Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders:

A Blueprint for Systems Change

Final Report

Second National Dialogue of the
Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders
June 22-23, 1999
Washington, DC

Sponsored by:
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April 2000

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ACKNOWLEDGMENTS

The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) are pleased to present this report of the June 1999 meeting of their Joint Task Force on Co-Occurring Mental Health and Substance Abuse Disorders. Established in 1998, the Task Force guides the Associations' program-related efforts to help ensure that the needs of individuals with co-occurring mental health and substance abuse disorders are identified and met throughout the nation.

Participating State Alcohol and Other Drug Directors included Michael Couty (MO), Christie Dye (AZ), Lewis Gallant, Ph.D. (VA, Co-Chair), Elizabeth Howell, M.D. (GA), Thomas Kirk, Ph.D. (CT) and Mayra Rodriquez-Howard (MA). Mental Health Commissioners included Sharon Autio (MN), Paul Gorman, Ed.D. (NH), Stephen Mayberg, Ph.D. (CA), James Stone, M.S.W. (NY), Marylou Sudders (MA) and Roy Wilson, M.D. (MO, Co-Chair). We are grateful for the participation and contributions of Paul Barreira, M.D. (MA) and Jeff Davis, M.S.W. (OR), representing the National Association of County Behavioral Health Directors (NACBHD) and Elizabeth Earls (RI), representing the National Council for Community Behavioral Healthcare.

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

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April 2000

EXECUTIVE SUMMARY

Traditional barriers between the mental health and substance abuse systems have too often prevented them from working together on behalf of individuals with co-occurring mental health and substance abuse disorders. That began to change in June 1998, when the first *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* was held.

Two key outcomes resulted from that discussion, which was supported by two Substance Abuse and Mental Health Services Administration (SAMHSA) centers — the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) — and co-sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

First, participants developed **a conceptual framework** that views co-occurring disorders in terms of symptom multiplicity and severity rather than specific diagnoses. The framework specifies the level of service coordination — defined as consultation, collaboration, or integration — needed to improve consumer outcomes. Use of the conceptual framework encourages development and funding of a continuum of care for people with co-occurring disorders.

Second, to further their commitment to work together, participants in the first national dialogue urged their respective national associations to formally name **a joint task force**. This report summarizes the June 1999 meeting of the *Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders,* and the group's progress in finding ways to: 1) finance a system of care for people with co-occurring disorders and 2) market the work of the task force (i.e., the conceptual framework) to help bring about widespread improvements in care for persons with co-occurring disorders.

The June 1999 meeting was also supported by CMHS and CSAT and co-sponsored by NASMHPD and NASADAD. Representatives from the National Association of County Behavioral Health Directors (NACBHD) and the National Council for Community Behavioral Healthcare (NCCBH) provided a unique, local perspective.

Developing and Financing a Comprehensive System of Care

Task Force members stressed that a comprehensive, coordinated system of care for people with co-occurring disorders must be the *expectation*, not the exception. Developing and financing a comprehensive system of care requires a significant commitment of time, creativity, resources, and expertise.

In particular, Task Force members agreed that there is no single set of financing mechanisms that will be appropriate in all cases. They pointed to the lack of an economic model that clearly delineates how the specific levels of coordination reflected in the framework — consultation, collaboration, and integration — should be funded, and what the cost savings (if any) and consumer outcomes of such models might be.

However, Task Force members embraced a set of general principles needed to finance a continuum of care for people with co-occurring disorders that parallel those needed for its creation. These principles include:

- joint purchasing of effective services,
- use of funding combined from multiple sources, and
- adoption of performance-based contracts that align financial incentives and disincentives with system goals.

Marketing the Conceptual Framework

To help further the dialogue, Task Force members discussed ways to market the conceptual framework and financing principles to those who fund, provide, and consume mental health and substance abuse services. The critical marketing messages for funders are that the framework is flexible, cost-effective, client-centered, evidence-driven and can lead directly to the development of best practices.

For providers, the framework is a useful tool, one that will allow them to recognize the full array of a client's symptoms and craft a treatment plan that draws on the expertise found in both mental health and substance abuse systems. The framework's message to consumers is four-fold: we heard your concerns, we are working together to resolve them, we understand the critical need to plan for serving the whole person, and the level of care for people with co-occurring disorders will improve as a result.

Moving Forward

The overarching goal of the Task Force's efforts is to help make appropriate services available for person with co-occurring disorders throughout the country. Each of the key players who participated in the second national dialogue has an important role to play in that broad-based system change. Task Force members encouraged SAMHSA, through its Centers, to support research on treatment models and consumer outcomes; recommended that the States reduce or eliminate financial barriers to serving the needs of people with co-occurring disorders; and urged NASMHPD and NASADAD to begin collecting case studies that illustrate model approaches and best practices for financing and delivering co-occurring mental health and substance abuse services.

Despite the inherent difficulties in financing a comprehensive system of care and marketing the conceptual framework, Task Force members pledged their commitment to move forward together.

By joining forces at the State level — and working in partnership with their Federal funders, national associations, county authorities and community counterparts — State mental health commissioners and State alcohol and drug abuse directors have taken another vital step forward in placing co-occurring disorders at the forefront of the national agenda.

INTRODUCTION

There is no question about the need to improve treatment and support services for people with co-occurring mental health and substance abuse disorders. As a group, these difficult-to-serve individuals tend to have multiple health and social problems, requiring a variety of sometimes costly services. Traditional barriers between the mental health and substance abuse systems — each with its own treatment philosophies, administrative structures, and funding streams — have too often prevented individuals from getting the care they need and deserve.

Though the problems associated with co-occurring disorders have long been acknowledged and discussed, there had been little consensus about how to proceed. That began to change in 1998, when the first *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* was held (see Appendix C for information on ordering the report of that meeting).

Supported by the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), the national dialogue was co-sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Invited participants included State mental health agency commissioners and alcohol and State drug abuse agency directors, representatives of NACBHD and NCCBH, expert panelists, and Federal officials.

A New Paradigm

Participants in the first national dialogue developed a conceptual framework that represents a new paradigm for considering the needs of individuals with co-occurring disorders and the system requirements necessary to address these needs. Among its unique characteristics, as described further in Section I of this report, the framework conceptualizes co-occurring disorders in terms of symptom multiplicity and severity rather than specific diagnoses, thereby encompassing the full range of people who have co-occurring mental health and substance abuse disorders.

In addition, the framework specifies the level of service coordination — defined as consultation, collaboration, or integration — needed to improve consumer outcomes. It does not prescribe specific treatment interventions. This makes it flexible enough to address the needs of all individuals with co-occurring disorders and to be adopted or adapted for use in any service setting.

As a testament to the success of the framework developed during the national dialogue, SAMHSA endorsed the principles the framework embodies in a policy statement on co-occurring disorders released June 11, 1999. The statement reads, in part, "SAMHSA enthusiastically endorses the conceptual framework that has been developed by the State Directors...[it] establishes a shared basis for defining terms and conceptualizing the issue, which is an essential precursor in engaging in a

dialogue to build consensus about how best to treat people with co-occurring disorders" (SAMHSA, 1999).

Further, the framework has already produced one significant outcome. In preparing suggested language for the SAMHSA reauthorization by Congress, NASMHPD and NASADAD agreed that their respective Block Grant funds — the Community Mental Health Services (CMHS) Block Grant and the Substance Abuse Prevention and Treatment (SAPT) Block Grant — could be used to fund services for people with co-occurring disorders as long as funds are used for the purposes for which they are authorized by law and can be appropriately tracked.

An Ongoing Commitment

Development of the framework itself represented the type of collective effort that participants agreed is vital to addressing the needs of people with co-occurring disorders. To further their commitment to work together, State mental health commissioners and State alcohol and drug abuse directors urged their respective national associations to consider formally naming a joint Task Force on co-occurring disorders (see Appendix A for a roster of Task Force members).

This report summarizes the second dialogue held among members of the *Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders* and the group's progress in addressing two key issues that came out of the initial national dialogue: exploring ways to finance a system of care for people with co-occurring disorders and marketing the conceptual framework and financing principles. Subject area experts guided the discussion of financing and marketing principles.

A new feature of the second national dialogue was the participation of representatives from the National Association of County Behavioral Health Directors and the National Council for Community Behavioral Healthcare, which provided a local perspective based on their own unique experiences (see Appendix B for a list of meeting participants).

State mental health commissioners and State alcohol and drug abuse directors who are members of the Task Force exemplify a broad spectrum of treatment, administrative, and funding arrangements. These individuals represent State mental health and alcohol and drug abuse systems that are organizationally separate; those in which mental health and substance abuse agencies are combined; large and small systems; and urban, rural, and mixed geographic areas. Their extensive, collective experience framed the group's discussions.

Financing a System of Care

Use of the conceptual framework encourages development of a continuum of care for people with co-occurring mental health and substance abuse disorders. As described by others, most notably Konrad (1996), relationships among key stakeholders tend to become more formal as a system moves, in this case, from no or limited coordination to consultation, collaboration and integration.

Funding a comprehensive system of care for people with co-occurring disorders requires, first, that policy makers and planners understand the key elements that such a system must address. These include leadership, consensus building, resource identification, staff training, development and implementation of new models, outcome measurement, and evaluation. Task Force members discussed the barriers to putting each of these elements in place, and the solutions they are already adopting to overcome them.

Because each State and community funds mental health and substance abuse services in unique ways, Task Force members agreed that there is no one set of financing mechanisms that will be appropriate in all cases. However, they embraced a set of general principles needed to finance a continuum of care for people with co-occurring disorders, including:

- joint purchasing of effective services,
- use of funding combined from multiple sources, and
- adoption of performance-based contracts that align financial incentives and disincentives with system goals.

Marketing the Conceptual Framework and Financial Principles

The work the Task Force has begun is an evolving process. The conceptual framework has proven its usefulness as a foundation to promote further discussion. Further, it highlights the flexibility it allows policy makers, providers, and funders to plan and fund services for individuals regardless of their specific diagnoses or the current unique structure of the health care delivery system in their State or community.

Task Force members discussed ways to market their work to a broader audience and craft specific messages that will reach key stakeholders concerned about the needs of people with co-occurring disorders. In doing so, they focused on two key questions: 1) Why should the framework matter to them? 2) How can they use it?

Using This Report

This report represents a summary of the Task Force discussions and serves as a companion piece to the original report produced after the first national dialogue (see Appendix C for information on ordering this document). Section I briefly highlights the conceptual framework that formed the basis for the Task Force deliberations.

The key components of developing a continuum of care for people with co-occurring disorders and the barriers to putting these elements in place are discussed in Section II. This section also highlights solutions to development barriers, with specific case examples. Section III describes the financial principles that parallel the system development components.

A number of general marketing principles and specific observations regarding the conceptual framework are highlighted in Section IV. Finally, Section V presents recommendations for future strategies designed to move the national agenda forward, in part through the work of the Task Force. Appendices include a roster of Task Force members, a list of meeting participants, and ordering information for the report of the first meeting that lays out the conceptual framework in greater detail.

SECTION I

An Overview of a Comprehensive System of Care

The conceptual framework for addressing co-occurring disorders developed by participants in the June 1998 *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* formed the backdrop for discussion at the June 1999 Task Force meeting.

The Need for a Common Language

Reaching any type of consensus on treatment and services for people with co-occurring disorders requires that the substance abuse and mental health communities speak the same language. As observers have long noted, there are significant opportunities for language confusion both within and between the two treatment communities. Of particular importance to mental health and alcohol and drug abuse service providers is the need to define specific co-occurring population groups to be served.

Modifying a model originally developed in the State of New York, participants in the first national dialogue formulated a conceptual framework for discussing symptom multiplicity and severity, locus of care, and level of service coordination needed among the mental health, substance abuse, and primary health care systems. Highlighted in Figure 1, the framework effectively responds to the need for a common set of reference points and allows policy makers, providers, and funders to plan and fund services for individuals *regardless* of their specific diagnoses or the current structure of the health care delivery system in their State or community.

The framework represents a new paradigm for considering both the needs of individuals with co-occurring mental health and substance abuse disorders and the system characteristics required to address these needs. Unique features of the approach include:

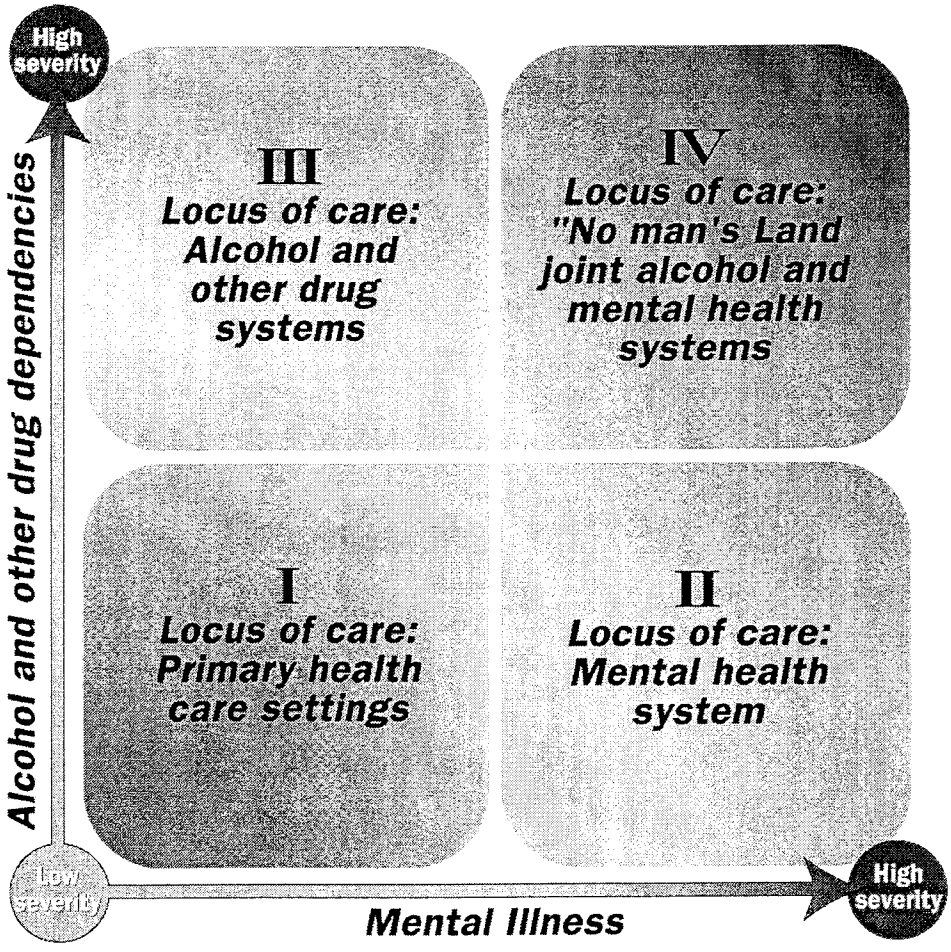
- The framework is based on symptom multiplicity and severity rather than specific diagnoses and uses language familiar to both mental health and substance abuse providers. It encompasses the full range of individuals who have co-occurring mental health and substance abuse disorders. It points to windows of opportunity within which providers can act to prevent exacerbation of symptom severity.

- The framework allows discussion of co-occurring disorders along several dimensions, including symptom multiplicity and severity, locus of care, degree of service coordination and the primary sources of funds associated with each quadrant. The framework also permits a number of key decisions

to flow from it, including the level of service coordination required and the best use of available resources.

Figure 1

New York State generic model of locus of care based on severity of mental illness and alcohol and drug dependencies



- The framework accommodates different levels of service coordination rather than specifying discrete service interventions. It represents a flexible approach that can be adopted or adapted for use in any community or service delivery setting.

- The framework identifies two levels of service coordination — consultation and collaboration — that do not require fully integrated services, pointing to the fact that many individuals can be served with interventions that do not require full service integration. This is important for those service settings in which integration is not feasible or desirable, and for those individuals whose needs can be addressed with a minimum amount of system change.

A Flexible Approach

The underlying assumption of the model is the fact that people with co-occurring disorders vary in the severity of their mental health and substance abuse disorders, from less severe mental health and substance abuse disorders to more severe mental health and substance abuse disorders. Individuals for whom one or the other disorder is predominant are also accommodated within the model.

Participants in the national dialogue recognized that this is a simplified categorization designed to encourage further discussion. Individuals at various stages of recovery from mental health and substance abuse disorders may move back and forth among these categories during the course of their diseases.

Further, the model is based on the fact that these differences in severity determine the service system location in which individuals receive their care. These include the primary health care, mental health care, and alcohol and other drug treatment systems, as well as the criminal justice system, the homelessness service system, and so on.

Use of the model highlights the need for special attention to the needs of three groups of persons with co-occurring disorders: 1) those individuals, especially children and adolescents, whose disorders are not severe enough to bring them to the attention of the mental health or substance abuse treatment systems at this time but who are at risk for developing more serious disease; 2) those individuals engaged in one of the two treatment systems whose severe mental health needs or severe substance abuse needs are being addressed, while the other, less severe aspect of the co-occurring disorder remains a lower priority for treatment; and 3) those individuals with more severe mental health and substance abuse disorders who are likely to be found in inappropriate settings (e.g., jails, homeless), to use the most resources, and to have the worst outcomes.

Finally, the conceptual framework identifies three levels of service coordination among the mental health, substance abuse, and primary health care systems that are required to address the needs of people with co-occurring disorders. These levels of coordination correspond to the level of severity

of the disorder. The greater the severity, the more intense the level of coordination and special expertise required to promote effective service delivery.

The continuum of intensity begins with informal **consultation**, which ensures that both mental illness and substance abuse problems are sufficiently understood by all parties to allow effective identification, engagement, prevention, and early intervention. An example of this type of consultation is a telephone request for information or general advice regarding the origins and clinical course of depression in a person abusing alcohol or drugs. Under this scenario, discussion of a particular client usually does not occur, or if it does, it occurs at a relatively general level.

As the nature of the individual's disabilities requires more specific information and more complex and targeted intervention, providers move to more formal collaboration. This level of working relationship ensures that attention to both mental health and substance abuse disorders is included in the treatment regimen. An example of such collaboration is the interagency staffing conference where representatives of both mental health and substance abuse agencies take part in the development and implementation of a specific treatment program for individuals with co-occurring disorders. A much greater focus is placed upon the creation of an individualized treatment plan that is then implemented under the auspices of one system or the other.

Finally, those individuals with the most severe mental health and substance abuse disorders require service **integration**. There is no single set of treatment interventions that constitute integrated treatment. Instead, the term refers to the availability and delivery of a comprehensive array of appropriate mental health and substance abuse services and interventions that are identified within a single treatment plan, coordinated by a single treatment team and both effective and responsive to the high degree of severity of both mental illness and substance abuse experienced by the client. Under the "no wrong door" approach supported by the Task Force, integrated services should be available, as necessary, through both mental health and substance abuse treatment systems.

Together, these efforts represent a comprehensive continuum of care for individuals with all levels of co-occurring disorders. Use of the framework permits discussion of how such a system should be developed and funded.

Key Components of a Comprehensive System

The framework is a necessary, but not sufficient, piece of the puzzle. Task Force members agreed that to finance such a system, they must first understand the components that have to be addressed and the barriers to implementing them. These concepts are discussed in the next section, along with some suggested solutions and program examples.

SECTION II

Developing a Comprehensive System of Care

A comprehensive, coordinated system of care for people with co-occurring disorders must be the *expectation*, not the exception. Development of such a system is an evolving process that begins with top-level leadership. Key stakeholders must agree on system goals, with a focus on improved consumer outcomes. Staff training is critically important.

These and other key elements of a comprehensive system are discussed in this section, along with some of the significant barriers planners must address. Potential solutions to those barriers and examples of successful system development strategies are highlighted.

Designing a System

Lead the Way

Development of a comprehensive, coordinated system of care for people with co-occurring disorders is an evolutionary process that requires the time to plan, organize stakeholders, train staff, develop services, find resources, and evaluate results. Committed leadership is key to the success of these efforts.

BARRIERS

System change takes time. Often, charismatic or entrepreneurial leaders move a system forward, but the changes they put in place may not outlast their tenure.

SOLUTIONS

- **Seize or create an opportunity for change.**

Leaders in the mental health and substance abuse communities, including those at the State and local level, must seize or create an opportunity to promote a comprehensive system of care for people with co-occurring disorders. Sometimes a legislative mandate or department reorganization can be used to move the system forward. But often, as one Task Force member noted, key leaders must "create a problem" for the system to address, knowing that at the outset, the solutions won't be there.

For example, the Massachusetts Department of Mental Health has put providers on notice that it expects them to be able to serve people with co-occurring disorders. But this won't happen overnight, State officials acknowledge. Shaking up the system from the top means there will be gaps

in services during the three to five years it may take to put a comprehensive system of care in place. The goal should be creation of an infrastructure that supports long-term change.

Agree on Common Values

Moving forward together is easier when everyone agrees where the system is headed. Most successful system change begins with the broad participation of all key stakeholders involved in, and concerned about, care for people with co-occurring disorders.

BARRIERS

Achieving consensus requires changing ingrained and institutionalized attitudes and work habits and overcoming the inertia of systems and individuals who have always worked in a certain way. Providers lack knowledge of how each other's systems work and may fear their inability to handle unfamiliar clients or problems.

SOLUTION

- **Achieve consensus on a set of common values.**

Based on experiences in their States and communities, Task Force members urged their colleagues to reach consensus on a set of common values that may include, but not be limited to, the following:

- mental illness and substance abuse are unique, primary medical conditions that deserve treatment;
- the simultaneous occurrence of mental illness and substance abuse disorders creates a need for specialized and targeted services geared to the unique nature of co-occurring disorders;
- services should focus on recovery, rather than just symptom reduction;
- a "no wrong door" approach, in which consumers can receive help for both disorders no matter where or how they enter the service system, is vital;
- providers and programs must be culturally appropriate; and
- the system must be prepared to address the needs of all people with co-occurring disorders, not just adults who have serious mental illness or children who have severe emotional disturbance.

As illustrated by the program examples that follow, this values clarification process may take from several months to a year or even longer, but it is an absolutely essential first step. State level task forces, and/or regional or community-based workgroups, begin to hammer out system goals and values, often with the guidance of experts in the field of co-occurring disorders. This collaborative process mirrors the design of the systems they work to create.

Find the Money

Availability of flexible funding, often from multiple sources, is a necessary prerequisite for local mental health and substance abuse providers are to meet the needs of individuals whose disorders don't fall neatly into one or another categorical funding stream. This requires creativity, persistence, and a fair amount of planning.

BARRIERS

The barriers to funding a coordinated system of care are many and varied. First and foremost, mental health and substance abuse systems are faced with increasing levels of need, competing priorities, and insufficient money to go around. This situation is not likely to change any time soon.

Further, each system must contend, both separately and together, with categorical funding streams and a set of assumptions and regulations about how such money can and should be spent. In some cases, the barriers to using categorical funding to support services for people with co-occurring disorders may be related more to misperception or selective interpretation than to actual restrictions on the use of funds.

State statutes that limit the use of general revenue funds to people with serious mental illnesses may restrict development of a comprehensive system for all individuals who have co-occurring disorders. Together with categorical funding, State regulations may also act as a disincentive to the development of creative treatment models.

Finally, there is no current economic model that clearly delineates how the specific levels of coordination–consultation, collaboration, and integration–should be funded, and what the cost savings and consumer outcomes of such models would be. Task Force members agreed that further research is needed, but acknowledged that a "one-size-fits-all" funding model is not likely to emerge which meets the unique needs of communities and the individuals they serve.

SOLUTIONS

- **Align financial incentives with expected outcomes to achieve goals.**

The ability to align financial incentives with expected outcomes in order to achieve system goals is a high priority. Financing mechanisms should provide incentives for performance and not just units of service. The need to allow for local reallocation of funds from high cost services to alternative programs is critical. For example, communities that reduce the use of costly in-patient hospitalization should be able to keep those funds and redirect them to appropriate outpatient options for people with co-occurring disorders.

- **Reduce or eliminate statutory barriers.**

States can reduce or eliminate statutory barriers that impose unhelpful restrictions on the individuals they serve. Federal and State funders can instruct providers on the existing statutory and regulatory latitude to use categorical funds to serve people with co-occurring mental health and substance abuse disorders.

- **Combine funds at the local level.**

Maintenance of separate funding streams at the Federal and/or State level will help ensure that the mental health and substance abuse systems remain viable and able to complement one another, each retaining and refining their areas of expertise. However, coordination of those funding streams at the local level by county behavioral health authorities and/or community providers may permit the most effective response to the unique needs of consumers with co-occurring disorders.

Train Staff

Staff in both the mental health and substance abuse systems must be trained to work effectively with people who have co-occurring disorders. In fact, Task Force members were united in their belief that no system can adequately care for people with co-occurring disorders if this training does not take place.

BARRIERS

Provider inexperience and fears may stymie efforts to have them work with people who have co-occurring disorders. Also, cross-training alone does not make an individual an expert in the other field, and credentials in a specific area do not necessarily equal competence. When budgets are tight, money for staff training is often the first area to be cut.

SOLUTIONS

- **Train staff to develop clinical competence at all front doors of service.**

Training must be a high priority in order for long-term system change to occur. Programs should emphasize the development of clinical competence at the front doors of the local service system. This means providers must be prepared to identify multiple needs and refer consumers to the most appropriate setting capable of addressing both their mental health and substance abuse disorders. Some States are now exploring specialty credentialing in co-occurring disorders for mental health and substance abuse providers.

- **Train primary health care providers.**

Primary health care providers would also benefit from further training in mental health and substance abuse disorders. Family practitioners, pediatricians, and emergency room staff may well be able to help engage and ensure appropriate care for individuals who are not in the formal mental health and substance abuse treatment systems.

- **Train future providers.**

Training future providers is equally important. Educational and training programs in treating co-occurring disorders for medical doctors, psychiatrists, social workers, counselors, and other clinical staff will help produce a future work force that is better prepared to serve individuals with such disorders effectively.

Develop New Models

Working effectively with people who have co-occurring mental health and substance abuse disorders may or may not require the development of new program models specifically geared to this population. Often, new programs for people with co-occurring disorders are really additions or changes to existing programs for people with mental health or substance abuse disorders. For example, by adding staff with psychiatric expertise, Massachusetts has created a substance abuse detoxification program capable of treating individuals who have serious mental illnesses.

BARRIERS

Task Force members cited a lack of applied research, especially for people with co-occurring disorders who have less than serious mental illnesses, as a barrier to developing new program models. They also pointed to the absence of models for coordinated efforts in the areas of consultation and collaboration, those that fall short of the need for integrated services.

The lack of a common assessment tool and inadequate cross-training make it difficult for providers to fully embrace the "no wrong door" approach. Finally, significantly different clinical practice approaches, such as not allowing a person on psychiatric medication to be enrolled in a substance abuse treatment program or not insisting that an individual seen in a mental health setting maintain abstinence, make it difficult to blend existing services or to create new models that are more responsive to individual needs.

SOLUTIONS

- **Adopt or adapt program models and best practices.**

System planners should not have to reinvent the wheel; the two associations were urged to develop a catalogue of program models and best practices. New programs for people with co-occurring disorders can be adopted or adapted from either evidence based protocols – program models developed as a result of pilot studies and research demonstration projects – or consensus-based protocols – program models that providers can agree are appropriate based on their experiences. [1]

- **Create new service configurations.**

Financial and other incentives should allow for the creation of new service configurations, such as the Massachusetts detox program.

- **Develop a common assessment tool.**

Development of a common assessment tool will help providers determine what services are most appropriate for individual consumers.

Focus on Outcomes

Fundamentally, any system designed to address the needs of people with co-occurring disorders should provide high quality care. Therefore, focusing on improving consumer outcomes is among the highest priorities for system change.

BARRIERS

Traditionally, contracting in mental health and substance abuse programs has been focused more on process (i.e., units of service) than on client improvement. Lack of performance-based outcomes, particularly for people with co-occurring disorders, and lack of common data have made it difficult to assess client improvement.

SOLUTIONS

- **Develop performance-based outcome measures.**

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[1]CMHS recently funded the production of a publication titled: "Co-Occurring Psychiatric and Substance Abuse Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies and Training Curricula." The report results from the work of a panel chaired by Ken Minkoff, M.D., and includes a review of the literature, as well as a compilation of best practices and optimal clinical approaches. Although produced with a "managed care" label, it is applicable to any service system.

Programs and services must be geared toward achieving improved consumer outcomes in such key domains as symptom reduction, housing stability, employment, benefits, and overall quality of life, among others. The development of performance-based outcomes specific to people with co-occurring disorders will allow those who contract for services to tie financial incentives to achievement of key outcome measures.

- **Examine societal costs.**

Outcomes may also include reduced costs to consumers, their families, and society at large. These might include such measures as decreased involvement with the criminal justice system, decreased use of inappropriate emergency room visits, and less frequent and shorter hospital stays.

Evaluate Success

Any system change must be evaluated to determine whether stated goals are being met. Information on cost-effectiveness will be especially useful to program planners and funders, as will measures of both client- and system-level outcomes.

BARRIERS

Incomplete, inappropriate, and incompatible data hamper evaluation efforts. Lack of funding for longitudinal or cross-site studies may also be a barrier to evaluating system change and client recovery over the long-term.

SOLUTIONS

- **Build evaluations into program designs.**

Evaluation should be a key component of program design. Expertise and experience now exist at the local, state and national levels to identify and implement evaluation strategies which measure the impact of programs designed for persons with co-occurring disorders. If appropriately employed, evaluation strategies will help document program effectiveness and justify the funding required to more adequately meet the need.

- **Design information systems to record relevant data.**

Task Force members noted that information systems must be capable of handling the data necessary to assess program performance. Recent experience suggests that available information systems continue to produce data that are not comparable across programs, jurisdictions or geographical areas, severely hampering efforts to understand the nature, scope and response to the problem of co-occurring disorders.

- **Use evaluation results to provide immediate feedback.**

Evaluation results should be made immediately available to key stakeholders to allow providers to make course corrections and funders to revise expectations for future contracts.

Putting Principles Into Practice: State Examples

The solutions to implementing a comprehensive system of care for people with co-occurring disorders proposed by Task Force members are more than just good ideas. They represent actual program activities and models that members have begun to adopt or adapt in their States. In many cases, State mental health and alcohol and drug abuse agencies have just begun the process of achieving consensus and agreeing on common values and goals. Others have implemented pilot projects.

Each State is dealing with unique administrative structures, funding priorities, and client needs. The examples which follow demonstrate how a number of States are setting in motion a process for long-term change that reflects their overriding goal of making treatment for co-occurring disorders the expectation, not the exception.

Combining Resources in Texas

The State of Texas is in its third round of pilot projects for people with co-occurring disorders, according to Ms. Terry F. Bleier, former Executive Director of the Texas Commission on Alcohol and Drug Abuse. Ms. Bleir served as a consultant and facilitator for Task Force deliberations.

Funding for the Texas pilot projects comes largely from the SAPT Block Grant. The first projects began in 1996 with $500,000 in SAPT funds and $500,000 in mental health general revenue funds. The State mental health agency and the alcohol and drug abuse commission hired joint staff and funded five pilot projects for people with serious mental illnesses, based on proven models of integrated services. These programs provide case management services for people with co-occurring disorders; treatment costs are covered out of regular agency funds.

In a second round of funding, the State added nine more projects, with $2 million in SAPT funds. Fiscal year 2000 funds will include $7 million in SAPT monies and $500,000 in mental health general revenue funds, according to Ms. Bleir. Texas has adopted a "no wrong door" approach so that individuals with co-occurring disorders who enter the system at any point are referred for treatment to integrated programs with specially trained staff.

Reaching Consensus in Massachusetts

Paul Barreira, M.D., Medical Director of the Massachusetts Department of Mental Health, described the State's use of a CMHS Community Action Grant to build consensus around a model of care for people with co-occurring disorders. Community Action Grants support identification of evidence-based models of exemplary practices that may be selected by communities for adoption into their local systems of care.

Massachusetts formed a statewide leadership council that includes representatives of the mental health and substance abuse agencies, the Medicaid agency, and the State's Medicaid managed behavioral health care organization, as well as consumers, advocates, and vendors. The statewide group worked with an expert consultant to develop a set of principles for developing a continuous, integrated system of care for people with serious mental illnesses who have co-occurring disorders. Their initial task was to agree on these principles, not to discuss how to implement or fund the system, Dr. Barreira pointed out.

As part of this year-long process, Massachusetts has created six regional groups that mirror the statewide council, and each of these regional groups will implement a pilot project based on the principles the groups agreed to and an assessment of local needs. The State will provide technical assistance to the local projects in such areas as cultural competence and peer training.

Focusing on Outcomes in Arizona

Arizona has built on the process Massachusetts began by using the principles Massachusetts developed to begin Arizona's own consensus-building process, according to Christie Dye, Chief of the Office of Substance Abuse Services and General Mental Health. The State's Division of Behavioral Health includes services for people with serious mental illnesses and substance abuse, children, and individuals with general mental health problems that don't fit the diagnostic criteria for serious mental illness.

Using a CMHS Community Action Grant to bring key stakeholders together, Arizona developed an action plan that details the goals and objectives of an ideal system designed to achieve optimal client outcomes. The Arizona Integrated Treatment Consensus Panel will compare this ideal system to the existing structures to identify gaps in services. Ms. Dye estimates the group is about two years away from being able to determine how to contract and finance a comprehensive system of care for people with co-occurring disorders.

Developing a Seamless System of Care in Missouri

Missouri's Department of Mental Health includes divisions of psychiatric services, alcohol and drug abuse services, and mental retardation and developmental disabilities. Beginning two years

ago, representatives of these divisions–together with legislators, consumers, and providers–came together to redesign the system to make it more efficient for all consumers, including those who have co-occurring disorders, explained Michael Couty, Director of the Division of Alcohol and Drug Abuse.

Five regional planning groups are now examining mechanisms to effectively serve consumers, no matter where they enter the system. Missouri's plans include development of a common screening instrument, joint training, and joint monitoring of mental health and alcohol and drug abuse programs. The project is proceeding in phases, with the final phase being implementation of a managed system of care for adults with serious mental illnesses and children with severe emotional disturbance. Programs will not be integrated at the administrative level, but will appear seamless to the consumer.

Creating a Client-Centered System in Connecticut

In 1996, the commissioner of Connecticut's newly formed Department of Mental Health and Addiction Services charged a task force with identifying client needs and examining ways to meet those needs, according to Thomas Kirk, Ph.D., Deputy Commissioner. The group has emphasized paying less attention to diagnosis and more attention to symptoms, and to broadening their efforts beyond people with co-occurring disorders who have serious mental illnesses.

To better serve individuals with co-occurring disorders, the State has committed significant resources to statewide training programs, and is exploring a special credentialing certificate for individuals who can demonstrate 18 core competencies identified as necessary to serve the co-occurring client. Connecticut is also testing a common screening instrument and has integrated its site visit, treatment, and crisis teams.

Building Relationships in New York

Individuals with co-occurring mental health and substance abuse disorders consume enormous resources, noted James L. Stone, M.S.W., Commissioner of the New York State Office of Mental Health. In one New York county alone, the per capita annual cost for 88 people with co-occurring disorders was $21,000, largely for inpatient care.

Building on a longstanding working relationship between Mr. Stone and Jean Somers-Miller, Stone's counterpart at the State Office of Alcohol and Substance Abuse Services, the two agencies signed a Memorandum of Understanding (MOU) to work together on behalf of people with co-occurring disorders. As part of their agreement, both agencies contributed $150,000 apiece to fund four pilot programs in the coming year. Each of the four successful applicants will hire a co-occurring disorders coordinator to draw local systems together to address the problem of co-occurring disorders at the community level.

Supporting Local Innovation in New Hampshire

Paul Gorman, Ed.D., Commissioner of the New Hampshire Division of Mental Health and Developmental Services, shared with his colleagues an example of the way in which State efforts can support innovative local programming. The City of Keane identified a group of people with co-occurring disorders involved with the criminal justice system. These individuals were joint clients of Marathon House, the local substance abuse agency, and the local community mental health center.

With planning money from the State, the two agencies developed a coordinated program that highlights their specific strengths in serving this group. Marathon House provides residential services, and the mental health center staff contribute extensive experience with assessment and a positive relationship with the local court system. After a year of operation, program evaluation reveals that consumers in the program have fewer arrests and emergency room visits and less frequent hospital admissions.

Promoting Financial Incentives in Georgia

Georgia's Division of Mental Health, Mental Retardation, and Substance Abuse funnels Block Grant and State funds for mental health and substance abuse services to 13 regional planning units, explained Elizabeth F. Howell, M.D., Substance Abuse Program Chief. Since Georgia does not conduct program-specific planning on a statewide basis, innovations for people with co-occurring disorders have happened at the local or regional levels or in individual hospitals.

Financial incentives have paved the way for some of these local efforts. Regions of the State that save money by reducing costly state psychiatric inpatient hospital stays are allowed to keep the money to reinvest in other programs (i.e., aligning financial incentives to expected performance outcomes). Since individuals with co-occurring disorders are high users of state hospital services, programs designed to keep them out of the hospital can be financed with the funds saved.

Training the Trainers in Virginia

In Virginia, a system of Community Services Boards serves individuals with mental illnesses, substance abuse disorders, and mental retardation. Two years ago, community providers, facility staff, and central office administrators began planning for the needs of individuals with co-occurring disorders, including those who have mental retardation, according to Lewis E. Gallant, Ph.D., Director of the Office of Substance Abuse Services. They began by studying the guiding principles developed by Connecticut's Co-Occurring Disorders Task Force.

Training was one of the key priorities the Virginia group identified. The State entered into a contract with the University of Virginia to conduct a statewide assessment of training needs. The

long-term goal is to train a group of individual trainers who can keep the local workforce up to date on the latest methodologies for providing services to people with co-occurring disorders.

Taking the Next Step

While barriers to implementing a comprehensive system of care are significant, the results of successfully surmounting them can be dramatic for both individual consumers and the service system. State mental health commissioners and State alcohol and drug abuse directors who comprise the *Joint NASMHPD/NASADAD Task Force on Co-Occurring Disorders* urged their colleagues to begin exploring creative ways to finance needed system change. The principles for doing so clearly parallel the steps in system development discussed in this section. These principles are highlighted in the next section.

SECTION III

Financing a Comprehensive System of Care

Developing a comprehensive system of care for people with co-occurring mental health and substance abuse disorders requires committed leadership, joint planning, and the willingness and ability to find creative solutions to difficult problems. Financing a comprehensive system of care requires no less a commitment of time, creativity, and expertise.

Facilitated by consultant James Bixler, who has consulted with 32 states on mental health and substance abuse services financing, Task Force members discussed the financing principles outlined in this section. Like the conceptual framework, these principles represent a set of flexible guidelines that can be adapted for use in any State or community, regardless of its political structure or current funding mix for mental health and substance abuse services.

Financing Principles

The steps involved in financing a system of care parallel those necessary to develop it (see table below). Each of these financing principles is discussed in more detail in the report narrative that follows.

Financing a Comprehensive System of Care for People with Co-Occurring Disorders	
KEY SYSTEM DEVELOPMENT COMPONENTS	**FINANCING PRINCIPLES**
Provide Leadership/Build Consensus	Plan to Purchase Together Define the Population
Identify Resources	Secure Financing
Develop New Models/Train Staff	Purchase Effective Services
Decide on Outcomes	Purchase Performance
Evaluate Program	Evaluate and Improve

Plan to Purchase Together

Successful systems for co-occurring disorders begin with committed leaders who bring key stakeholders together to move the planning process forward. With specific regard to financing,

Bixler noted that in most successful demonstration programs for people with co-occurring disorders, the State mental health agency and the State alcohol and drug abuse agency jointly planned and purchased services. To do so, the key players must be flexible and set measurable but realistic goals. Each participant must have an assigned responsibility, perhaps as part of a department or statewide task force, and they must be educated about system goals, service models, and population needs.

Define the Population

An important part of achieving consensus involves defining the populations to be served. As outlined in the conceptual framework, individuals with co-occurring disorders vary in the severity of both their mental illness and their substance abuse disorders. The vast majority of the research literature, and the bulk of the money invested, tends to focus on people with serious mental illnesses who also have substance abuse problems. The Task Force recognized that a broader approach than this is required if the needs of persons with co-occurring mental health and substance abuse disorders are to be fully understood and met.

Individuals with serious mental illnesses whose use of substances doesn't rise to the level of abuse or dependence also need help. So, too, do people with less serious mental health problems who abuse or are dependent on alcohol and other drugs. The Task Force expressed the need to support research into program models for these groups, as well as to more closely examine any existing funding restrictions that limit a program's ability to meet the needs of individuals with co-occurring disorders.

Secure Financing

Currently, State and local mental health and substance abuse agencies depend on similar sources of revenue–including CMHS and SAPT Block Grant funds, Medicaid, State general revenue, and local taxes, among others–but the proportion of funds available for both systems varies widely. For example, many state substance abuse agencies are almost completely dependent on SAPT funds, while CMHS Block Grant funds make up a very small percentage of most State mental health budgets. Medicaid is generally used more often to fund mental health services. In addition, the total state budget for mental health services is usually much larger than for substance abuse services. A specific example is Medicaid funding in the state of Massachusetts, where for every $9 allocated to mental health services, $1 is available for substance abuse treatment.

The specific form that a State's participation in Medicaid managed care takes, as well as any consent decrees or lawsuits that determine which populations can be served, will also impact the type and amount of funding available to serve people with co-occurring disorders. All state substance abuse agencies devote significant resources to the areas of prevention and early intervention.

To insist that new resources must be available to serve people with co-occurring disorders is likely to be unrealistic. States and communities may need to consider a mixed model that

combines different streams of existing funds while leveraging some new resources. Task Force members described joint projects for people with co-occurring disorders that use SAPT Block Grant and State mental health general revenue funds, Block Grant funds from both mental health and substance abuse agencies, and Block Grant funds and resources from the Temporary Assistance to Needy Families (TANF) program. It was noted that SAMHSA had recently issued a position statement acknowledging that SAPT and Mental Health Block Grant funds can be used "to provide 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." Though each of these programs specifies a certain set of services that can and cannot be funded, together they can be used to support a wide range of needs.

Purchase Effective Services

Enough information is now available to allow system planners and funders to use "good science" in buying services for people with co-occurring disorders. This is especially true in the area of integrated services for people with serious mental illnesses and severe substance abuse disorders, where findings from pilot studies and research demonstration projects provide effective service models that can be adopted or adapted. Task Force members agreed that more research is needed in the design of services for people with less serious co-occurring disorders, as well as for the consultation and collaboration services that form an important part of the conceptual framework.

Purchase Performance

To become a true purchaser of effective services, and not merely a funder, State and community agencies must develop more targeted requests for proposals (RFPs). RFPs should set clear expectations for program performance based on available research and on the community's needs. Purchasers should demand fidelity to the chosen model, allowing providers to make needed course corrections but not to stray far from a service model that has been validated by research.

A program's effectiveness should be judged not only by how many people it serves or units of service it delivers, but rather by the level of real change it helps bring about in the lives of consumers who have co-occurring mental health and substance abuse disorders. The best way to determine a program's performance is to measure improved consumer outcomes in such key areas as symptom reduction, housing stability, and employment, among others.

The focus on outcomes will require an examination of the specific financing mechanism chosen. Traditional grant and fee-for-service financing arrangements may not produce the desired results. Bixler encouraged Task Force members to consider performance-based contracts that tie financial incentives and disincentives to the outcomes they would like to see. This type of risk-based contract rewards success and acts to align financing with clinical performance and client improvements in functioning.

Evaluate and Improve

The final step in developing and financing a system of care for people with co-occurring disorders is to evaluate performance to improve results. It helps to set aside funds for an external evaluator and to promote what can be called an "action research agenda." This allows rapid feedback to all key stakeholders to become the basis for revising expectations and changing protocols, as needed. Programs are able to make more clear what they expect because they've discovered what works.

Getting the Word Out

The conceptual framework for addressing co-occurring disorders developed by participants in the 1998 *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* set the stage for Task Force members to outline the key principles of developing and financing a comprehensive system of care. The next step, they agreed, is to help spread the word about the conceptual model and financing principles and the direction for future discussions about the needs of people with co-occurring disorders. Some ideas for marketing the conceptual framework and financing principles and the decisions that flow from it are highlighted in the next section.

SECTION IV

Marketing the Framework to States and Other Stakeholders

Based on the presentations of the expert consultant and their own deliberations, Task Force members commited to move forward together to expand the range of appropriate services available to respond to the needs of people with co-occurring disorders. While some Task Force members expressed concern that it may be unwise to market services that may not yet be available, others noted that what is really being promoted at this point is a set of expectations about a service system that consumers *should* have access to. By joining forces at the State level–and working in partnership with their Federal funders, national associations, and community counterparts–State mental health commissioners and State alcohol and drug abuse directors have taken another vital step forward in putting co-occurring disorders at the forefront of the national agenda for program development.

To help further the dialogue, Task Force members discussed ways to market the conceptual framework, the financing principles and the decisions that flow from the work of the Task Force to a broader audience of individuals and organizations concerned about the needs of people with co-occurring mental health and substance abuse disorders. Highlights of their discussion about marketing are featured in this section.

Beginning with the Basics

To guide their marketing discussion, Task Force members turned to trade association marketing consultant Rhea Blanken. The group discussed some general marketing principles, including:

- Marketing is not the same as selling. Marketing involves the use of language to influence behavior.

- Marketers must address the following key questions: What am I marketing? To whom is my message directed? Why am I interested in promoting my position (or product or service)? When will I deliver my message? Where will I take it? How will I get my message across?

- Each audience will require a specific message and a particular messenger to deliver it. Therefore, marketing activities can occur simultaneously at several different levels.

- The successful marketer must establish a connection with those audiences, i.e., give the audience a reason to listen to the message.

- Audiences must believe that the message has clear and significant value to them, and that there is a sense of urgency in acting on it.

- No one agency or organization can market to all the audiences they need to reach. They must form alliances with like-minded groups, who will further promote the message for them.

Reaching a Broad-Based Group

Members of NASMHPD and NASADAD and their Joint Task Force are uniquely suited to position themselves in the forefront of the movement to secure better services for people with co-occurring disorders. The first and most important audience Task Force members must reach out to is their own colleagues at the State and community level.

From there, the message about the utility and the flexibility of the conceptual framework and financing principles should move to an ever widening circle that includes, but is not limited to: local, State, and national legislators; mental health and substance abuse providers; other providers of services to people with co-occurring disorders; public and private organizations that fund mental health and substance abuse services; consumers and their families; and the media.

Task Force members further delineated specific audiences within each broad category. For example, they noted that providers should include not only clinicians, but also administrative and clerical staff. In addition, other providers that work with people who have mental health and substance abuse disorders–such as housing and welfare agencies, primary health care providers, and the criminal justice system–must also learn about the framework's model for developing a comprehensive system of care. Businesses, communities of faith and of color, and schools are all appropriate audiences.

The consumer audience includes not just current users of service, but also those who have recovered or are recovering from mental health and substance abuse disorders, as well as those who may be at risk for developing such problems.

Determining Appropriate Language

Effective use of language is a key to good marketing. Task Force members were encouraged to think creatively about the words and the phrases they will use in promoting the conceptual framework. Some of those words and phrases the group agreed to include: "united approach", "leadership", "flexible funding", "cost-effective services", "consumer-centered", "appropriate and available services", "best practice". These and other terms can be used to build a comprehensive marketing plan that is appropriate for all audiences.

Choosing Specific Messages for Specific Audiences

Among the wide range of audiences Task Force members identified, three main groups emerged: 1) agencies that fund mental health and substance abuse services; 2) organizations and individuals that provide the services; and 3) adults and children who use the services. Task Force members were urged to select several specific messages for each of these three, broad target audiences, bearing in mind two key questions: 1) Why should the framework matter to them?, and 2) How can they use it?

Messages for Funders

Key funders, including governors and State legislators, SAMHSA and its Centers, and Congress, should hear the following messages about the conceptual framework and financing principles, according to the Task Force.

- *Flexible funding.* The framework gives States the flexibility to use all funds in ways that are most beneficial to consumers.

- *Best practices.* The framework allows agencies such as SAMHSA and its Centers to support States in moving toward adoption of best practices.

- *Consumer-centered.* The framework facilitates a focus on the needs of recipients rather than the requirements of the system.

- *Cost-effective.* The framework fosters responsibility, accountability and appropriate service delivery through State-local partnerships.

Messages for Providers

Mental health and substance abuse providers will be a key resource in demonstrating the effectiveness of the conceptual framework and revising it, as needed. Carefully developed messages to providers, such as the following, invite use and revision of the framework.

- "We know that people with co-occurring disorders can be difficult to serve effectively. Help us use this tool that we believe makes the process easier and then tell us how you think it works."

- "Help us develop a decision tree that determines how adults and youth with co-occurring disorders should move through a comprehensive system of care."

- "Help us identify incentives that will move the system forward to more effective service practices."

Messages for Consumers and Families

As previously noted, the consumer group includes past clients and their families, those currently in the system or in need of treatment but not yet engaged, and those adults and children who are at risk for developing mental health and substance abuse disorders. Task Force members feel that it is important to acknowledge to consumers and families that they have been heard, to assure them that the mental health and substance abuse communities are working toward building a stronger partnership, and to pledge that the future holds promise as a result of their collective efforts.

- *Acknowledgment.* Many people have both mental health and substance abuse disorders in different configurations. Mental health and substance abuse providers and systems have traditionally not worked well together to view the individual as "a whole person" in order to successfully address their disorders.

- *Stronger Partnership.* Two national associations of member state agencies - NASMHPD and NASADAD - have heard these concerns about the limitations in getting needed services and have begun to work and plan together to help with this problem.

- *The Future.* We expect that as a result of this work, people with co-occurring disorders will find it easier to get necessary and appropriate services that deal with both their mental health and substance abuse needs.

These general marketing principles and the specific messages outlined above provide a foundation and direction for more targeted and specific strategies that encourage state and regional implementation of the conceptual framework and financing principles.

Creating an Effective Marketing Strategy at the National Level

NASMHPD and NASADAD propose conducting a coordinated, three-phase marketing initiative, whose goal will be to inform state mental health commissioners, state substance abuse directors and other key stakeholders about the work of the Task Force, the conceptual framework and financing principles.

Phase I — Presentations at NASMHPD and NASADAD membership meetings and information dissemination to other key stakeholder groups

Phase II — Development of State action plans based on materials and support provided at membership meetings

Phase III Proposals to SAMHSA and its Centers for funding of case study reports, technical assistance to states and local communities and development of a Technical Assistance Tool Kit

Phase I: Presentations at Membership Meetings and Information Dissemination

A common presentation will be developed and delivered at NASMHPD and NASADAD membership meetings of state mental health and state substance abuse directors (possibly a joint meeting) as well as other key stakeholder venues, such as regional and state meetings that promote or reflect an interest in the co-occurring agenda. General information dissemination activities should also include such groups such as NAMI, AMBHA, NMHA and other advocates to ensure that partnerships are established which better promote implementation of the conceptual framework and marketing principles.

The goal of the presentation will be to inform and involve state and local leaders in discussions about expanding services for persons with co-occurring disorders through adoption of the conceptual framework and financing principles. The presentation will be designed to assist states to market to contracted providers, behavioral healthcare organizations, state trade associations, counties (where appropriate), community-based services and others.

The presentation will include:

- a summary of the Task Force's work, the conceptual framework, financing principles and marketing strategies;
- a brief review of successful state experiences in designing and implementing services for co-occurring disorders (e.g., Massachusetts, Texas);
- a listing of technical assistance and consultant materials and resources available to assist states in planning and financing services for persons with co-occurring disorders;
- recommended strategies for states to implement the conceptual framework and financing principles.

The presentation will be delivered by members of the Task Force and association staff. The power point file, two sets of transparencies and a hard copy will be provided to each state director for in-state marketing efforts. Recommended strategies will be based upon successful state experience to date, derived from in-depth case studies. Key strategies are likely to include: joint leadership actions for the state substance abuse and mental health directors; guidance in developing state-level Task Forces that involve key stakeholders; bibliographies and standards for care, practice guidelines, workforce competencies and training; joint financing methods; use of pilot and demonstration projects; strategies that have been successful in incorporating evidence-based clinical practice.

NASMHPD and NASADAD will also jointly inform key national stakeholder organizations about the conceptual framework and financing principles and the work of the Task Force. A letter and copy of this report will be widely distributed. In addition, we will also offer to make the joint presentation at national meetings and conferences.

Phase II: State Action Plans and Technical Assistance Resource Materials

A number of states have already begun implementing services for persons with co-occurring disorders. The Task Force wishes to encourage further development in states with a history of services to the co-occurring population and to support initiation of appropriate services in states which have more limited service histories.

NASMHPD and NASADAD intend to create and disseminate a list of resource materials and consultant experts who are available to assist states in developing state-specific implementation plans that include setting goals and objectives, making staff assignments, identifying financing strategies and other activities designed to improve services for the population. These technical assistance resource materials will include a summary of clinical research findings and practical experience from pilots and demonstrations, with an emphasis on successful state leadership experiences.

States will be encouraged to develop state action plans for the current fiscal year, if one does not already exist.

Phase III: Proposals to SAMHSA and Its Centers

Task Force discussions have identified four clusters of activities that would substantially increase the capacity of states and local communities to design, improve and fully implement services to persons with co-occurring disorders:

Case Studies. Development of case studies of successful state and local efforts to develop, finance and deliver services for individuals with co-occurring disorders. Case studies will describe the critical developmental steps taken by states and communities that have successfully implemented co-occurring services and the key systems change elements that they determined were required for success (e.g., political support; involvement of consumers and families; financing, cross-training, etc.) Case studies should address the extent to which available services constitute consultation, collaboration and/or integration efforts.

Technical Assistance and Training. Made available to states and local communities, technical assistance would include expert clinical and financial consultation, peer technical assistance and regional training conferences for teams from state and local communities. Expert consultation constitutes an investment that can help states and communities "jump-start" their efforts to plan and expand services. Any training offered would be based upon the successful practical experience of states and communities.

Co-Occurring Disorders Tool Kit. A Tool Kit would provide practical, state-of-the-art technical assistance to states and communities interested in strengthening their co-occurring service efforts. The Tool Kit would include web sites, recommended resources (e.g., sample MOU's, position descriptions, etc.), and other program guidance. The Tool Kit would be made available both in hard copy and over the Internet and would catalogue such information as: extent of the problem and characteristics of the population; need for collaboration between mental health and substance abuse providers; specific program models; examples of service adaptations; and financing principles and strategies.

Specialized National Support Services. A co-occurring disorders web site should be developed and maintained to disseminate research information, report on the status of state and local implementation activities, request review and comment on developing materials - such as a clinical assessment tool - and provide ongoing support of the work of the Task Force.

NASMHPD and NASADAD are prepared to accomplish these activities as a collaborative effort under the Task Force's leadership. Additional staff support will be necessary for the Task Force to accomplish the majority of these activities.

Working Together to Move the Agenda Forward

The conceptual framework and financing principles for developing and funding a comprehensive system of care for people with co-occurring mental health and substance abuse disorders is an evolving tool designed to promote substantive system change. As Task Force members noted, any significant change begins with reaching consensus. The framework has allowed members of NASMHPD and NASADAD to do just that. But much work remains to be done. Both national associations, the Federal agencies that support them, and the members they serve have critical roles to play in advancing this important agenda. Recommendations for each of these groups and next steps for the Task Force are outlined in the final section.

SECTION V

Recommendations for Next Steps

Federal agencies, national associations, and state, county and community leaders have a significant role to play in promoting the development of a comprehensive system of care for people with co-occurring mental health and substance abuse disorders. Participants in the first *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* outlined a series of recommendations for these groups. Task Force members recognized the accomplishments each group achieved in the intervening year, and suggested both new and continued efforts to pursue wider acceptance of the conceptual framework and financing principles.

The Federal Role

Initial recommendations for Federal agencies concerned with mental health and substance abuse disorders–including SAMHSA, CMHS, CSAT, and the Center for Substance Abuse Prevention (CSAP)–focused on the need to model cooperative efforts at the Federal level, to fund and evaluate different service models, and to identify national resources and experts to help meet the need for technical assistance and training in systems development and funding. While confirming the need for a continued emphasis in these important areas, Task Force members also suggested the following key roles for Federal agencies:

- **Support Research on Effective Treatment Models for People with a Range of Co-Occurring Disorders**. Current service delivery protocols tend to focus on people with the most serious mental illnesses and substance abuse disorders. Task Force members urged Federal agencies, in cooperation with States, to fund research on treatment models for individuals with serious mental illnesses whose abuse of substances doesn't rise to the level of dependence, as well as people with less serious mental health problems who abuse or are dependent on alcohol and other drugs.

- **Support Research on Improved Consumer Outcomes and Reduced Societal Costs**. Effective programs for people with co-occurring mental health and substance abuse disorders must be designed to improve consumer outcomes in key areas. Federal and State agencies can support research on performance-based outcome measures specific to people with co-occurring disorders.

- **Help States and Localities Understand the Appropriate Use of Federal Funds**. Both the CMHS and SAPT Block Grants include specific regulations about what services can and cannot be purchased with Federal dollars. But in many cases, States and communities may make selective, and perhaps erroneous, interpretations of these regulations. Task Force members encouraged Federal funders to help States and communities discriminate between real and perceived

barriers in the use of Block Grant funds to support services for people with co-occurring disorders.

- **Continue to Support State and Association Efforts, Including Development of a Catalogue of Program Models**. When Federal agencies act as a catalyst for events such as the national dialogue and Task Force meetings, they demonstrate their support of the collective efforts needed to address the problem of co-occurring disorders. Task Force members requested that Federal agencies continue to support their efforts, particularly the goal to develop a catalogue of program models and best practices.

The National Association Role

Working together, NASMHPD and NASADAD have taken steps to address the recommendations made by participants in the first national dialogue. Creation of a Joint Task Force was a key suggestion of last year's group, as was development of a set of financing principles and a plan to market the conceptual framework and principles. As the associations continue to move forward together, Task Force members encouraged them to address the following issues:

- **Gather and Disseminate a Catalogue of Program Models**. Task Force members were quite clear of their desire not to recreate the wheel. They shared some of their success stories with each other, and they urged NASMHPD and NASADAD, with Federal help, to solicit similar program examples and best practices from among the many pilot programs and research demonstration projects nationwide. The material should be gathered in written and/or electronic form and be easily available to all who need it in case study format.

- **Implement the Marketing Plan**. Marketing plans for the conceptual framework and financing principles should be implemented with a variety of audiences. Task Force members will help their national associations to move this process forward.

- **Keep This Issue on the Front Burner of Both Organizations**. By convening the first national dialogue and the first meeting of the Joint Task Force, NASMHPD and NASADAD have made co-occurring disorders a top priority for their organizations. They can continue to do so by their ongoing support of Task Force activities, sponsorship of overlapping and/or joint meetings, and development of position papers.

State and Local Roles

Much of the work of creating a comprehensive system of care for people with co-occurring disorders takes place through State/local partnerships which are based on and reflect their different activities, priorities and responsibilities. States provide system-wide leadership, establish and monitor policy, fund services and assess performance. Communities deliver services, assess local needs, establish provider networks and provide feedback to States regarding service implementation and outcome.

While these activities represent significant differences between State and local levels in terms of responsibility, authority and risk, Task Force members chose to make a series of joint recommendations for States and communities to consider as they implement the conceptual framework and financing principles:

- **Develop Consensus Around System Goals**. Task Force members believe that system change cannot and will not happen unless all the parties agree on where they are headed and what they are trying to accomplish. State level task forces and/or regional or community-based workgroups should work in partnership to develop and implement system goals and values to reach common ground before they proceed.

- **Align Financial Incentives to Performance-Based Outcomes**. As long as finances alone dictate the shape of mental health and substance abuse programs, system change will be both slow and haphazard. Task Force members urged their State colleagues to permit local reallocation of funds from high-cost care to alternative services and to promote joint purchasing. Performance-based contracting should be used to tie financial incentives and disincentives to achievement of measurable outcomes.

- **Reduce/Eliminate Statutory and Administrative Barriers**. To promote development of innovative services for people with co-occurring disorders, States and communities must examine the fiscal and administrative barriers that may stand in the way. Among them are statutes that limit the use of general revenue funds to people with serious mental illnesses. State commissioners and directors can use the conceptual framework and financing principles to begin a dialogue with their governors and legislators about the need to promote flexibility in financing and program design. County and community leaders can offer substantial educational support to state legislators in support of this process.

- **Create/Promote New Service Configurations**. State agencies should make clear that serving people with co-occurring disorders is the *expectation* and not the exception. This paves the way for local providers to implement and evaluate new service models based on their unique perspectives, needs and resources.

- **Support Research on Populations and Program Models**. Together with their Federal counterparts, States and local organizations have important roles to play in researching effective service models for people with a range of co-occurring mental health and substance abuse disorders. They can also contribute to development of performance-based outcome measures specific to people with co-occurring disorders.

Taking the Next Step

Task Force members left this meeting energized and empowered to take some critical actions. In addition to promoting use of the conceptual framework and financing principles in informal discussions with their colleagues to guide system development in their own States and communities, Task Force members agreed to address the following:

- **Finalize and Implement the Associations' Marketing Plan and Assist States in Developing Their Own Unique Marketing Plans**. Task Force members will comment on and help revise the draft marketing plan to be developed for NASMHPD and NASADAD. They will also be among the key messengers delivering information about the conceptual framework and financing principles to the associations' target audiences.

- **Help Develop a Catalogue of Program Models**. Together with their national associations and Federal funders, Task Force members can urge their colleagues to submit information about program models and best practices in the field of co-occurring disorders. Many Task Force members have success stories of their own to share.

- **Continue to Move Forward Together**. Most important of all, Task Force members pledged to continue to explore their role in promoting development of a comprehensive continuum of care for people with co-occurring mental health and substance abuse disorders. Their decision to move forward together, united in their approach, is a significant outcome of the Task Force process that brought them together. Additional highlights of the first Task Force meeting are recapped in the conclusion of this report.

CONCLUSION

This meeting of the *Joint NASMHPD/NASADAD Task Force on Co-Occurring Disorders* was both an outgrowth of the national dialogue that preceded it and proof that the conceptual framework which resulted from that dialogue is a useful tool to encourage coordinated efforts around the needs of people with co-occurring mental health and substance abuse disorders. Task Force members agreed that use of the framework–which conceptualizes co-occurring disorders according to symptom multiplicity and severity, locus of care, and level of service coordination–encourages development and funding of a continuum of care for people with co-occurring disorders.

Development of a comprehensive system of care for people with co-occurring disorders must be the *expectation*, not the exception. To achieve this goal, Task Force members stressed the importance of agreeing on common values, training staff in each other's disciplines, selecting evidence-based or consensus-based protocols, and focusing on improved consumer outcomes. They encouraged their colleagues at the State and local level to broaden the population of people with co-occurring disorders they serve beyond adults with serious mental illnesses and children with severe emotional disturbance.

Task Force members acknowledged that a "one-size-fits-all" funding model will likely not meet the unique needs of communities and the individuals they serve. However, they embraced a set of general principles needed to finance a continuum of care for people with co-occurring disorders that parallel those needed to create it. These include joint purchasing of effective services, the use of funding combined from multiple sources, and the adoption of performance-based contracts that align financial incentives and disincentives with system goals.

Further, to help spread the word about the utility and the flexibility of the conceptual framework, Task Force members discussed ways to market it to a broader audience that includes funders, providers, and consumers of mental health and substance abuse services. They want to let these groups know that the framework is flexible, cost-effective, client-centered, and can lead to the development of best practices; that it is a useful tool; and that it acknowledges consumer and family concerns and is designed to address them.

State mental health commissioners and State alcohol and drug abuse directors who are Task Force members have taken a vital step in helping to place co-occurring disorders at the forefront of the national agenda. To further these efforts, members encouraged SAMHSA, through its Centers, to support research on treatment models and consumer outcomes; recommended that the States reduce or eliminate financial barriers to serving the needs of people with co-occurring disorders; and urged NASMHPD and NASADAD to begin collecting program examples to prepare a catalogue of models and best practices in this field.

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APPENDIX A

NASMHPD/NASADAD Joint Task Force on Co-Occurring Disorders

APPENDIX B

Meeting Participants

APPENDIX C

Report of the First National Dialogue: Ordering Information

Title: *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders*

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

Date: March 1999

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