejudice, differing beliefs and cultures, and more organizational inertia. The culture must be changed, and that's not just about money."

Financial and Regulatory Incentives and Disincentives

HSC has identified a number of incentives that they believe promote effective services to persons with a dual diagnosis:

- OASA established a policy that substance abuse providers may not exclude consumers who are using psychotropic medications from service;

- New ASAM criteria encourage substance abuse programs to become "dual diagnosis capable" or "dual diagnosis enhanced";

- The Illinois Mentally Ill and Substance Abusing (MISA) Institute delivers free training on dual diagnosis treatment and a low cost annual conference;
- The Office of Mental Health is promoting the use of evidence based treatment and considering higher payments for the use of evidence based treatments.

A number of important regulatory disincentives have been successfully addressed in Illinois. The OASA information system previously required a primary substance abuse diagnosis and would reject any other entry. Effective July 1, 2001 the system now requires one substance abuse diagnosis but permits one additional mental health code.

Some bureaucratic barriers remain in both systems, however:

- OASA licenses substance abuse services, but does not have a clear policy about licensing community mental health centers that may want to serve persons with co-occurring disorders;

- Time required to obtain agency licensure is extensive and expensive;

- OASA's Medicaid rule requires that a provider be licensed and deliver substance abuse services

for two years before becoming eligible for Medicaid certification, limiting a revenue source for which persons with co-occurring disorders are frequently eligible;

- OMH's Medicaid rule requires a provider have existing State mental health funding to become Medicaid certified;

- OHM and OASA Medicaid rules and licensure cover different services and quite different staffing qualifications;

- OMH requires national accreditation, while OASA does not;

- OASA has a procedure for waiver of rules, while OMH does not.

It is apparent that policy development, funding, regulations, and procedures have occurred separately for mental health and substance abuse treatment services in Illinois, resulting in many differences in approach and expectation that impact on local programs' ability to effectively deliver services for persons with co-occurring mental health and substance use disorders. These differences, at a minimum, make it difficult and expensive to meet both sets of requirements and further act as barriers to accessing the traditional State funding sources for both substance abuse and mental health services.

Locally, the greatest barrier identified by HSC is limited staff time. Funding restrictions have resulted in the use of group treatment in the substance abuse system and large caseloads in the mental health system. It is difficult to find the needed time to work on an individual basis with consumers with co-occurring disorders, so staff too often find themselves responding to crises in the life of the consumers and are stretched too thin. Rate freezes and lack of "cost of doing business" adjustments in contracts have exacerbated this situation.

It has also become difficult to find the time needed for staff training, reflection concerning needed cultural and procedural changes, and clinical supervision, which are critical as the program's continues its transition from a traditional categorical focus to a truly consumer-centered dual diagnosis service agency.

According to HSC, there are few options to resolve these pressures. If additional resources cannot be found to add more staff, what remains is to: a) redesign paperwork requirements to free up staff time, or b) negotiate with purchasers to serve fewer clients within existing resources and spend more time with the clients enrolled in service. HSC has begun the use of clinical checklists and rating scales rather than narrative progress notes, and are "discharging" fewer clients after acute episodes of care. HSC and state leaders are also discussing the potential for contracts that focus upon positive outcomes rather than only upon units of service and numbers of clients. However, HSC recognizes the problems associated with declining to serve severely and persistently mentally ill clients.

Dual Diagnosis Services
Dorchester County Detention Center
Cambridge, Maryland

"We can't afford to be in an environment where our attitudes create issues."

Program and Organization

This section describes services for persons with co-occurring mental health and substance use disorders that are delivered in and by the Dorchester County Detention Center. The county is one of the state's 23 jurisdictions that participate in the State of Maryland's Community Criminal Justice Treatment Program (MCCJTP), which is recognized by the National Institute of Corrections, the National Institute of Justice and the GAINS Center. Both the county program and the state initiative are addressed.

The Dorchester County Jail was opened in February 1992 and operates within the County Department of Corrections under the jurisdiction of a Warden appointed by the County. The current Warden has held the position since October 1992. The facility is state-of-the-art, costing $10.5 million in combined state and county funding. Originally designed to house 204 male and female inmates, the facility has since been modified (for example, adding medical holding areas) and now maintains a capacity of 275 beds for minimum, medium and maximum security inmates. The average census of the Detention Center has steadily decreased over the years and is currently well under capacity, typically approximately 70-80%. In fact, having established a statewide reputation for excellence and effectiveness, the Dorchester County Detention Center regularly fields requests from other county detention centers to accept residents of other counties.

Staff directly employed by the Detention Center include:

(1) Warden
(2) Chief of Security
(3) Chief of Programs
(4) Transportation Supervisor
(5) Administrative Officer
(6) Classification Supervisor
(7) 50 Correctional Officers
(8) Maintenance staff
(9) Administrative support staff
(10) Cadets

Target figures are set for staff to ensure that detention center personnel "mirror" the inmate population, in terms of gender and ethnicity.

The following behavioral health staff are assigned to the Detention Center:

(1) One *Community Service Coordinator* who is employed directly by the Detention Center

through funding provided by the Maryland Department of Mental Hygiene. This individual coordinates all mental health and substance abuse services provided through the Jail Mental Health Program and provides the following direct services, as well: screening and assessment; case management and counseling; emergency/crisis intervention; referrals to other services; jail diversion; aftercare; training and consultation to Detention Center staff.

(2) One Masters level *Clinical Social Worker* funded by the Maryland Department of Mental Hygiene under contract to the Dorchester County Mental Health Clinic. This individual provides in-center services to persons with serious mental illness and collaborates with addictions staff to meet the needs of persons with co-occurring mental health and substance use disorders.

(3) One Masters level *Addictions Specialist* funded by the State Alcohol and Drug Abuse Authority under contract to the local Health Department. This staff person is responsible for developing coordinated treatment of inmates with dual disorders.

(4) One Masters level *Trauma Specialist* to deliver services both in the county jail and in the community. The position's salary is funded entirely by the Mental Hygiene Administration to the local core service agency, which in turn sub-contacts for the service to a local mental health service provider.

(5) Other community agency staff specialists deliver services to inmates in the jail setting on an ongoing basis.

The Center contracts out for the following services: (1) food service; (2) medical services; (3) inmate telephone services; (4) barber services; (5) commissary services; (6) pest control; (7) solid and medical waste; (8) x-rays and laboratory.

The Dorchester County Detention Center is committed to supporting the development of an integrated system of care for the men and women for whom it has responsibility, maintaining that dealing with individuals with co-occurring mental health and substance use disorders who have become involved with the criminal justice system is both intricate and challenging. Assertive implementation of this value has led to the development of an active and proactive mental health and substance abuse service system within the Center's walls and after discharge from the Center back in to the community.

Upon incarceration, each inmate receives a comprehensive screening and assessment for mental illness and substance abuse problems, with immediate crisis intervention and stabilization services provided as necessary. A medical evaluation is performed; any prescribed medication is managed on an ongoing basis. Development of an individual plan leads to any indicated individual and group treatment, which are begun as soon as possible. Recovery-oriented mental health and substance abuse-related programs and services that are available to inmates on site during their incarceration include:

(1) Mental health services are offered by Warwick Behavioral Health Services (the local mental health center) with funding from the Maryland Department of Health and Mental Hygiene.

(2) Trauma Addictions Mental Health and Recovery (TAMAR), a trauma treatment program designed for the female inmate population. Funding from the Maryland Department of Health and Mental Hygiene supports a full-time clinician who coordinates the program and facilitates individual and group treatment on a regional basis. The program works with women in the Detention Center and provides community-based follow-up by Detention Center Trauma staff.

The negative impact of early physical and sexual abuse on men is recognized as well. Current plans call for the expansion of the TAMAR program to include the male inmate population.

(3) Pre-Natal Care Management, offered by the Health Department, is a new internal program to teach mothers how to care for themselves and their new born child.

(4) Drug-Alcohol Recovery Training (DART), a 28-day in house addictions program with aftercare offered by the County Health Department and funding by the State Alcohol and Drug Abuse Commission. DART is available during the morning, afternoon and/or evening of each weekday.

(5) Narcotics Anonymous, offered separately for males and females several evenings a week.

(6) Alcoholics Anonymous, offered separately for male and female inmates several evenings a week.

(7) AIDS/STD Program, education and treatment services offered by the Health Department.

(8) General Equivalency Degree classes offered several days a week separately for male and female inmates through the Board of education.

(9) Parenting Program, offered by the Health Department one day a week.

(10) Smoking cessation is supported through the local Red Cross. Smoking by inmates is not permitted.

The foundation for treatment and recovery services delivered to individuals after their discharge from the detention Center is built through these programs during incarceration. Relationships are established between the inmate, corrections officers and treatment staff that can be depended upon after discharge. Preparation for discharge includes the development of an aftercare services plan by the case manager that targets case management and other aftercare services focused on treatment and recovery, housing and employment.

Housing support has been a particular focus of the MCCJTP from its inception. The Shelter Plus Care Program was developed in 1995 by the Mental Hygiene Administration in response to a lack of housing for persons with mental illness who were homeless or at risk of homelessness upon discharge from detention centers. The program provides tenant and sponsor-based rental assistance totaling $5.5 million from 1996-2001 in all but one of Maryland's 23 counties.

The Projects for Assistance in Transition from Homelessness (PATH) has contributed significantly to the success of MCCJTP. Development and maintenance of a secure living environment upon discharge is seen as essential to a successful transition from detention center to community. Outreach, screening and diagnostic services, case management, community mental health, alcohol and drug treatment services, supportive and supervisory services in residential settings, and consumer and staff training are all offered to individuals preparing for/upon discharge from the Detention Center. The state allocated $694,000 in PATH funds to meet the housing and support needs of persons in this program statewide during FY 2002. During FY 00, a total of 1,573 MCCJTP clients received PATH-based services statewide.

History of Services and Financial Development

Maryland's Mental Hygiene Administration has implemented the Maryland Community Criminal Justice Treatment Program in 23 jurisdictions in order to meet the needs of persons with serious mental illness and/or co-occurring disorders who are incarcerated in local jails. The goals of this statewide program include:

(1) to provide comprehensive treatment and support services for persons incarcerated in local detention facilities;

(2) to appropriately transition clients into a community-based system of care after incarceration;

(3) to reduce the rate of recidivism to state psychiatric hospitals and detention centers and to reduce homelessness statewide; and

(4) to enhance the quality of life and enable those served to become productive Maryland citizens.

Begun in 1992, the statewide program was developed in response to the fact that the mental health needs of inmates were largely ignored prior to that time, unless individuals were suicidal or disruptive. Corrections staff spent significant portions of their time dealing with mental health-related crises, leading to frustration and exacerbation of existing problems. A Governor's task force appointed in 1991 examined the problem and recommended that a coordinated approach by criminal justice and behavioral health treatment systems was necessary. The state Mental Hygiene Administration allocated $50,000 in seed money to establish Jail Mental Health Programs in four counties. These pilots resulted in the creation of the Maryland Community Criminal Justice Treatment Program.

MCCJTP operates on the assumption that the degree to which key community agencies – as a cohesive group of leaders – participate in and take responsibility for identifying solutions to community-wide problems is directly related to the community's quality of life, specifically the level of public safety enjoyed by all its citizens. Many of the individuals served through this program – in addition to their serious mental illness and substance abuse issues – are also homeless or from unstable housing situations, they lack secure employment, and may be diagnosed with HIV and other physical health problems. The complexity of the health and behavioral issues they face demands a coherent, community-wide response, since no one agency has the capacity to respond completely to all of their needs. In effect, Maryland's MCCJTP "wraps" services around the individual, both during incarceration and after incarceration has ended. These services significantly increase the likelihood that individuals will maintain themselves in a stable living environment and not return to jail.

Financial support for the Center's treatment program has been developed from a number of different sources. Some years ago, state staff successfully applied for funding from the Department of Justice's Edward Byrne Memorial Program to support substance abuse services in conjunction with treatment for serious mental illness. Although no longer a source of funds, this seed money helped develop the addictions services that are now at the program's core. The TAMAR project, originally funded through a SAMHSA Women and Violence grant, is now fully supported by the Mental Hygiene Administration. A total of $5.5 million has been available through HUD's Shelter Plus Care program from 1996-2001.

Psychiatric services are supported by a contract with the Mental Hygiene Administration to the local mental health center. The Mental Hygiene Administration supports delivery of mental health services on site at the jail through Community Care Coordinators/Case Managers. The County Health Department, as the agency responsible for addictions services, provides a full-time staff substance abuse specialist. Administrative support services are contributed by a number of local community agencies.

By its own admission, funding for the Jail Mental Health Program is "a patchwork of blended funding." The state has a long and successful history of aggressively seeking outside funding and foraging for in-state funding to support services. Maintenance of this continued partnership to identify necessary funds is a major source of satisfaction for state and community collaborators.

Role of County and/or State Government

The role of state and local governments in the success of behavioral health services offered to persons with co-occurring mental health and substance use disorders at the Dorchester County Detention Center cannot be overemphasized. State level leadership from the director of the Mental Hygiene Administration and the director of the office of special needs populations has been instrumental in launching and strengthening the program in this county and in the state's other counties, beginning in 1992.

At the county level, the fact that agency directors and community leaders identified quite early in the program's evolution a common goal of enhancing public safety helped direct local efforts toward meeting the needs of this population in order to support their transition back into the community. As a

result, the stigma with which the population is generally perceived has dramatically decreased. State and local leaders have created a community-based partnership that champions the idea that: (1) these individuals are part of society; and (2) their success will contribute to a heightened sense of public safety.

Unique Features, Program Lessons and Future Plans

(1) *Communication and coordination*

The Center depends upon the strength of its relationships with state and community agencies that each contribute to a comprehensive system of individually-centered care. The Center participates in the Dorchester County Criminal Justice and Treatment Network, a collaborative effort among State, County and City officials including law enforcement, treatment, education, social services, corrections and the judicial system. Formed in 1996, this partnership is designed to develop and maintain mutually beneficial programs and services that enhance the public safety of county citizens. Meeting monthly at the Detention Center, the Network is comprised of key decision-makers who can discuss, resolve and implement new approaches to community problems. It is built on the assumption that the integration of community-based efforts will increase the likelihood of greater public safety. The Detention Center is seen as an essential partner in this collaborative.

The Network's value lies, in part, in providing a forum for each agency or service system to address both shared and unique problems with their colleagues and generate solutions that would – in a less collegial environment – be much more difficult to identify and implement. Regular face-to-face meetings among decision-makers (e.g., agency directors, senior staff) has led to significant improvement in this broadly-defined public safety service system, including:

- District Court "DROP" Program for drug violations for supervised offenders;
- Dorchester County Addictions "Assessment Center" at the District Court Building;
- Parole and Probation and the Dorchester County Sheriff's Office Community Policing Agreement;
- Felony Sex Offender registration program through the Sheriff's Office;
- SAVE ("Stop Arrest and Violence Early") program for county youth run by the Detention Center and used by local churches, civic groups and the education system;
- The ALEX ("Automated Labor Exchange") system installed in the Detention Center by the Maryland Department of Labor to assist inmates in finding jobs upon their release;
- Child safety seat program established through the Sheriff's Office;
- Cross training between public safety and mental health/substance abuse treatment communities;
- Coordination of the local "Hot Spots" team with city police, probation and parole and juvenile justice departments.

The Network demonstrates the power of intergovernmental agency leadership, a shared vision and a strong commitment to improve services within existing resources. Recognized by the Lieutenant Governor

in 1997 for its efforts and accomplishments, the Network's members plan to continue strengthening open communication among all community agencies as a way of successfully implementing new and existing programs, services, laws and regulations in the service of public safety.

(2) *Focus on the Role of Trauma*

An increasingly important feature of the program – both in Dorchester County as well as in other parts of Maryland – is its understanding of the critical role that early physical and sexual trauma experienced by men and women who have been incarcerated plays in the development of illegal and otherwise dysfunctional behaviors that have led them to jail. Originally cultivated as a result of the state's involvement as one of the SAMHSA Women and Violence study sites, this focus has led to the development of "TAMAR" programs ("Trauma, Addictions, Mental Health and Recovery") in a number of the state's detention centers, including Dorchester County.

The TAMAR project is a voluntary trauma treatment and education project for adult women, and includes trauma treatment groups in the Detention Center as well as in the community. A peer support group also meets in the county. The state's goal is to expand trauma treatment capacity into each of the 23 detention centers.

(3) *Consultation, Training and Education*

An essential component of the Jail Mental Health Program's success lies in the understanding of mental health and addictions issues that is engendered in corrections staff. Training is ongoing and focuses on developing a greater understanding of a wide range of behaviors, including the etiology of mental illness and substance abuse and the impact of early childhood trauma. Corrections officers, medical and treatment staff meet on a weekly basis to discuss the status of new and current inmates, in the process learning from one another about different perspectives and styles that, according to staff, "make things work a whole lot better."

The community treatment team meets on the first Tuesday of each month to discuss shared cases. A confidentiality release is signed by all clients which allows full sharing of relevant information among mental health, addictions, social services, probation and parole, education, judiciary, law enforcement and other community agencies.

(4) *Aftercare*

Staff suggest that a stronger aftercare program – one in which former inmates maintain daily contact to address their mental illness and substance abuse issues – would constitute a more controlled and effective aftercare treatment environment. They indicate that more off-site work with families of inmates – especially those that have children – would intensify the program's impact by strengthening the community bonds necessary to successful community life.

Financial and Regulatory Incentives and Disincentives

Maryland's Jail Mental Health Program Mental operates within the state's managed public mental health care environment, whose administrative services are provided by Maryland Health Partners. A critical aspect of preparing for the discharge of inmates from the Detention Center is approval by the office of special needs populations of aftercare services designed to ensure a successful transition back into and long-term maintenance in the community. In fact, the underlying assumption is that in-jail services are only the beginning of the service continuum.

The smooth transition of inmates from incarceration to community life requires that great care be taken to adequately prepare individuals physically, emotionally and financially to prevail under the pressures that they will face upon discharge. Since upon incarceration inmates lose their eligibility for the health and financial benefits under Medicaid and SSI/SSDI that most of them depend on to survive, aftercare planning and services aim to create stability in housing , employment and finances by re-applying for entitlement programs prior to discharge.

Pre-discharge planning results in an aftercare plan which is approved through Maryland Health Partners, which in turn subcontracts with local providers for housing, co-occurring mental health and addictions treatment, etc. A monthly report detail progress toward accomplishing the aftercare plans goals and maintains the integrity of the financial arrangements supporting the client in the community. Any deviation can be identified and quickly corrected.

SECTION III

Fiscal Analysis

Co-Occurring Program Revenue

One of the central questions that this project was designed to address was: Who pays for the co-occurring services delivered by relatively mature, integrated programs which utilize multiple sources of funding? This section responds to that question by reviewing the following areas of fiscal analysis:

a. Data limitations
b. Start-up funding
c. Current sources of revenue

<u>Data Limitations</u>

The co-occurring case study sites themselves served as the primary sources for information in this section. Service providers were asked to provide financial data prior to all teleconference calls and site visits and at various points throughout the project. The comprehensiveness of the data submitted in response to these requests varied widely. Although the project has attempted to collect uniform financial data, key questions regarding amounts of revenue by source were responded to differently by different programs. This report both rests upon and reflects the variability in available data describing revenue and expenditures for co-occurring services programs, a point which should not be lost on the programs, funders or advocates.

Two other limitations related to data deserve special mention.

(1) Because providing integrated services to persons with co-occurring disorders is a relatively recent phenomenon and because there is no "categorical" source of funds for these services, information from this sample of nine providers should be considered preliminary and somewhat descriptive in nature. Project staff originally requested that each program provide three years worth of fiscal data on expenditures for co-occurring programs and services. Obtaining these data was not possible because most programs do not have a management information system in place that allows them to track revenue and expenditure by client or by client diagnosis. The request then shifted to focus on revenue figures that support the time that staff spend on serving people with co-occurring disorders. Many of these sites see individuals with co-occurring disorders within general mental health and/or substance abuse service components, along with clients who do not have dual diagnoses. The most that could be done to derive a co-occurring revenue target figure was to estimate a "best guess" regarding the proportion of the revenue figure that is devoted to the support of persons with co-occurring disorders.

(2) The second limitation is that the unique program design for persons with co-occurring disorders at the Human Service Center in Peoria, Illinois results in the entire agency – with all of its mental health and substance abuse services – being seen as part of the co-occurring program effort. As the result, the agency's entire operating budget has been included in the tables and analyses that follow. Because HSC has an annual budget in excess of $15 million, their fiscal data represents an unusually large part of the total displayed in Chart 1.

Despite these data limitations, the information gathered and analyzed under the auspices of this project represent the most comprehensive data currently available on a national level regarding the financing of integrated services for persons with co-occurring mental health and substance use disorders. Consequently, the NASMHPD-NASADAD Task Force has concluded that a number of credible and useful observations can be made regarding fiscal support of co-occurring mental health and substance abuse services, based on the experience of these case study sites.

Start-Up Funding

All case study programs reported that the source of revenue to support the "intellectual capital" which is always required to conceptualize co-occurring program design came from existing revenue sources. Put another way, none of the programs had a special source of funds for the *initial design and conceptualization* of their program.

Sources of start up funds for first year operation varied, as is reflected below from highest to lowest frequency:

- #1 Existing revenue sources
- #2 Federal funds through special program grants
- #3 State general revenue
- #4 Foundation funding
- #5 Private investment funds

The most common methods – the use of existing funds and special federal grants – account for two-thirds of all identified program start-up costs. Federal funds came from the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), the National Institute on Disability and Rehabilitation Research, and the Department of Justice, among others.

Current Sources of Revenue for Co-Occurring Services

As has been mentioned, each of the nine programs interviewed during the project period was selected based on the criterion that the co-occurring program was mature – i.e., that it had moved beyond its start-up phase and was now approaching or in a relatively stable operating phase. The revenue that allows for that relative program stability is reflected in Chart 1.

Table 1: Revenue for Co-Occurring Programs, in Thousands of Dollars, by Source and Provider, FY 2001

Source	Access Maine	Access SE PA	NDF	Arl Co.	CAM	Found.	Harris Co	HSC	DCDC	Total
State GR	155.2	-	-	1,704.8	151.0	1,130.4		8,513.0	84.0	11,738.4
SAPT	-	-	44.0		-	-	916.1	2,159.0	-	3,119.1
CMHS	-	-	-	16.2	-	444.9	101.8	617.0	-	1,179.9
Other fed	-	-	82.0	-	-	878.4	-	1,038.0	-	1,998.4
Medicaid	460.8	1,073.9	96.0	177.4	277.7	160.0	-	1,242.0	-	3,487.8
County	-	254.4	525.0	1,590.6	185.2	-	-	327.0	-	2,882.2
Charitable	-	-	-	-	-	15.0	-	163.0	-	178.0
Client fees	-	-	25.0	50.0	-	40.0	-	869.0	-	984.0
PF	-	-	35.0	-	10.0	25.0	-	-	-	70.0
Other	-	-	-	-	-	10.0	-	224.0	-	234.0
Total	616.0	1,328.3	807.0	3,539.0	623.9	2,703.7	1,017.9	15,152.0	84.0	25,871.8

Program Key:

Access Maine	ACCESS Team, Maine Medical Center
Access SE PA	ACCESS, Mental Health Association of Southwest Pennsylvania
NDF	New Directions for Families, Arapahoe House
Arl Co.	Arlington County MH/SA Services
CAM	Consumer Advocacy Model, Wright State University
Found	Foundations Associates
Harris Co	Harris County MH/MR Authority
HSC	Human Service Center
DCDC	Dorchester County Detention Center

Revenue Source Key:

State GR	State General Revenue
SAPT	Substance Abuse Prevention and Treatment Block Grant
CMHS	Mental Health Block Grant
Other fed	Other federal funds (e.g., CSAT, CMHS, SAMHSA)
	Medicaid Medicaid, state and federal
County	County and city funds
Charitable	Charitable contributions (e.g., United Way)
Client fees	consumer or family, insurance
PF	Private foundation
Other	other revenue sources not identified

These programs operate within a variety of funding environments. For example, the Maine program is within a hospital setting and depends primarily upon an established Medicaid case rate, with additional funding derived from state general revenue. In Philadelphia, the majority of ACCESS West Philly's budget is fee-for-service through the county-owned managed care organization for behavioral health services for Medicaid clients. Arlington County's co-occurring services are lodged within a community mental health, mental retardation and substance abuse services agency in a county-based authority structure. The CAM/SARDI program is within a university-based school of medicine. Medicaid funding provides the largest source of its fee-for-service resource base.

The Dorchester County co-occurring services program is operated through a county jail, with limited categorical funding from the state mental health authority through its fee-for-service managed care program. Foundations Associates is a free-standing, "single-focus" agency (i.e., all clients are diagnosed with dual disorders) located within a state that was one of the first to move into a managed care environment. In addition to state general revenue, large portions of the agency's budget are from specialized federal contracts. The Texas Program is one of the few which is based upon categorical co-occurring services funding identified by the state as the primary funding mechanism.

Human Services Center has been developed as an internal medicine practice within the outpatient setting of a community mental health center. In Colorado, the bulk of funding for New Directions for Families comes through contractual arrangements with state and county authorities.

These nine agencies have attempted to maximize the advantages of each of the management and fiscal environments within which they operate. As the fiscal analysis section indicates, however, a number of financial disadvantages cannot be impacted by any one service agency, since they are built into the current broader state systems which are not amenable to single agency influence.

Although a number of the programs studied operate with quite diversified sources of revenue, a key observation regarding revenue sources is the extent to which several of these programs rely on just two or three sources of revenue. These include the ACCESS program of the Maine Medical Center, which operates using only state general revenue and Medicaid; the ACCESS program of the Mental Health Association of Southeastern Pennsylvania, which depends only upon Medicaid and state general revenue; the Harris County Mental Health and Mental Retardation Authority, now in the fourth year of a pilot project, using primarily Substance Abuse Prevention and Treatment and Mental Health Block Grant funds.

Table 2 displays the types, amounts and percentages of revenue sources, by total number of dollars. The top three sources of revenue – state general funds, state Medicaid reimbursement and SAPT block grant – represent 71% of all revenue for these programs.

Table 2 Types, Amounts and Percentages of Revenue Source, by Number of Dollars (in thousands).

Rank	Source of revenue	amount in thousands	% of total
1	state general revenue	11,738.4	45.4
2	Medicaid	3,487.8	13.5
3	SAPT Block Grant	3,119.1	12.1
4	county/city	2,882.2	11.1
5	other federal funds	1,998.4	7.7
6	MH Block Grant	1,179.9	4.6
7	fees and insurance	984.0	3.8
8	other sources	234.0	0.9
9	charitable	178.0	0.7
10	foundations	70.0	0.2

Barring unforeseen economic downturns or other factors that dramatically affect the availability of state and federal revenue, these mature case study sites appear to be funded, at this point, primarily with relatively stable sources of funding. Their dependence on time-limited sources, such as special federal grants and contracts, is limited. It should be remembered, however, that their initial start-up costs were much more heavily dependent upon such time-limited federal and state initiatives.

Continuing review of the revenue sources for co-occurring services over time may indicate a continuing migration toward more stable sources of funding (e.g., Medicaid) as these and other programs become more sophisticated in attracting funding and better able to document their effectiveness to prospective funding sources.

B. Incentives and Disincentives in Financing Services

Financial Incentives

Working intensively with case study sites to reach an understanding of the ways in which they have developed, maintained and monitored the multiple sources of funding that support delivery of co-occurring mental health and substance use services allows for the identification of a number of important financial incentives, including regulatory incentives that impact directly upon services and financing. It is difficult to overestimate the crucial role that fiscal incentives play in encouraging development of co-occurring services. These incentives can include:

Financing and Payment Mechanisms

- Use of a case rate payment system that allows for comprehensive treatment of the individual, in that it recognizes and permits integration of service delivery;
- Availability of and access to Medicaid, TANF and other funds that, when woven together,

support the full range of client needs;

- Targeting of specialized funds for dual diagnosis pilot programs.

Identification of Individuals with Co-Occurring Disorders as Priority Population

- State definitions of priority populations by the mental health and substance abuse departments that each allow for the "other" disability to be served within a co-occurring disorder framework;

- Changes to state information systems that allow for more than one diagnosis for persons with co-occurring disorders, and not rejecting information about consumers that does not contain the single, acceptable diagnosis. Issues related to "poly co-morbidity" are increasingly coming to the attention of researchers and clinicians.

Licensure and Certification

- Outpatient licensure for mental health and substance abuse programs that requires approximately the same paperwork, so that the same or similar client information is collected regardless of the door through which the client enters.

- Licensure and certification regulations that permit programs to provide both mental health and substance abuse services rather than limiting programs to one or the other service license or certification.

Standards and Regulations

- Administrative rules and other guidance that make it clear that substance abuse treatment providers must assess for mental health problems, provide or otherwise arrange for mental health services (including medication) when needed, and may not exclude an individual from substance abuse treatment due to mental health diagnoses, conditions or treatment received;

- Administrative rules and other guidance that make it clear that mental health treatment providers must assess for substance abuse problems, provide or otherwise arrange for substance abuse services when needed, and may not exclude an individual from mental health treatment due to substance abuse diagnoses, conditions or treatment received;

- Application of new American Society of Addiction Medicine criteria for "dual diagnosis capable" and "dual diagnosis enhanced" programs.

Technical Assistance, Training and Education

- Access to free/subsidized education, training and technical assistance delivered by local, state and national experts in co-occurring service development, financing and delivery;

- Participation on a list serv that would allow state and local agencies to share policies, procedures, regulations, incentives and initiatives that have been developed rapidly with others, to promote widespread systems change.

Based on the project's work with these case study sites, it appears that a number of states have made significant progress in reducing the regulatory and financial barriers that discourage providers from developing and delivering integrated services for dually-diagnosed consumers. However, the limited funding for mental health and substance abuse treatment services in general, combined with lack of specific financing vehicles that promote and support services to the co-occurring population in most states, means that integrated services are still not readily available in many parts of the United States.

Financial Disincentives

Study site programs are not reluctant to identify the financial disincentives that they believe to be barriers to developing and delivering effective and integrated services for persons with co-occurring mental health and substance use disorders. These disincentives and barriers continually and negatively impact on program resources and energy as they seek to serve this complex population. Financial disincentives identified include:

Financing and Payment Mechanisms

- Limited or non-existent Medicaid benefits in individual State Plans, especially for substance abuse services;

- Low Medicaid reimbursement rates that are set well below the actual cost of services, especially for clients with multiple disorders and significant levels of impairment, and the adoption of those same inadequate Medicaid payment rates by county behavioral health authorities;

- Medicaid payment rules for targeted case management that require a diagnosis of major mental illness for reimbursement;

- Medicaid certification requirements for mental health that require existing state mental health funding to become a Medicaid provider;

- Lack of financial incentives to serve persons with co-occurring disorders – e.g. payment rates do not vary by the complexity of the consumer's problems and no additional funds are available to serve this population;
- Difficulty in juggling funding from multiple sources for individuals with multiple problems, e.g., women with substance abuse, mental health, child rearing, and trauma histories served in a managed care environment where purchasers specialize in one problem only. This usually ends up requiring referral and duplication of effort and prevents integration;

- A lack of funding for psychiatric consultation time and psychotropic medications, especially for co-occurring services agencies that have not traditionally delivered mental health services;

- Cash flow problems, especially with Medicaid reimbursement;

- Difficulty in establishing or "growing" the program when purchasers primarily pay using a fee-for-service reimbursement mechanism;

- Separate, divided and sometimes antithetical state funding streams for substance abuse and mental health services;

- Limited staff time within a local program, due to allowable rates and limited funding, making it difficult to provide individual counseling to persons with co-occurring disorders and to find time for training and clinical supervision. This is particularly true in substance abuse programs where the model and rates are based on a predominate group counseling model.

Licensure and Certification

- The costs of compliance with separate and very diverse sets of state regulations and standards for substance abuse and mental health services;

- De-facto state limits on the number of providers, due to limited funds, making it difficult to become a new provider within a "closed" system;

- Mental health and substance abuse licensure regulations that conflict at the state level and result in "either-or" licensure – i.e. obtaining a second license can result in losing the first license and its related funding;

Standards and Regulations

- Medicaid certification rules that require two years of substance abuse licensure and service delivery prior to eligibility as a Medicaid provider;

- State Medicaid rules that cover different services and require different staff qualifications for the provision of substance abuse and mental health services.

Treatment Technologies

- Outmoded and ineffective practitioner ideas about how services – mental health, substance abuse and co-occurring – should be delivered. It has been suggested that states and providers need to "trade out" many of the old approaches for new evidence-based treatment practices.

Management and Administration

- The administrative time required to establish relationships and contracts with multiple purchasers for regional providers in a state supervised, county administered system.

The list of disincentives to adequate funding and development of co-occurring services is long and somewhat daunting. The separate histories and development of substance abuse and mental health agencies within most states have resulted in separate methods of licensure, contracting, reporting, and monitoring. These differences make it both expensive and difficult for local programs who specialize in providing services to persons with both a mental health and a substance abuse disorder to do so efficiently and effectively.

Auditing Procedures and the Substance Abuse Prevention and Treatment and Community Mental Health Block Grants

According to policy guidance provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1999 (see appendices):

> "States may use the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Services Block Grant (CMHSBG) to provide services for individuals with...co-occurring [mental health and substance abuse] disorders...The statutes and applicable regulations pertaining to the SAPTBG and CMHSBG clearly permit those funds to be used to provide treatment services for individuals with co-occurring substance abuse disorders and mental illnesses in a variety of treatment settings, including settings where integrated services are delivered. However, all funds must be used in accordance with the specific regulatory and statutory requirements that govern the funding source, including the purposes for which the funds are authorized, and the reporting and audit requirements...SAPTBG and CMHSBG funds may not be blended in such a way that would render use of those funds subject to only the statute and regulations governing one or the other source of funding. *Funds from each block grant*

must be allocated in a manner which allows them to be appropriately tracked for accounting purposes (emphasis added)."

The specific auditing procedures that state and federal governments use to monitor the financial operations of community based programs and service providers – including programs and providers that deliver services to persons with co-occurring substance use and mental health disorders – are based in the funding relationships between the federal government and states. Statutes that established the federal Substance Abuse Prevention and Treatment Block Grant and the federal Community Mental Health Services Block Grant require a state's Governor to name a unit of state government that is responsible for the administration of the block grant funds. The state then establishes contracts and reporting requirements that meet the state's needs and are consistent with federal requirements. State contract and reporting requirements may be established by units of state government that are separate from the programmatic units that have been named by the Governor to be responsible for mental health or substance abuse block grant funds.

The critical federal auditing requirement is Circular A-133, the Single Audit Report, as established by the federal Office of Management and Budget (OMB Circular A-133). This circular requires providers that have received more than $300,000 in federal funds during the previous year to meet the audit requirements as set out in the circular. Among other requirements, the provider must list the federal sources of funds, categorical program name and amounts received.

In addition to OMB Circular A-133 requirements, states independently establish year-end financial reporting requirements. These requirements include the submission by the service provider of an independent audit. The independent auditor inspects the accounting records of the service providers and renders an opinion as to whether the accounting records represent the financial transactions of the provider. Auditors use Generally Accepted Accounting Principles (GAAP) as the standard for inspection.

Independent audits provide an opinion about the soundness of the providers' accounting systems. When the OMB Circular A-133 requirements are met, additional information in contained in the independent audit concerning sources and amounts of revenue from the federal government, whether received directly by the provider or received through state contracts. Additional state required year end financial reporting requirements may include cost reports for the purpose of setting rates of payment; contract close out reports concerning dollars, clients and services; and other state-generated reports. In general, these state requirements for year-end reporting are well established. Should changes in year-end reporting be required, state procedures may dictate that changes to administrative rules be proposed and approved prior to implementation of changes.

As part of the project, administrators and accountants at each case study site were asked to identify the state agency or agencies that establish requirements for the program's annual independent audit. They were also asked to consider whether these requirements specifically address any accounting or auditing practices required for Community Mental Health Services Block Grant and Substance Abuse

Prevention and Treatment Block Grant fund expenditure. In no case does it appear that states require auditing or accounting practices that are specific to the receipt of substance abuse or mental health block grant funds.

Each of the case study programs was also asked to identify the organizations that receive a copy of their independent (CPA) audit. The number of organizations listed as receiving a copy of the independent audit varied from a low of one to a high of 17. They were also queried whether the independent auditor or any agency or organization to whom they've submitted a copy of the audit – including the state mental health and/or substance abuse authority – has ever raised questions concerning the program's accounting practices related to the use of Mental Health or SAPT Block Grant funds to provide integrated services for persons with co-occurring disorders. None of the programs that responded indicated that questions had ever been raised specifically about their use of block grant funds to support integrated services for persons with co-occurring mental health and substance use disorders.

Mental health and substance abuse prevention and treatment block grant funds – often combined at the state level into one local program allocation – are currently used to support the delivery of integrated services to persons with co-occurring mental health and substance use disorders in a variety of settings consistent with applicable statutes. Review of the experience of the nine programs participating in this project suggests that existing and well-established accounting and independent auditing procedures that are now in place to guide expenditures of all revenue sources, including block grants, are sufficient to meet auditing and tracking requirements that have been required to date by either federal, state or local funding entities. There are cases in which the local agency receives a single allocation from the state and is unaware of whatever multiple sources of revenue may have gone into making up that single allocation.

In the course of completing this project, some participants in site interviews articulated their concern that state authorities might be reluctant to allocate block grants funds to support community-based service delivery of integrated services for co-occurring mental health and substance abuse disorders because of the uncertainty surrounding block grant auditing requirements (see SAMHSA policy quoted above). However, programs also expressed apprehension regarding the imposition of any additional informational needs or more detailed auditing requirements designed to track expenditures of SAPT and CMHS block grant funds. Expanded information tracking would require that data systems be developed to link delivery of specific clinical and support services with the specific sources of funds that support their delivery. Based on the experience of this project, such sophisticated informational capacity is beyond the existing management information system capacities of even the most mature integrated co-occurring services programs and state systems. Block grants are allocated to states with a great deal of variance in the administration and manner in which services are purchased – i.e., grants, fee-for-service, case rates, managed care models. Efforts to impose a uniform tracking system would present an onerous and unjustifiable burden on mental health and substance abuse agencies in states and communities.

There has been no indication, as a result of this project, that either the Substance Abuse Prevention and Treatment Block Grant or the Community Mental Health Block Grant are inappropriately used by

states or programs to deliver integrated treatment services for persons with co-occurring mental health and substance use disorders. In predominately substance abuse settings, these individuals are assigned primary Axis I substance abuse diagnoses; they are also likely to receive diagnoses related to their mental illness. SAPT Block Grant funds are among the sources of financing supporting these co-occurring treatment services. Individuals served in predominately mental health settings receive primary Axis I (and Axis II) diagnoses of mental illness; they are also likely to receive diagnoses related to their substance use/abuse. CMH Block Grant funds are among the sources of financing supporting these co-occurring treatment services. Treatment programs that originated as fully integrated co-occurring service sites comply with applicable state regulation and guidance regarding the assignment of primary and secondary diagnoses, which may vary from state to state. All participating sites indicate that the primary disorder for which each block grant has been authorized is addressed, together with whatever co-occurring mental health or substance use disorder exists and requires treatment and support.

According to participating programs, no external auditing agency has expressed concern regarding the appropriateness of their SAPT and CMH Block Grant expenditures because they provide integrated co-occurring treatment services. It appears that case study sites receiving SAPT and CMH block grant funds: 1) successfully "braid" these funding streams to support delivery of integrated services for persons with co-occurring mental health and substance use disorders, and 2) track expenditures in a manner that is consistent with and responsive to federal law and SAMHSA policy. *The most significant problem that has come to light regarding use of SAPT and CMHS block grant funds is that funds from either source standing alone are insufficient to meet the needs of persons with serious mental illness, substance abuse disorders, and co-occurring mental health and substance use disorders.*

Program Analysis

The nine program sites that participated in this project employ many creative strategies to achieve their goals, especially in the face of limited funding, staff uncertainty and general system's inertia. Agencies have faced a set of common problems and then applied the innovative strategies detailed in each of the case studies that appear to work effectively for each of them, based on their own circumstances and settings.

Despite differences in approach, some general observations can be made about the operation of these agencies that: (1) help explain the basis for their ongoing decision-making surrounding program philosophies and interventions, and (2) identify their common ground in developing integrated services for persons with co-occurring disorders. Understanding the characteristics they share can also guide other state and community agencies and systems in strengthening their capacity to meet the needs of individuals with co-occurring mental health and substance use disorders in an integrated manner.

This section highlights some of the major common program characteristics of the study sites gleaned from interviews with key informants at each site and review of program background materials.

Organization and Administration

♦ Agency leaders have created a shared vision and established a set of expectations that staff are encouraged, supported and expected to follow. The importance of the role and vision of agency leaders in strengthening integrated co-occurring service delivery is difficult to overestimate.

Models of Integrated Services

♦ Case study sites have not adopted one particular model of "integrated" services. They have developed their programs based on a perception of client need and on other unique characteristics of their environment, such as level and type of funding, agency organizational structure, staffing, etc. Nonetheless, in general they do share commonly-accepted criteria for integrated services.

(a) they operate "comprehensive" service systems capable of responding to most or all of the needs of individuals with co-occurring disorders, including their needs for physical health care. While some necessary services may be contracted out to other community agencies (e.g., psychiatric consultation, physical examinations), each of these agencies maintains overall

responsibility for developing and implementing a comprehensive service plan.

(b) treatment is person-centered. These sites strive to maintain a seamless service system where there is "no wrong door" point of entry.

(c) treatment is flexibly organized. This project intentionally avoided defining integrated services because it sought to assess the broadest possible range of what are, in the opinion of staff and observers alike, successful service systems. These 9 sites offer mental health and substance abuse services that are delivered by one clinician within a service component, by a cross-trained clinical team within one agency or by close collaboration and clear and shared responsibilities with sister agencies.

(d) they recognize that persons with co-occurring disorders have been treated by both mental health and substance abuse services systems for some years. What appears to be shifting is the capacity of service agencies to respond effectively to the needs of this population. Consequently, these sites share a reliance upon the unique strengths of both substance abuse and mental health communities, in their common commitment to maintain the strongest systems of care.

(e) they see outreach to other agencies in their communities who can help them create, maintain and strengthen co-occurring services as critically important. This report describes many of the ways in which these sites reach out to their communities in collaboration.

(f) each has made a commitment to maintain the highest levels of quality in serving clients by continually seeking ways to evaluate and improve integrated services.

(g) cross-trained program staff are prepared to offer clinical intervention for both mental health and substance use disorders as a cohesive and mutually-responsible team, irrespective of their own orientation or background and whether or not they operate within a single-service agency or in a co-located program environment.

Clients/Consumers

- Individuals with co-occurring disorders are present in all quadrants of the conceptual framework. Their recovery occurs in a dynamic and non-linear fashion. Staff engage with clients wherever they are. There is a general appreciation of the "small" steps taken in the recovery process.

- Clients interviewed repeatedly identify the importance of the relationship with "their" therapist, case coordinator, or counselor. They believe that no matter what, staff will not abandon them. Although criminal or threatening behavior may ultimately lead to discharge, programs are remarkable for the strength of those relationships that are constructed and maintained between staff and clients under almost all circumstances.

- ♦ Clients express a sense of hope about their recovery, often for the first time in long and difficult histories.

Workforce

- ♦ Staff are cross-trained in both mental health and substance abuse disciplines and in cultural competency. They operate with a healthy respect for the contributions of each field -- to appreciate their mutual strengths, to maintain a healthy skepticism regarding the claims made by each discipline and to understand their common ground rather than to try to convert one another. Each disability is considered a primary disability that requires a comprehensive, integrated clinical response.

- ♦ Agency staff <u>expect</u> that their clients will present to them with a full range of co-occurring symptoms and disorders. They are prepared for the multiple challenges that co-occurring disorders present and they have assumed responsibility for their lead role in helping individuals effectively cope with their co-occurring disorders.

- ♦ The agency and its staff retain responsibility for the client. Even though some services related to co-occurring disorders may be delivered by staff of other agencies (e.g., vocational support, housing, etc.), these program sites always see the client as "theirs" and coordinate all treatment.

- ♦ Staff describe their stance as "intelligent caring", suggesting that successfully working with these individuals requires both head and heart.

Screening and Assessment

- ♦ Agencies recognize that the complex needs of persons with co-occurring disorders of mental health and substance abuse and increasingly, HIV, physical and sexual trauma, brain disorders, physical disabilities, etc., require that each agency be capable of performing a comprehensive screening and clinical assessment to determine the nature and extent of problems requiring attention.

- ♦ Programs use a variety of screening and assessment instruments[*], although they indicate that further work is necessary to develop instruments that are targeted specifically to persons with co-

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[*] Substance Abuse Subtle Screening Inventory (SASSI); Simple Screening Instrument for AOD (SSI); Brief Psychiatric Rating Scale (BPRS); Triage Assessment for Addictive Disorders (TAAD); Mental Health Screening Form (MHSF); Self-Administered Alcoholism Screening Test (SAAST); Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

occurring disorders and are appropriately validated.

- Initial screening may result in the decision to engage the client in the co-occurring service delivery system. A more comprehensive assessment is often completed after a period of weeks and even months that then serves as the basis for the agency's decision:

    (a) to offer the client all required services directly, within a single agency - i.e., a fully integrated service system; or,

    (b) to offer the client some of the needed services directly, with additional required services delivered in close coordination with other community agencies. The "home" agency retains responsibility for the overall service plan and for service delivery.

This decision-making process, based upon a comprehensive screening and assessment phase (which often includes consultation with other community agencies), defines the concept of "no wrong door" entry into a service delivery system.

Clinical Intervention

- Patient-driven services are seen as key to successful treatment outcomes for persons with co-occurring disorders. Consequently, interventions are matched to the client's stage of recovery and unique needs for service.

- Programs operate with a "corporate culture", which keeps them on the cutting edge of practice developments, consistently asking, "What more can we do?"

- There is a shared responsibility for clients. A team approach to clinical intervention is common, which tends to generate a "flexible accountability" that allows for creativity and staff support. Intensive ongoing supervision is generally available.

- Staff do not operate outside of their fields of expertise, but rather refer individuals to someone with the skills to provide the necessary clinical intervention.

CONCLUSIONS AND RECOMMENDATIONS

"We seek common ground as we build systems around client needs."

The National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Directors fully appreciate the challenges faced by local mental health and substance abuse programs that decide to expand their capacity to more effectively serve persons with co-occurring disorders.

The agencies participating in this project use a variety of successful approaches to developing and delivering integrated services for persons with co-occurring disorders. In some cases, the agency delivers virtually all of the services needed by the population. Other agencies have developed their core co-occurring service functions and then closely coordinated with other community agencies to arrange for any necessary additional services. All agencies have developed and support their integrated co-occurring services by using multiple sources of federal, state and local funds in innovative and productive ways.

At its meeting in November 2001, the NASMHPD-NASADAD Task Force considered the fiscal and clinical operations of these agencies and articulated a set of fundamental assumptions on which further development of integrated services for occurring mental health and substance use disorders can be based.

#1 *The value of the conceptual framework lies chiefly in the opportunity it presents to raise important questions regarding what is expected regarding a service system's capacity to respond effectively to the needs of persons with co-occurring disorders.*

#2 *Consumers with co-occurring disorders are currently seen throughout the mental health and substance abuse systems, in all quadrants of the conceptual framework. Their recovery depends, in part, on how effectively service agencies respond to their needs. Agency capacity to fully and effectively respond to the needs of persons with co-occurring disorders varies widely across the country.*

#3 *Significant improvement can be made <u>within existing service delivery structures and financing mechanisms</u> to strengthen and expand integrated services delivery for persons with co-occurring mental health and substance use disorders.*

#4 *State and federal mental health and substance abuse authorities can create the organizational and financial environments needed to strengthen integrated co-occurring service systems capacity. This includes reducing or eliminating any licensing and financing barriers that currently inhibit development of integrated co-occurring mental health and substance abuse services. The more difficult it is for agencies to develop, finance and deliver effective and integrated co-occurring services, the less likely they will be to move in that direction.*

#5 *The needs of persons with co-occurring mental health and substance use disorders are complex and require effective intervention from a number of different systems and agencies. Failure to effectively meet the needs of individuals with co-occurring disorders is likely to result in those individuals entering other service systems (e.g., corrections) and generating additional "downstream" service costs.*

#6 *While differences exist in training, staffing, ideology, funding, and program orientation, our most important shared objective as mental health and substance abuse authorities is the desire to improve the health of the nation's citizens by strengthening the "core" capacity of co-occurring mental health and substance abuse service delivery systems.*

Members of the NASMHPD-NASADAD Task Force on Co-Occurring Mental Health and Substance Use Disorders recommend that the following steps be taken to move mental health and substance abuse systems forward in ways that are fully consistent with their fundamental assumptions.

Recommendation # 1 Examine Models of State/Local Collaboration

State and federal agencies should continue their collaboration to examine various models of state-local financial partnerships that support development and delivery of integrated and effective co-occurring services. Future collaborative efforts might respond to the following questions:

(a) What state-local financial partnerships exist?
(b) How do they operate?
(c) How are they financed?
(d) What outcomes do they produce?
(e) How can various approaches be adapted for use by other systems?

Models for further study include:

1. The Pennsylvania MISA pilot project which uses block grant funds and targeted state funding to bring about long-term systems change. The program uses three separate fiscal budgeting and tracking streams and unique client identifiers to report outcome data.

2. The Arizona Integrated Treatment Initiative which is based upon the deliberations of a diverse consensus panel charged with guiding systems change. The program "braids" state appropriations, tobacco settlement funds and SAPT and CMHS Block Grants to promote the development of co-occurring services.

3. The New Mexico systems change initiative designed to create incentives for local program development of integrated co-occurring services.

4. The New York State Dual Recovery Model which establishes full-time "coordinators for dual

recovery services" in selected localities across the state that are jointly funded and monitored by the New York State Office of Alcoholism and Substance Abuse Services and the New York State Office of Mental Health.

5. Connecticut's recognition, respect and utilization of the expertise and traditions of both substance abuse and mental health professionals in its ongoing efforts to bring about major systems change in co-occurring services.

6. The Ohio CAM program is a clinical extension of the School of Medicine in Wright State University. As such, the project can bring additional resources and funding availability to a program which has greater flexibility to be innovative and individualized in services. It also has the opportunity for recruiting a wider range of individuals in serve in clinical capacities.

Recommendation # 2 Review Licensure and Regulatory Requirements

States should conduct a comprehensive review of their licensure and regulatory structures to better understand the ways in which they might be made more supportive of integrated co-occurring service development and delivery. Examples include:

(a) The application of clear, consistent and collaboratively-developed standards that can be applied to agencies providing co-occurring mental health and substance abuse services;

(b) Coordinated or integrated licensure and certification site reviews;

(c) Staff licensure and certification programs to develop the basic staff competencies necessary to effectively treat co-occurring mental health and substance use disorders (e.g., CT, IL, NY).

Recommendation # 3 Analyze the Financial Impact of Integrated Services

Federal, state and local authorities should collaborate to document the impact of integrated co-occurring service delivery models in reducing overall system expenditures for persons with co-occurring mental health and substance use disorders. Such a study should examine the costs savings of reduced incarceration when integrated services are appropriately provided in mental health, substance abuse and correctional settings.

Recommendation # 4 Identify Fiscal Incentives for Providing Co-Occurring Services

States should explore and share the full range of financial incentives that can be used to reward programs that strengthen their capacity to serve persons with co-occurring disorders (including physical and cognitive disabilities). Financial incentives should be targeted to help agencies maintain their ability to meet the needs of persons in Quadrant IV ("high MH /high SA") and enhance the ability of agencies to meet the needs of

persons in Quadrants II ("high MH/low SA") and III (high SA/low MH) – i.e., move toward the ASAM concept of dual diagnosis "capable" and dual diagnosis "enhanced" systems. Examples of such incentives include:

(a) state contracts that identify persons with co-occurring mental health and substance use disorders (including children and adults) as a priority population to be assessed and served;

(b) contracts that offer financial rewards to agencies that utilize evidence-based practices;

(c) funding pilot programs that use creative strategies to develop and deliver co-occurring services.

Recommendation # 5 Review Existing Finance Practices

States should review the ways in which their financing practices either inhibit or support the development and delivery of co-occurring services. Examples include:

(a) criteria for populations/disorders that unnecessarily restrict eligibility for service reimbursement. For example, the Axis II diagnoses often associated with persons with co-occurring mental health and substance use disorders do not fall within most state definitions of "serious mental illness" and cannot, therefore, be reimbursed through all available state and federal funding streams;

(b) reimbursement rates that do not adequately reimburse for the full range of services required to effectively meet the needs of persons with co-occurring disorders;

(c) requiring an "either/or" approach to diagnosis or service coding that, although it allows for reimbursement, prevents an accurate depiction of the full extent of co-occurring disorders encountered within systems. For example, billing for the comprehensive mental health and substance abuse services required by individuals with co-occurring disorders can occur either under primary mental health or under substance abuse diagnoses, but not some combination of the two that would reflect the range of co-occurring services needed and the system's response.

Recommendation # 6 Deliver Technical Assistance to States

The federal government should provide technical assistance and support to states in examining and changing regulatory, licensing and financial systems to support and encourage development and delivery of co-occurring services.

Recommendation # 7 Confirm Aggregate Block Grant Auditing and Tracking

SAMHSA should confirm that tracking and reporting on the use of block grants can be done in the aggregate. That is, that separate identification of the mental health and substance abuse services delivered at the client level is not required and that tracking of funds supporting delivery of co-occurring services need not be detailed at the client level.

Implementing these recommendations will require additional resources or resource reallocation at national, state and local levels. As representatives of the nation's public mental health and substance abuse service systems, NASADAD and NASMHPD are committed to collaborating with their partners in order to secure the funding necessary to implement these recommendations.

APPENDIX A

SAMHSA Position on Treatment for Individuals with Co-Occurring Addictive and Mental Disorders (June 16, 1999) - http://www.treatment.org/topics/dual.html

It is widely recognized that people with co-occurring addictive and mental disorders are a large and significantly underserved population in this country. These individuals experience multiple health and social problems and require services that cut across several systems of care, including substance abuse, mental health and primary health care services, as well as a host of social services. Many people with co-occurring disorders are homeless or located within the criminal justice system. None of these systems of care is, on its own, well equipped to serve individuals with co-occurring addictive and mental disorders. At the same time, new evidence is emerging from the research community about effective services that can have substantial positive outcomes for people with co-occurring disorders.

Historical barriers to improving services to people with co-occurring disorders have included definitional problems (e.g., how to define "integrated treatment" or "co-occurring disorders"), lack of prevalence data, philosophical differences between the substance abuse and mental health fields, and concerns over adequacy of resources and/or the ability to access resources. While these barriers remain problematic in some areas, particularly the lack of resources, an atmosphere of collaboration is growing within the mental health and substance abuse fields as both fields recognize the critical need for effective treatment for co-occurring disorders, the multiplicity and complexity of problems experienced by people with co-occurring disorders, and the need to draw on the strengths of both fields in addressing these problems.

In June 1998, SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) supported a dialogue among representative State Substance Abuse and Mental Health Directors through the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD). A major outcome of that meeting was a conceptual framework for considering the issue of how best to serve people with co-occurring addictive and mental disorders. This framework is based on recognition of the multiplicity of symptoms and variations in severity of dysfunction related to co-occurring addictive and mental disorders, thereby encompassing the full range of people who have co-occurring addictive and mental disorders. The framework specifies three levels of service coordination--consultation, collaboration or integration--which can improve consumer outcomes across the population of individuals with co-occurring addictive and mental disorders. The model represents a major step forward in conceptualizing the issue, and adoption of the three levels of coordination as currently depicted in the model would be a substantial improvement in treatment for individuals with co-occurring disorders.

SAMHSA enthusiastically supports the conceptual framework that has been developed by the State Directors, in particular the framework's definitional reliance on the severity of functional impairment and the framework's ability to capture all levels of functional impairment related to substance abuse and

mental disorders. This framework establishes a shared basis for defining terms and conceptualizing the issue, which is an essential precursor to engaging in a dialogue to build consensus about how best to treat people with co-occurring disorders. SAMHSA is continuing to work with NASADAD, NASMHPD, the State Directors, provider organizations, consumers and families of consumers to further refine the framework, build consensus and begin to implement the changes that are needed to improve outcomes for individuals with co-occurring disorders.

Development of the State Directors' conceptual framework involved substantial review of the scientific literature that is currently available on co-occurring addictive and mental disorders. Most research in this area is focused on the population of individuals who have both a serious mental illness and a severe substance abuse disorder, a population for which the scientific evidence suggests that an integrated approach to care may be best. Among the critical needs with regard to co-occurring disorders is the need for additional knowledge and research regarding the effective and efficient delivery of services to people who have co-occurring disorders but do not have both a serious mental illness and a severe substance abuse disorder. The State Directors' framework identifies consultation and collaboration as two potential approaches to coordinating care for these individuals.

A consultative approach involves informal relationships among providers that ensure that both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention and early intervention. This approach may be most appropriate for individuals with less severe substance abuse disorders as well as less severe mental disorders. A consultative approach would also be appropriate for those who do not have, but may be at risk for, substance abuse and/or mental disorders. An example of the consultative approach to coordination of care might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.

The collaborative approach involves more formal relationships among providers that ensure both mental illness and substance abuse problems are addressed in the treatment regimen. The State Directors envision this approach as being most appropriate for individuals with either a severe substance abuse disorder or a serious mental illness who have a co-occurring, but less severe, mental illness or substance abuse disorder. An example of the collaborative approach to coordination of care is the use of interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co-occurring disorders and contribute to service delivery.

With regard to integrated treatment, SAMHSA agrees that, as depicted in the framework developed by the State Directors of mental health and substance abuse services, individuals with two or more severe, independent but co-occurring addictive and mental disorders, may best be served through an integrated approach to treatment. SAMHSA encourages and supports the development, delivery and evaluation of integrated service models for the treatment of people with severe co-occurring disorders as described in the framework developed by the State Directors. In making this statement, SAMHSA strongly

emphasizes the need to be clear about what constitutes "integrated treatment."

There is no single set of treatment interventions that constitute integrated treatment for people with severe co-occurring addictive and mental disorders. Integrated treatment includes an array of appropriate substance abuse and mental health interventions identified in a single treatment plan based on individual needs and appropriate clinical standards and provided or coordinated by a single treatment team. Integrated treatment embodies several key principles in the delivery of services to people with co-occurring disorders. These principles include the following:

- Integrated services for people with co-occurring disorders should take a "no wrong door approach" to services. That is, services must be available and accessible no matter how or where an individual enters the system.

- Individuals should have access to a comprehensive array of services appropriate to their needs. Treatment for co-occurring disorders should be individualized to accommodate the specific needs of different subtypes and different phases of treatment for all established diagnoses. Recent scientific evidence suggests that assertive outreach and motivational interventions (i.e., to engage people in treatment and keep them in treatment) for substance abuse are necessary components of effective integrated treatment programs for individuals with co-occurring disorders.

- Services should be consumer-focused and consumer-family centered. Services should be provided in a manner that welcomes individuals with co-occurring disorders and their families at every level.

- Staff in settings providing integrated treatment should be fully oriented in each other's disciplines. Individuals with co-occurring disorders should be able to receive services from primary providers and case managers who are cross-trained and able to provide integrated treatment themselves.

- Administrative functions should not become a barrier to the integration of treatment.

The approaches to providing integrated treatment will of necessity be varied due to the diversity of clients who need services and the unique characteristics of the communities in which they are delivered.

The dialogue currently taking place regarding treatment for people with co-occurring disorders exists within a context of many factors which affect services delivery. A major concern in achieving improvement in the treatment of co-occurring disorders (and indeed improving substance abuse and mental health services generally) is the severe lack of resources for both substance abuse and mental health services. Improving access to adequate funding, including third party insurance, Medicaid, Medicare and other Federal and State fiscal resources, is a necessary aspect of the drive to improve the services that are delivered. The many service delivery systems which are affected by and involved in the delivery of services to people with co-occurring disorders must work together, in respectful partnership, to achieve the changes that are needed. Improvements will not be achieved without recognition of the strengths each sector brings to the table and respect for the values, professional standards and achievements each sector has developed.

A second issue relating to the delivery of services to this population is the perception by some that

the separate reporting requirements for various sources of funding (e.g., Medicaid, State funding, Federal mental health and substance abuse block grant funds, Federal discretionary funds) are burdensome and may inhibit the delivery of services. Particular concerns have been expressed about the reporting requirements associated with Federal block grant programs. SAMHSA issued a position statement in February 1999 that clarifies that, specifically the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds and Community Mental Health Services Block Grant (CMHSBG) funds may be used to provide services for people withco-occurring disorders as long as those funds are used for the purposes for which they are authorized by law and can be appropriately tracked for accounting purposes. SAMHSA is working with States and providers to ensure that the reporting requirements associated with SAMHSA funds do not present an undue barrier to providing services, including integrated treatment, for people with co-occurring disorders. Technical assistance is available through the Block Grant programs for States that need help in using Block Grant funds effectively to provide services for individuals with co-occurring substance abuse and mental health disorders, including integrated treatment.

SAMHSA's activity with regard to co-occurring disorders is extensive and varied. SAMHSA has funded a range of discretionary grant programs to identify and evaluate models of services delivery for a variety of populations with or at risk for co-occurring disorders. Some of these projects have been focused exclusively on co-occurring disorders, while others include co-occurring disorders within the context of a broader set of issues. SAMHSA's block grant funds have been utilized by several States to provide services to individuals with co-occurring disorders. SAMHSA has also engaged in an array of policy-related activities intended to advance the development of services for people with co-occurring disorders, including extensive consultation with SAMHSA and Center Advisory Councils.

SAMHSA recognizes that much remains to be done to achieve the systems changes that are needed to adequately serve individuals with co-occurring disorders. SAMHSA is committed to working collaboratively with the substance abuse and mental health fields to effect these changes. SAMHSA will continue to foster further discussion among all involved stakeholders on the organization, provision and funding of treatment for co-occurring disorders; fund research and evaluation on co-occurring disorders and appropriate treatment methods, including integrated treatment; support training and technical assistance initiatives to improve service system capabilities; and work with States and all other interested parties to develop best practices and guidelines to improve the care of individuals with substance abuse and mental disorders.

1. Drake, et al. "Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders. "Schizophrenia Bulletin. Vol. 24. No. 4. 1998. pp. 589-607.

SAMHSA Position on SAPTBG and CMHSBG Funds
to Treat People with Co-Occurring Disorders (2/11/99):
http://www.samhsa.gov/2000archive/news/content2000/whatsnew/saptbg.htm

SAMHSA is committed to improving services for individuals with co-occurring substance abuse and mental illness. As discussed in greater detail below, States may use the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Services Block Grant (CMHSBG) funds to provide services for individuals with such co-occurring disorders. SAMHSA is very interested in working with States to identify ways to facilitate local provision of the full array of services needed by individuals with substance abuse and/or mental disorders, while assuring that the requirements are met for both block grants.

The statutes and applicable regulations pertaining to the SAPTBG and CMHSBG clearly permit those funds to be used to provide treatment services for individuals with co-occurring substance abuse disorders and mental illnesses in a variety of treatment settings, including settings where integrated services are delivered. However, all funds must be utilized in accordance with the specific regulatory and statutory requirements that govern the funding source, including the purposes for which the funds are authorized, and the reporting and audit requirements.

- SAPTBG funds must be used for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse.

- CMHSBG funds must be used for the purpose of carrying out the State plan for comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbances; for evaluating programs and services carried out under the plan; and for planning, administration and educational activities related to providing services under the plan.

SAPTBG and CMHSBG funds <u>may not</u> be blended in such a way that would render use of those funds subject to only the statute and regulations governing one or the other source of funding. SAPTBG and CMHSBG funds may be provided by the States to service providers for treatment services for individuals with co-occurring disorders. In such instances, the funds from each funding source (i.e., SAPTBG and CMHSBG) must be allocated to the program based on the purposes for which the funds are authorized--that is, in treating this co-occurring disorder population, SAPTBG funds may be used to provide substance abuse treatment services, and CMHSBG funds may be used to provide mental health treatment services so long as such services are provided to adults with serious mental illness or children with serious emotional disturbances as defined at 58 Fed. Reg. 29425 (May 20, 1993). Funds from each block grant must be allocated in a manner which allows them to be appropriately tracked for accounting purposes.

It should be noted that SAPTBG funds may be used for substance abuse prevention activities for those who are at risk of developing co-occurring substance abuse disorders and mental disorders. To the extent that States use the SAPTBG 20% primary prevention set-aside for such activities, they must use such funds in accordance with the statutory and regulatory requirements which govern this set-aside.

There currently exists a significant gap between the need for substance abuse and mental health services and the availability of those services. SAMHSA has an obligation to address the needs of individuals with substance abuse disorders and mental illnesses who do not have co-occurring disorders as well as individuals who do have co-occurring substance abuse disorders and mental illnesses. In clarifying the agency's position with regard to use of the SAPTBG and CMHSBG funds, SAMHSA is not altering the responsibility, authority, and flexibility of the States to determine the allocation of block grant funds to support services in programs for individuals with co-occurring disorders.

1. However, CMHSBG funds may not be used for inpatient services, and SAPTBG funds may not be used for inpatient hospital services except if it is a medical necessity as defined by the law and applicable regulations.

Appendix C

December 27, 2000

XXXXX, Director
Department of Mental Health OR
Department of Alcohol and Substance Abuse
YYYYY
YYYYY

RE: Identification of Model Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Abuse Disorders

Dear XXXXX:

As you know, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) have collaborated closely in recent years to help strengthen working relationships between the mental health and substance abuse treatment communities. These efforts have resulted in:

- creation of the joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders;
- a conceptual framework for developing co-occurring programs and services;
- a briefing paper on financing and marketing the new conceptual framework;
- a PowerPoint presentation which explains the conceptual framework; and
- brief case studies of innovative programs serving persons with co-occurring disorders.

You and your state agency have been key to the success of these efforts. While these activities support ongoing positive and long-term systems change, a major question still to be answered is: *"How can integrated services for person with co-occurring services be financed?"* Answering that question practically and accurately is the objective of this project.

With support from the Center for Mental Health Services and the Center for Substance Abuse Treatment, NASMHPD and NASADAD are coordinating an exciting new national effort to identify 6-10 exemplary programs that are delivering integrated mental health and substance abuse treatment services by securing and using multiple sources of funds. **We will work closely with these programs to understand and document how they are successfully financing effective integrated services for persons with co-occurring disorders. This information will then be provided to states and communities who are considering their own challenges and opportunities in financing services for this population.**

Our first step will be to identify integrated service programs across the country from which the smaller group of in-depth case studies can be drawn. This is where we need your help. Please use the attached form to **tell us by Monday, January 15** which service programs in your state are successfully providing and financing integrated services to persons with co-occurring disorders. We will contact them directly and then choose a small number to work with in developing detailed case studies during the coming year.

We hope and expect that this exciting project will contribute significantly to the ongoing efforts of many individuals and organizations as they work to meet the needs of persons with co-occurring mental health and substance abuse disorders. Project activities are being coordinated by Bruce Emery. Please contact Bruce directly at (703) 532-9799 or emerybd@msn.com with any questions.

Thanks again for your willingness to work with us in accomplishing this important goal.

Sincerely yours,

Robert W. Glover, Ph.D.
Executive Director
NASMHPD

Lewis Gallant, Ph.D.
Executive Director
NASADAD

cc: Joint Task Force on Co-Occurring Disorders
Michael English, J.D., CMHS
Jane Taylor, Ph.D., CSAT
Bruce D. Emery, M.S.W.

National Association of State Mental Health Program Directors
National Association of State Alcohol and Drug Abuse Directors

Case Studies of Exemplary Methods of Financing Integrated Services for Persons with Co-Occurring Mental Health and Substance Abuse Disorders

CASE STUDY SITES
2001-2002

Study Site	Contact	Description
Access Team Maine Medical Center Portland, Maine	Paul Renucci, Ph.D., Team Leader T - (207) 780-0020 F - (207) 780-0022 olived@mmc.org	In operation since 1993, funded through Medicaid and general revenue through SMHA and SAOD at $576K/yr. Program serves 50 dual diagnosis clients in long-term intensive treatment who have high utilization of ER, detox and homelessness. ACT model modified for dual diagnosis. Licensed in both MH and SA.
Access-West Philly MH Association of SE Pennsylvania Philadelphia, PA	Christine Simiriglia, Director Residential and Treatment Services T - (215) 557-0434 F - (215) 636-6300 csimiriglia@mhasp.org	One in 1994 as of 18 CMHS-funded ACCESS sites, currently funded by county behavioral health and fee-for-services. Outreach, case management and engagement for homeless SMI, addicted population. Modified PACT model, “service on demand.”
New Directions for Families Arapahoe House Intensive Residential Treatment Thornton, CO	Nancy Van DeMark, COO T - (303) 657-3700 F - (303) 657-3727 nancy@ahinc.org	Operating since 1995, originally funded by CSAT under residential women and children’s demo. Serves 16 families with current budget of $1.3m thru state AOD (BG and general funds). Mgd care structure, contracts with DSS (TANF and child welfare), some Medicaid.
Arlington County MH and SA Services Arlington, VA	Ed Hendrickson, Clinical Supervisor T - (703) 228-4913 F - (703) 228-5324 ehendr@co.arlington.va.us	County-based comprehensive system with dual diagnosis services instituted in 1982. Both mental health and substance abuse components have capacity to provide integrated services (i.e, “no wrong door”). Multiple sources of funding. Award-winning program, published staff.
Consumer Advocacy Model Wright State University Dayton, OH	Dennis Moore, Ed.D., Coordinator T - (937) 775-1484 F - (937) 775-14 95 dennis.moore@wright.edu	University-based services program serving urban area. Started in 1994, current active caseload of 100+ with substance abuse disorders and other disabilities (50% SMI). Certified MH and SA provider through regional authority.

Dorchester County Detention Center Cambridge, MD Maryland Dual Diagnosis Services Annapolis, MD	Steven Williams, Warden T - (410) 228-8101 F - (410) 221-0424 swilliams@shorenet.net Joan Gillece,Ph. D., Dir. Special Needs Pop. T - (410) 724-3238 F - (410) 724-3239 gillecej@dhmh.state.md.us	Dorchester County is one of 22 state counties funded through state, federal and local resources to provide case mgt, treatment and housing, services to persons with co-occurring disorders involved in criminal justice system. Selected by National Institute of Corrections as a national model.
Foundations Associates Nashville, TN	Michael Cartwight, Executive Director T - (615) 345-3216 F - (615) 256-9005 foundati@bellsouth.net	Not-for-profit licensed in 1995 by department of Mental Health/Mental Retardation and Bureau of AOD Services. Comprehensive 74-bed treatment, housing and educational services serving 1800/year with $2.6million budget from CSAT, CSAP, block grants, Department of Mental Health, TennCare, VR and others.
Harris County Dual Diagnosis Project Houston, TX Texas State Dual Diagnosis Initiative Austin, TX	David Lewallen, Dual Disorders Grant Mgr T - (713) 970-3429 F - (713) 970-3308 david.lewallen@mhmraharris.org A.J. Ernst, Dual Diagnosis Project Coordinator T - (512) 206-4763 F - (512) 206-4784 aj.ernst@mhmr.state.tx.us	Comprehensive county-based dual diagnosis initiated through a state-funded pilot (expanded from 5 pilots in 1996 to 15 currently) operating with multiple sources of funding from both MH and SA systems.
Human Services Center Peoria, IL	Michael Boyle, Executive Vice-President T - (309) 671-8025 F - (309) 671-8007 mboyle@fayettecompanies.org	Not-for-profit, comprehensive service site operating since 1976, with fully integrated services using multiple funding sources. Currently moving toward Medicaid billing for dual diagnosis services.

APPENDIX E

Center for Mental Health Services
National Association of State Mental Health Program Directors
Project on Co-Occurring Mental Health and Substance Abuse Disorders
FY 2001-2002

Project Objectives:

- To identify and document exemplary programs that deliver integrated mental health and substance abuse treatment services to persons with co-occurring disorders by using multiple sources of funds.

- To develop 6-8 detailed case studies that identify successful funding and fiscal accounting strategies that permit blending multiple funding streams at the provider level.

- To provide specific, well-documented examples of how states and localities can organize and finance effective services for persons with co-occurring disorders.

Site Visit Protocol

This project is funded by the Center for Mental Health Services to help support long-term systems change in serving individuals with dual disorders. While no one set of solutions applies throughout the country, many of the lessons learned in recent years by experienced co-occurring service providers can clearly guide community, state and federal agencies working at improving services for this population.

Our focus is on community programs largely because there has been some success in developing local programs that effectively serve persons with co-occurring disorders in integrated settings. We are hoping to explore the experience of 6-8 of these programs to learn how they operate administratively and clinically. The project will also focus on the regional and state systems within which these programs function and on ways in which those larger systems support the work of community programs.

Project staff will work with these participating sites over a period of several weeks to gather information and understand local operations. Site visits with single organizations are planned for one working day; site visits that involve two or more affiliated organizations are likely to involve additional time. Site visit team members (on average, two-three per site) will focus on fiscal, organizational and clinical areas.

Participating sites will receive a list of questions in advance of the team's visit. Team staff would like to meet with the CEO, CFO, Clinical/Program Director and selected line staff during

the visit. Information may be gathered before or after the visit. Draft case study reports will be developed by project staff and sent to the program for review, revision and comment. Staff will generate project-wide conclusions and recommendations for inclusion in the overall case study report.

The following areas will be explored with each participating site:

Clinical

- definition of co-occurring disorders
- % of individuals on caseload with co-occurring diagnoses
- geographic area covered by program
- socio-economic characteristics of population
- philosophy or principles that guide services (e.g., etiology of disorder; consistency with conceptual framework)
- program development/history (e.g., incentives, barriers, solutions)
- criteria that clients meet to be enrolled/stay enrolled in integrated co-occurring program
- description of services provided
- nature and type of formal and informal linkages between co-occurring services and other programs and services within the program and in the community
- description of services provided and program model ; are particular program models tied to particular funding mechanisms?
- clinical standards of care followed (e.g., size of caseloads for optimal care, standardized assessments; cultural competence)
- nature of clinical record keeping/documentation for tracking source of payment (e.g., MH and SA block grant, Medicaid, county, etc.)
- internal clinical and administrative auditing strategies
- staff composition
- training and education of clinical staff
- staff turnover rates
- evaluation results (i.e., how do we know clients are benefiting from our services?)
- plans to further strengthen services

Fiscal

- sources and amounts of resources to support co-occurring services, for 3 years and YTD:
  1) State general revenue
  2) Federal SAPT block grant
  3) Federal MH block grant
  4) Medicaid
  5) County funds
  6) Charitable contributions
  7) Client fees

8) Foundations
9) Other

- sources of initial "venture capital"
- fee/rate schedules
- business office staffing
- surplus or loss (i.e., amount of subsidy required at various stages of development)
- accounting practices across the period (e.g., co-occurring as separate cost center)
- fiscal reporting to purchasers (e.g., tracking use of MH and SA block grant funds)
- fiscal compliance strategies (e.g., successful ways that fiscal and auditing standards have been met, outstanding concerns)
- state and system level incentives and barriers to serving persons with co-occurring disorders in integrated setting

Advocacy

- involvement of advocacy community
- relationships with related service agencies (schools, criminal justice, employers, public welfare, etc.)

Management and Administration

- relationship with regional and state authorities: purchasers, regulators, leaders
- securing resources (e.g., money, staff, facilities)
- nature and type of existing regional or state co-occurring pilot efforts?
- management practices and policies that guide service delivery
- internal management/organizational structure (e.g., org. chart)
- inter-organizational relationships
- state requirements for co-occurring services
- ability to justify integrated co-occurring services on basis of cost effectiveness

Observations and Recommendations

- clinical or administrative recommendations to better support service delivery and financing
- system incentives and disincentives that exist in the system of care
- any special conditions that exist locally which might affect feasibility of replicating chosen approach in different environments
- assessment of extent to which exemplary program could be replicated outside of its current environment; conditions that would have to exist for successful replication
- general program "advice to colleagues"

APPENDIX F

National Dialogue on Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Abuse Disorders

NASMHPD-NASADAD Task Force
on Co-occurring Mental Health and Substance Use Disorders
November 20, 2001
Club Quarters Hotel
Washington, DC

Sponsored by:
National Association of State Alcohol and Drug Abuse Directors (NASADAD)
National Association of State Mental Health Program Directors (NASMHPD)

Supported by:
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Center for Substance Abuse Treatment (CSAT)

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