Final Report of the Steering Committee

Substance Abuse/Mental Health Integration Project

June 2000 – August 2001

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Executive Summary.

1. Introduction. In July 2000, the Alaska Department of Health and Social Services (DHSS), in partnership with the Alaskan Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse, embarked on a project to identify problems and barriers associated with improving care to persons with co-occurring mental health and substance use disorder diagnoses. Although delivery of treatment services to this special population has long been a problem, there was a renewed and heightened emphasis placed on the issue beginning in 1999.

For the current project, the DHSS Commissioner convened a steering committee to investigate issues related to delivery of services to persons with co-occurring disorders and to make recommendations for improving services. In a scoping document dated June 1, 2000, the Commissioner identified the goals and objectives for the project.

A. Project Goals. The long-term goals supported by the project:

- Improving treatment outcomes;
- Improving accessibility of services and quality of care; and
- Improving efficiency in administration to minimize costs and facilitate greatest use of available funds to support client services.

B. Project Objectives. The Scoping Document also identified the objectives of the project:

- Establish a working definition of "integrated mental health and substance use disorder" accepted by both fields.
- Inventory best practice models of integration for mental health and substance use disorder services.
- Address philosophical and practice issues that impede integration of the two fields' distinctly different treatment orientations.
- Propose actions to facilitate the provision of integrated mental health and substance use disorder services.
- Develop recommendations regarding processes for planning, advocacy, administration, and oversight of mental health and substance use disorder services that would facilitate more integrated services.

The project methodology included three main components. These components were a steering committee discussion and decision-making process, research, and a survey of mental health and substance use disorder treatment providers in Alaska.

2. Survey of Substance Use Disorder and Mental Health Providers. Between August and November 2000, the project contractors conducted a mail survey of all publicly and privately funded substance use disorder programs and publicly funded mental health providers. The survey was designed to gather various pieces of information:

- Perceived prevalence of co-occurring disorders

- Administrative barriers to delivery of treatment
- Perceived level of integration of the various providers
- Training needs related to co-occurring disorders
- Recommendations for improved delivery of service

The response rate for the survey was 52.8% and there was good representation from rural and urban communities, mental health and substance use disorder providers, and good geographic distribution. Some of the most important findings from the survey were:

- Prevalence. Mental health treatment providers perceive a higher prevalence of co-occurring disorders among their client population than do substance use disorder treatment providers. 66.7% of mental health providers reported that between ¼ and ¾ of their clients experienced co-occurring disorders compared with 41.7% of substance abuse providers.
- Administrative Barriers. The most serious administrative barrier, according to providers who have consolidated services, is the necessity of working with two separate grant systems with their application processes, conditions, and reporting requirements.
- Perceived Level of Integration. Providers delivering both mental health and substance use disorder treatment reported a much higher level of integration in the delivery of services than did either type of stand alone mental health or substance provider.
- Training Needs. All types of providers identified recovery for the dually diagnosed, integrated treatment planning, and integrated case management as important training needs.
- Recommendations. Among the diverse recommendations for improving services identified by providers, a common theme was simplification of the grant process for consolidated programs.

3. Service Delivery Issues. A variety of issues impact the quality and appropriateness of services whether the provider is a mental health treatment agency, a substance use disorder treatment agency, or a consolidated organization providing both types of treatment. The following issues were identified as critical by the Steering Committee:

- Accessing Services. Service delivery systems must be designed such that, no matter where or how a person contacts the system, appropriate services are ensured, whether delivered by a single, consolidated agency or by multiple agencies working in collaborative partnerships.
- Assessment and Screening. Agencies delivering substance use disorder and mental health treatment must ensure that appropriate screenings are accomplished and, as appropriate, assessments completed and referrals made for other services.
- Meeting Client Needs. Organizations should design service delivery systems based on needs of clients. This includes client and family involvement in the treatment planning process. Providers should have mechanisms in place for accurately assessing client needs, identifying available resources, and making appropriate and effective referrals.
- Treatment Planning. Treatment planning for clients with co-occurring disorders should be consolidated as much as possible. If treatment services are delivered by multiple agencies, they should all be working from a single treatment plan.
- Case Coordination and Continuity of Care. To provide the most appropriate care for

persons with co-occurring disorders, providers should emphasize cross training for clinical staff, find ways to bridge the philosophical gaps between the mental health and substance use disorder fields, use multi-disciplinary teams, and provide treatment in the least restrictive, most appropriate setting. Treatment plans should be individualized and should include the client and, as appropriate, their family in the planning process. Finally, admission criteria should be inclusive and the treatment organization should be culturally competent.

- Recovery and Ongoing Support. Organizations must recognize that both recovery and relapse are processes. They must recognize and plan for the possibility of acute episodes that may or may not include the use of psychoactive substances. Treatment teams must resolve conflicts between the two disciplines to provide ongoing consolidated support to the client.

4. Administrative Barriers. For agencies that currently deliver consolidated services or desire to consolidate and deliver both mental health and substance use disorder services from within the same organization, there are a number of barriers in place that hinder this effort.

- Data Systems. Both the Division of Mental Health and Developmental Disabilities (DMHDD) and the Division of Alcoholism and Drug Abuse (ADA) maintain data collection systems to support management and decision-making at the state level. Not only are the two systems completely separate and independent, they also take different approaches to capturing data. Service providers that offer only mental health or substance use disorder treatment are not impacted by the differences. For providers that are consolidated and offer both mental health and substance use disorder treatment from within the same organization, however, the differences offer the potential for duplication of effort. This is only a potential problem because, under the present systems, organizations that offer both services report all data using the management information system for ADA. There is currently no way to move the mental health data originating at consolidated programs from the ADA database to the DMHDD system. The end result is that, while there is currently no duplicative burden on providers, DMHDD is not receiving mental health service delivery data from consolidated programs.
- Grant Application, Reporting, and Administration. Providers that offer both mental health and substance use disorder treatment services funded through state grants must currently apply for funding through two separate grant processes. Each process has its own set of criteria, reporting, and administration responsibilities. This is compounded by the fact that grant application for both systems is typically done during the same period of time. The Department of Health and Social Services is currently considering actions to simplify the grant process including the issuance of consolidated grants.
- Quality Assurance/Program Oversight. DMHDD and ADA have quality assurance and oversight responsibilities for providers within their respective fields. Although the two divisions take different approaches, both use a system of site visits to ensure compliance. Currently, there is little coordination between the two oversight processes, which can lead to timing conflicts for consolidated providers. Additionally, there is currently no mechanism for examining the regulations and standards of each division to ensure that there are no regulatory conflicts between the two sets of standards.
- Billing and Funding Streams. This administrative barrier refers primarily to Medicaid billing. One issue involving Medicaid billing is that, in order to bill for either mental

health services or substance use disorder services, the billing organization must be a grantee of the respective division. Since grant processes are competitive, there is no guarantee that an organization providing both types of services would be awarded grants from both divisions. Another issue that plagues consolidated programs is that there are not provisions for consolidated billing. Services are designated as mental health services or substance use disorder services, each with their own set of requirements. Finally, rural programs find that, in order to bill Medicaid for mental health services, a master's level clinician must either provide the services or provide clinical supervision for the individual providing the services.

5. Staff Recruitment, Training, and Retention. The section on staff recruitment, training and retention provides a snapshot of the existing systems for providing and managing staffing requirements for substance use disorder and mental health services in Alaska. Additionally, by including this section and examining this issue, the Steering Committee acknowledges that, regardless of any plans or recommendations from this committee or any other, improvements in accessibility, quality, and integration of services to persons with co-occurring disorders will ultimately be accomplished by program staff. The quality of staff training, education, and experience in both disciplines will be a major factor in providing quality services for persons with co-occurring disorders.

Individuals that provide mental health treatment come from various professions and include psychiatrists, psychologists, case managers, social workers, and therapists. By contrast, credentialed substance use disorder counselors are certified by the Alaska Commission for Chemical Dependency Professional Certification (ACCDPC). The mental health professions are, for the most part, governed by state law and require occupational licensing while certification for substance use disorder counselors remains voluntary.

One of the major problems presented by this diversity is ensuring appropriate training and knowledge regarding co-occurring disorders for professionals providing mental health or substance use disorder treatment. Another problem that faces both the mental health and substance use disorder field is recruiting and retaining qualified individuals. Both fields continue to face a shortage of qualified professionals. Pay and benefits as well as some working conditions in rural Alaska contribute to this problem.

6. Steering Committee Recommendations. The following recommendations were developed and adopted by the Steering Committee.

A. Service Delivery Recommendations.

1. Core Values. The Steering Committee recommends that the following core values governing service delivery to persons with co-occurring disorders be adopted by DMHDD and ADA and consolidated into the standards for all providers for which they have oversight responsibility:

a. ***Consumer-Centered.*** Any successful service system must be consumer-centered. A consumer-centered system is one in which the mental health and substance use disorder consumers and their families are actively involved not only in treatment decisions, but also in program design, administration, and evaluation.

b. ***Availability of Services.*** Individuals should have access to a comprehensive array of services appropriate to their needs. Treatment of co-occurring disorders should be individualized to accommodate the needs of different sub-types and different phases of treatment for all established diagnoses.

c. ***Culturally Competent.*** Service systems should observe and respect the values and beliefs of the diverse cultures of our consumers and should be provided by staff that are culturally competent.

d. ***"No Wrong Door."*** Services for persons with co-occurring disorders must be available and accessible where, and whenever, the person enters the service system. The "no wrong door" approach ensures that an individual can be treated, or referred for treatment, whether he or she seeks help for a mental health problem, a substance use disorder, or a general medical condition.

e. ***Administrative Systems.*** Administrative systems and procedures should not present a barrier to effective delivery of services to persons with co-occurring disorders.

f. ***Respectful Partnership.*** In order to deliver the most appropriate services to persons with co-occurring disorders, substance use disorder and mental health professionals must work together in a respectful partnership that honors the strengths that each sector brings to the table and respects the values, professional standards, and achievements that each sector has developed.

g. ***Resources for Services.*** Any system for delivery of services to persons with co-occurring disorders should have adequate resources to ensure a safe, comfortable physical setting, appropriate program materials, and trained and appropriately compensated staff.

2. <u>New York Model Contextual Framework</u>. The Steering Committee recommends that both DMHDD and ADA adopt the New York Model Contextual Framework, particularly as it relates to the designation of locus of care and responsibility for ensuring delivery of appropriate services. This model or framework is particularly useful for a number of reasons. First, it is not prescriptive in addressing treatment methods. It recognizes that substance use disorder providers use different approaches and methods than mental health providers and does not seek to dictate a single "best" approach. Second, it recognizes that clients with co-occurring disorders have symptoms of the two different disorders in various degrees of acuity and severity. The framework uses these differences as the basis for identifying the best level of service coordination and accountability. Finally, this model recognizes that mental health and substance use disorder services will likely be provided by different providers and provides a method of determining accountability among multiple providers. The following graphical representation shows the four quadrants in this model based on the level of acuity and severity of symptoms for the two different disorders.

New York Conceptual Framework

Locus of Care **Mental Health** Mental Health Diagnosis (High Severity) Substance Use Disorder Diagnosis (Low Severity)	**Locus of Care** **Collaborative/Consolidated Service Delivery** Mental Health Diagnosis (High Severity) Substance Use Disorder Diagnosis (High Severity)
Locus of Care **Medical /Corrections/Public Safety** Mental Health Diagnosis (Low Severity) Substance Use Disorder Diagnosis (Low Severity)	**Locus of Care** **Substance Abuse** Mental Health Diagnosis (Low Severity) Substance Use Disorder Diagnosis (High Severity)

3. Index of Recommended Screening and Diagnostic Tools. The Steering Committee recommends that DMHDD and ADA develop an index or library of recognized and/or recommended screening and diagnostic tools that can be used by both single-focus, stand-alone providers as well as consolidated organizations. The divisions should also develop and maintain training resources as appropriate for those tools.

4. Practice Guidelines. The Steering Committee recommends that DMHDD and ADA develop and implement practice guidelines for organizations providing services to persons with co-occurring disorders. These guidelines should include, as a minimum, the following elements:

a. "No wrong door" for accessing appropriate services.

b. Every provider will ensure an appropriate assessment process for clients that includes screening and, as indicated, diagnosis for substance use and mental health disorders.

c. Single-focus, stand-alone providers, will identify the most appropriate qualified referral for a client whose needs exceed the capability and/or capacity of the organization.

d. Treatment plans for persons with co-occurring disorders should be highly

consolidated. The plans should identify client needs based on a holistic, biopsychosocial perspective and mandate specific services based on these needs.

e. Delivery of care should be highly coordinated, regardless of the locus of care. The responsibility and accountability for this coordination should rest with the organization in the primary locus for cases in which the service providers are single-focus, stand-alone organizations. This element should include case coordination, staffing, scheduling, consistent objectives, and resolution of any programmatic conflicts.

f. Clients should receive continuing care and ongoing support to promote their recovery. This element should recognize the nature of both mental health and substance use disorders, the likelihood of acute episodes and the concept of recovery as an ongoing process.

B. Administrative Barriers Recommendations.

1. Data Collection. The Steering Committee strongly supports the move toward an eventual consolidated data system. In the short term, the Steering Committee recommends that consolidated programs continue to report data to only one system and that DMHDD and ADA identify a method of capturing data relating to mental health and substance use disorder services from consolidated providers to each data system.

2. Consolidated Grant Pilot. The Steering Committee recommends the issuance of a request for proposals for fiscal year 2004 for consolidated services. This grant opportunity should be available only to organizations that are consolidated and provide both mental health and substance use disorder services to clients needing either (not just clients with co-occurring disorders).

3. Quality Assurance/Program Oversight. The Steering Committee recommends that the two respective systems of program oversight and quality assurance commit to a heightened level of coordination and collaboration. This should include:

a. Inclusion of professionals from both fields in site visits by either division.

b. Offer the opportunity for combined site visits subject to the preferences of the individual providers.

c. Closely coordinate the timing of site visits to minimize the administrative burden for providers.

d. Carefully review all program and performance standards to ensure that there are no conflicts.

4. Medicaid Billing. The Steering Committee recommends that a working group be convened to assess the problems related to Medicaid reimbursement for clients with co-occurring disorders and develop recommended solutions that can be implemented prior to the pilot integrated grant RFP that is recommended for fiscal year 2004.

C. Staff Recruitment, Training, and Retention Recommendations.

1. Establish Core Competencies.

a. ***Non-consolidated Programs.*** For organizations that are not consolidated, a set of minimum core competencies should be established that require staff to:

- Demonstrate knowledge of the signs and symptoms of the "other disorder" (for example, a substance use disorder provider recognizing signs and symptoms of mental health issues and a mental health provider recognizing signs and symptoms of substance use disorder). This would include the ability to conduct a screening and, if indicated, referral to an appropriate professional for formal assessment and diagnosis.
- The professionals of each discipline must demonstrate knowledge of the treatment system in place to provide services for "the other disorder." This is necessary in order to make appropriate referrals for diagnosis and/or services.
- The professionals of either discipline must demonstrate understanding of the treatment principles and course of treatment for the other discipline. This will allow them to coordinate delivery of services such that the two courses of treatment are complementary rather than conflicting. Examples include an understanding of pharmacology and the use of psychotropic medications, the role of 12-step programs, relapse prevention principles, and recovery concepts.

b. ***Consolidated Programs.*** Core competencies for individuals working in consolidated programs are recommended for two different professional groups. The first group, comprised of professionals who work in an organization that identifies professionals as either substance use disorder or mental health, would have core competencies similar to those for non-consolidated programs. Those professionals working in programs that are consolidated and in which professionals are expected to provide both services would have a more rigorous set of competencies. Individuals who provide both mental health and substance use disorder services should possess the competencies normally expected of both mental health clinicians and substance use disorder counselors. They should, however, also possess additional special competencies related to services to persons with co-occurring disorders. These competencies should include:

- Demonstrated ability to recognize and diagnose both disorders occurring simultaneously;
- Demonstration of competency in developing and implementing treatment plans that appropriately address both disorders as well as the interaction between the disorders;
- Demonstration of understanding of locus of care issues, that is, the primary focus of care at any given time depending on presenting problems;
- Demonstration of understanding the appropriate roles of abstinence, recovery, harm reduction, and other concepts and practices that must be

brought to bear in order to provide effective services; and

- Demonstrated ability to develop a plan of continuing care that recognizes the possibility of relapse in both substance use and mental health symptoms.

2. Development of Recruiting Tools. Because much recruiting is done out of state, both fields could benefit from the development of a recruiting tool (video, interactive CD-ROM, short correspondence course, etc.) that would help to prepare a prospective mental health or substance use disorder staff member for many of the issues and problems faced by service providers in Alaska.

3. Consolidated Training Program. Currently, the substance use disorder field provides a very systematic, structured approach to training counselors through the use of a statewide contract training coordinator as well as the Annual Addictions School. This system, in addition to providing critical training, also serves as a forum for discussions and information dissemination regarding key emerging issues. Finally, this system helps to build cohesiveness among the counselors and fosters the growth of professional relationships. With appropriate planning and funding, this concept could be expanded. A renewed commitment to coordinated, quality training can also be viewed as a source of support for rural professionals thus helping to reduce turnover.

4. Expansion of CMH/ARP Project Cross Training. The Community Mental Health/API Replacement Project (CMH/ARP) cross-training component is an effort to improve the quality of care and access in the Anchorage area by providing extensive cross training to providers on treating persons with co-occurring disorders, cultural competency, and emergency mental health service delivery system characteristics. The Steering Committee recommends that this concept be expanded to provide similar training opportunities to service delivery providers throughout Alaska.

5. Rural Human Services Training Expansion. The Rural Human Services program in Alaska has provided trained human service workers in many villages. Because these individuals are often the only local persons with any training in mental health or substance use disorder issues, they are called upon to deliver some level of service to village residents with varied needs. In addition to the core training provided to RHS students, there is a clear need to provide additional training that will enable them to deliver a minimum level of service to persons with co-occurring disorders. This additional training should be provided once the core training is completed. Phasing the training delivery this way will help to prevent the students from being overwhelmed. Finally, the Steering Committee recommends expansion of RHS capacity in Alaska.

6. ACCDPC Certification for Counselors Serving Clients with Co-Occurring Disorders. The Steering Committee recommends that the Alaska Commission for Chemical Dependency Professional Certification (ACCDPC) develop a set of standards and corresponding certification for substance use disorder counselors serving clients with co-occurring disorders.

D. Implementation. The Steering Committee recommends that the Commissioner of Health and Social Services identify a responsible entity or group with authority to ensure that

recommendations made in this report and approved by the commissioner are implemented in a timely fashion.

Table of Contents.

I. Introduction.

A. Background. In July 2000, the Alaska Department of Health and Social Services (DHSS), in partnership with the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse, embarked on a project to identify problems and barriers associated with improving care to persons with co-occurring mental health and substance use disorder diagnoses. Although delivery of treatment services to this special population has long been a problem, there was a renewed and heightened emphasis placed on the issue beginning in 1999.

There have been Alaskan programs in the past that have helped to address some of the needs of persons with co-occurring disorders. The Rural Human Services Program is one example of a very successful effort that has helped to provide a more coordinated approach to providing services to this population in rural areas. In 1999, The Commissioner of Health and Social Services directed that relevant divisions and boards develop recommendations for improving services to persons with co-occurring disorders using a stakeholder process.

At the same time, the Community Mental Health/API Replacement Project (CMH/ARP) was looking at better integration of emergency mental health services for persons with co-occurring disorders in the Anchorage area. Although rural areas such as Aniak and McGrath have long delivered integrated services to persons with co-occurring disorders, Anchorage, because of its size, number of providers, and complexity of service delivery systems, had not integrated services to the same extent as rural areas.

Additionally, in October 1999 at a meeting of the Rural Mental Health Providers Association, the Division of Mental Health and Developmental Disabilities (DMHDD) and the Alaska Mental Health Board (AMHB), a recommendation was made for the AMHB and Advisory Board on Alcoholism and Drug Abuse (ABADA) to establish a multi-stakeholder Steering Committee to develop recommendations to move towards more integrated mental health and substance use disorder services. The rural mental health providers were primarily interested in reducing duplication and streamlining administrative procedures in such areas as funding, grant applications and oversight, data/reporting requirements, and quality assurance reviews.

For the current project, a scoping document was developed by the DHSS and a steering committee, co-chaired by the Executive Directors of AMHB and ABADA, was convened to oversee the project. The Steering Committee members are listed in Appendix A and the project scoping document is included as Appendix B to this report.

1. Overview of National Efforts to Serve the Population. The problems associated with delivery of services to persons with co-occurring mental health and substance use disorders is not limited to Alaska. Indeed, this is a topic that, at the time of this project, has a high degree of national visibility. In July 1998, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) met in Washington, D.C. in a meeting supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS). The report of that meeting, published in March 1999, provided substantial background as well as a framework for initiating a dialogue at the state level.

The goals of the national meeting, as outlined in the report were:

a. To define the population of individuals who have co-occurring mental health and substance use disorders;

b. To identify specific groups within this population;

c. To describe the characteristics of an effective service system designed to address the needs of these groups; and

d. To make recommendations for future strategies to move this agenda forward.[1]

The report also provided a summary of various state efforts as well as a recommended set of service delivery system characteristics and index of resources. This report served as a "starting point" for the Alaska project in terms of identifying a framework for discussion and targeted avenues for research.

2. Prevalence of Co-occurring Mental Health and Substance Use Disorders. Prevalence estimates for co-occurring substance use disorder and mental illness in the United States vary depending on the criteria used and whether the estimates relate to the entire population or just the adult population. The report for the 1998 conference of NASMHPD and NASADAD (see sub-paragraph A.1 above) provided an estimate of 10 million people (or about 4% of the population) in the country as having a co-occurring mental health and substance use disorder in any given year. Three million people are estimated to have at least three diagnoses from these two groups and at least one million have at least four diagnoses.[2] A 1990 study sponsored by the National Institute of Mental Health concluded that about 5% of the total population suffered from co-occurring disorders, although this study included diagnoses such as antisocial personality in addition to serious and persistent mental illness such as schizophrenia and bipolar disorder. Likewise, this study included both alcohol and drug abuse in addition to dependence.[3] Reliable, conclusive data on numbers of persons in Alaska with co-occurring disorders are not as readily available. A number of barriers have conspired over the years that make estimation a problem:

a. Either a substance use disorder treatment provider or a mental health treatment provider typically provides services to this population. Because of confidentiality restrictions, the data from these two sets of providers have not been integrated to identify the numbers of individuals served by both systems.

[1] National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, March 1999, Washington, D.C.

[2] Substance Abuse and Mental Health Services Administration, Improving Services for Individuals at Risk of, or with, Co-occurring Substance-related and Mental Health Disorders, 1997, Rockville, MD.

[3] Regier, D., Farmer, M., Rae, D. Lock, B. Keith, S. Judd, L. and Goodwin, F., "Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study." Journal of the American Medical Association, 1990 Nov 21;264(19):2511-8, Rockville, MD.

b. There is some question regarding how thorough the assessments conducted by either type of provider are for the "other" disorder (assessment for mental disorders by a substance use disorder provider or vice versa). Because some of the symptoms of each type of disorder can reflect several different diagnoses, providers often assess, diagnose, and treat the disorder that they know best. The failure to provide a thorough assessment and, where appropriate, diagnosis, results in incomplete prevalence data.

c. There are estimated to be a significant number of individuals in Alaska who are underserved or unserved. Utilization data from both disciplines reflect prevalence only among those who are treated. Those who go untreated are not reflected in the utilization reports. No population based needs assessment has ever been undertaken.

There are an estimated 40,412 adults and children with a experiencing a serious mental illness or a severe emotional disorder in Alaska[4]. According to a survey of mental health and substance use disorder service providers conducted as a part of this project, 67% of mental health providers estimate that between 25% and 75% of their mental health clients have a co-occurring substance use disorder.

A 1997 – 1998 study sponsored by the U. S. Center for Substance Abuse Treatment and the Alaska Division of Alcoholism and Drug Abuse estimated the number of persons with substance use disorders (includes both dependence and abuse) in Alaska to be about 14.9% of the adult residents (age 18 and older) of Alaska or about 65,015 (Alaska adult population at 2000 census was 436,345). The report also indicates that, based on these data, 12.6% of the adult population need treatment for alcoholism, 1.2% of the adult population need treatment for both alcoholism and other drug disorders while 0.5% need treatment for drug use disorders only.[5] In the survey of providers accomplished as a part of this project, 42% of the substance use disorder providers estimated that between 25 % and 75% of their clients had a co-occurring mental health disorder.

As noted above, the process of estimating prevalence of persons with co-occurring mental health and substance use disorders is problematic primarily because there is no formal process for diagnosing and/or reporting co-occurring disorders other than the normal diagnoses and reporting accomplished within each type of program. A lack of formal definitions adds to this problem. For this project, persons with co-occurring disorders are those individuals with co-existing conditions of serious, persistent mental illness (axis 1 diagnosis only) together with a diagnosis of substance dependence. It should be noted that this definition is more restrictive than the criteria noted in the citations above. As a result, the prevalence as defined in this project, although not known precisely, is less than the prevalence reported in the literature cited.

3. Forces for Change in Alaska. Two primary forces are moving the mental health and substance use disorder service delivery systems toward change in Alaska.

a. ***Gaps in Service to Persons with Co-occurring Disorders.*** Providers in both the mental health and substance use disorder service delivery systems, along with policy makers

[4] Substance Abuse and Mental Health Services Administration, United States Mental Health, 1998, Rockville, MD
[5] Alaska Division of Alcoholism and Drug Abuse, Summary of Recent Findings Regarding Substance Abuse in Alaska, 1999, Juneau, AK

and consumers, have long known that there are gaps in the service delivery systems for persons with co-occurring disorders. The failure to properly screen, assess, and/or diagnose either of the two disorders results in these clients being severely underserved. As a result, many of these individuals turn up in the homeless population or in the corrections system. Typically, clients are referred back and forth or are seen as "ineligible for treatment" because of the "other disorder." Moving from one system to the other without change in the clients' condition is costly, inefficient, and demoralizing.

b. ***Administrative Burdens on Rural Consolidated Programs.*** For providers in rural Alaska who deliver both substance use disorder and mental health services, the administrative burden of complying with requirements of both the Division of Mental Health and Developmental Disabilities (DMHDD) and the Division of Alcoholism and Drug Abuse (ADA) is considerable. These administrative requirements include data collection and transfer; grant application and administration, dual site survey requirements, and funding utilization restrictions. These issues, along with an emphasis on the prevalence of persons with co-occurring disorders in rural Alaska, were discussed at length in the rural providers conference in Anchorage during April 2000.

These primary forces combined with a heightened need to produce positive results with service delivery make this project particularly relevant and timely.

4. Project Scoping Document. In June 1, 2000, the Department of Health and Social Services produced a scoping document that outlined the frame work for this project.

a. ***Long Term Goals.*** The scoping document provided the following long term goals supported by the project:

- Improving treatment outcomes;
- Improving accessibility of services and quality of care; and
- Improving efficiency in administration to minimize costs and facilitate greatest use of available funds to support client services.

b. ***Project Objectives.*** In addition to providing background information and steering committee structure and membership, the scoping document identified the following objectives of the project:

- Establish a working definition of "integrated mental health and substance use disorder" accepted by both fields.
- Inventory best practice models of integration for mental health and substance use disorder services.
- Address philosophical and practice issues that impede integration of the two fields' distinctly different treatment orientations.
- Propose actions to facilitate the provision of integrated mental health and substance use disorder services.
- Develop recommendations regarding processes for planning, advocacy, administration, and oversight of mental health and substance use disorder services that would facilitate more integrated services.

B. Methodology/Group Process. This project involved a number of different, parallel tasks, each with its own methodology.

1. Group Process. The Steering Committee was comprised of 16 individuals representing mental health and substance use disorder service providers, consumers, board members (AMHB and ABADA), DMHDD, ADA, DHSS, and the Rural Human Services (RHS) program. In addition, a staff member from the Alaska Mental Health Board provided support. The structure and membership of the Steering Committee was defined by the Project Scoping Document. A listing of Steering Committee members and their associations is included as Appendix A to this report. A contractor, C & S Management Associates, was retained to provide process and research support for the project. The primary role of the Steering Committee was to oversee the project, define the boundaries of inquiry and discussion, review research provided by the contractor, and develop consensus points that resulted in the recommendations included in the report. The group met four times in person and three times by teleconference. The group agreed at the outset that all decision-making would be by consensus. As the group reviewed research and documentation provided by the contractor, they gave guidance and instruction for additional research as appropriate.

2. Research. The contractor conducted research both within Alaska and at the national level as directed by the Steering Committee. The research was primarily key informant interviews and documentation collection/review. Documents gathered as a part of this research were distributed to the Steering Committee as directed by the co-chairs.

3. Providers' Survey. The contractor, as a part of this project, conducted a mail survey of all public and private substance use disorder and public mental health service providers. The issues addressed in this survey were identified in a Steering Committee brainstorming session with the contractor, producing a draft of the survey instrument. The instrument was reviewed and approved by the Steering Committee co-chairs. The surveys were sent out with a cover letter and a stamped, self-addressed envelope. Because the surveys were not anonymous, the contractors were able to follow up with those providers not responding. The initial mailing and follow-up effort yielded a 52.8% response rate. The data from the surveys was analyzed and the results are detailed in Section II of this report.

C. Scope of the Project. Early in the process, the Steering Committee was concerned with the magnitude of the project; therefore, they carefully defined the boundaries or limits of the research and discussion at the very beginning along with clear guidelines to the contractor. First, the question of merging the two divisions (DMHDD and ADA) was not considered to be an issue for discussion and therefore the Steering Committee directed that research in this area not be undertaken. There was also a clear directive that merging the two service delivery systems into a single behavioral healthcare model was not one of the goals, and therefore, targeted research into this issue was minimal. Finally, as the project unfolded, there were other topics that, because of the findings, the Steering Committee directed that further research and analysis not be conducted. Of these, the primary issues that were limited were:

1. The Development of an Integrated Data System. The group recognized that data collection is an ongoing problem for both the DMHDD and ADA and that efforts are underway

to address these problems. While recommending long-term consolidation of the data systems of both divisions, the Steering Committee recognized that an in depth treatment of the subject was beyond the scope of this project.

2. Detailed Analysis of Clinical Issues. While the Steering Committee recommends that practice guidelines be developed covering delivery of services to persons with co-occurring disorders, the focus of the Steering Committee was on policy issues and development of a framework or foundation from which to work. Investigation of specific clinical methodology and practices was considered beyond the scope of this effort, given the resources, participants, and time available. The Steering Committee felt that DMHDD and ADA, working directly with service providers and consumers, would most effectively accomplish the detailed work around clinical practices.

3. Development of Standardized Assessment or Screening Tools. Assessment and screening tools are considered to be pivotal elements in the delivery of services to persons with co-occurring disorders. Because of the diversity of the instruments and techniques in use in Alaska and the technical nature of the subject, the broad recommendation of the Steering Committee is that service providers ensure that qualified staff accomplish appropriate screenings and assessments. The Steering Committee recommends that DMHDD, ADA, and service providers develop a list appropriate instruments and techniques.

4. Discussion of Philosophical Differences. Finally, the Steering Committee recognized that there are a number of philosophical and practical differences between the mental health and substance use disorder disciplines. Some are based on experience, others on perceptions. Understanding and minimizing these differences is a process that begins with consensus building and trust. The group chose to concentrate on areas of agreement where action could be taken, believing that working together and solving problems would help to build the trust between the two groups. While some differences were discussed, in the end, the group elected not to dwell on this issue.

II. Glossary.

A. General. One of the first major tasks undertaken by the Steering Committee was to develop a set of working definitions.

B. Working Definitions. To ensure consistency of perception as we discuss specific treatment issues, the following working definitions are presented. These definitions were developed and adopted by the Steering Committee at the beginning of the project.

1. Co-Occurring Disorders**.** For purposes of this project, this term is defined as co-existing conditions of serious, persistent mental illness (axis 1 diagnosis only) together with a diagnosis of substance dependence.

2. Levels of Integration. Service delivery levels describing the extent to which mental health and substance use disorder services are delivered cooperatively. The three defined levels of integration are consultation, collaboration, and consolidated services. These levels of integration are defined in sub-paragraphs (1) through (3) below.

a. ***Consultation.*** Those relationships among providers that ensure both mental illness and substance use disorder are addressed, especially with regard to identification, engagement, prevention and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.

b. ***Collaboration.*** Those more formal relationships among providers that ensure that both mental illness and substance use disorders are included in the multi-disciplinary treatment plan. An example of such collaboration might include interagency staffing conferences where representatives of both substance use disorder and mental health agencies specifically contribute to the design of a treatment plan for individuals with co-occurring disorders and contribute to service delivery.

c. ***Consolidated Services.*** Those relationships among mental health and substance use disorder providers in which the contributions of professionals in both fields are included in a single treatment team and treatment plan for co-occurring disorders.

3. Assessment. The process by which presenting problems and factors are considered in order to develop diagnoses and determine an appropriate course of treatment.

a. ***Diagnosis.*** The formal finding that a specific condition exists for a client. For mental health and substance use disorders, diagnoses are normally made using criteria and titles from the Diagnostic and Statistical Manual (DSM) - Effective Edition.

b. ***Screening.*** Screening is a process in which symptoms and presenting problems are reviewed in order to determine the likelihood that a specific disorder does or does not exist. Screening is a less precise process than the diagnostic process. The result of a screening in which the likelihood of a disorder is determined to exist would be referral for a full

assessment and diagnosis by an appropriately qualified professional.

4. Referral. Referral is the process of selecting a provider in another or related field for a full assessment, diagnosis, and/or treatment. Referral encompasses positive efforts to ensure that the client meets with the other agency or professional and positive efforts to develop a treatment plan that includes the work of the other professionals.

III. Survey of Substance Use Disorder and Mental Health Providers.

A. Introduction. Between August and November 2000, the project contractors conducted a mail survey of all publicly and privately funded substance use disorder programs and publicly funded mental health providers. The survey was designed to gather various pieces of information:

1. Perceived Prevalence. The survey was designed to investigate the perceived prevalence of co-occurring disorders from the perspective of the substance use disorder providers and the mental health providers, that is, the percentage of their client populations with co-occurring substance use disorder and mental health disorders.

2. Administrative Barriers. Since there had been significant discussion, particularly among rural providers, about administrative barriers to providing services to clients with co-occurring disorders, the survey sought to identify and quantify, to the extent possible, the seriousness of each of these barriers.

3. Perceived Level of Integration. Even at the national level, there is a great deal of confusion and lack of consensus regarding the exact definition of integration. The Steering Committee drafted and approved a working definition of terms and asked providers to identify their level of integration.

4. Training Needs. The survey queried providers about the level of cross training of their staff and perceived training needs in this area.

5. Recommendations. Finally, the survey solicited recommendations from the providers for improving services to persons with co-occurring disorders.

B. Methodology.

1. Pre-Survey Investigation. Prior to conducting the survey, the contractor conducted key informant interviews with directors of service provider agencies to gain a better understanding of the relationship of mental health and substance use disorder service provision in different parts of the state. The focus of these interviews was the organizational relationships between mental health and substance use disorder providers in communities and how services for persons with co-occurring disorders were coordinated. While there are a variety of specific relational models in existence, they can be synthesized down to four basic organizational models. These four basic models are summarized in the table below.

Model	Organizational Characteristics	Service Delivery Characteristics
Stand-alone	Stand-alone providers can either be self-contained, independent providers or be a part of a larger organization. If part of a larger organization, in this model, the larger organization does not have a program offering "the other" service.	Stand-alone providers offer either mental health or substance use disorder services; not both. When clients need services for "the other disorder," they are offered through referral or by arranging for an onsite consultation by another provider.
Common Parent	Common parent providers are programs operated by a larger organization, such as an Alaska Native health corporation, which also operates a program offering "the other" services. For this model, the two services do not have common programmatic supervision.	Common parent providers offer either mental health or substance use disorder services; not both. They are distinguished from the stand-alone providers in that their parent organization operates a program that offers "the other" service. Coordination of care occurs through liaison between the two programs; not through common programmatic supervision.
Common Programmatic Supervision	Common programmatic supervision models are similar to common parent models in that they are a part of a larger organization. They differ in that the common supervisor within the larger organization provides programmatic as well as administrative supervision.	Common programmatic supervision models offer either mental health or substance use disorder services; not both. Because they have supervision that is also programmatically responsible for "the other service," coordination of care tends to have a higher level of integration. Joint staffings and frequent consultation are common.
Consolidated Program	Consolidated providers can be either independent or a part of a larger organization. These providers offer both mental health and substance use disorder services from within the same program.	Consolidated providers offer both mental health and substance use disorder services. Care is delivered by a single treatment team that may have cross-trained staff or sufficient staff in each discipline. Records for mental health and substance use disorder clients are usually integrated records.

2. Population Surveyed. The survey instrument, which is included as Appendix C to this report, was mailed to 106 publicly and privately funded substance use disorder providers and publicly funded mental health service providers in Alaska. For the substance use disorder programs, the list of providers was obtained from the Division of Alcoholism and Drug Abuse and reflected the private and public programs approved by the Division. For the mental health providers, a list was obtained from the Alaska Mental Health Board and included all grantees of the Division of Mental Health and Developmental Disabilities. Private mental health providers were not included in the survey because there is no centralized listing of providers to draw from as there is on the substance use disorder side.

3. Follow-up and Response Rate. Within a month after the initial mailing, the response rate was about 30%. Because programs were asked to provide their identity on the survey form, the contractor was able to track response and follow up with those programs not responding. After thirty days, a follow-up letter was sent to those programs not responding along with another copy of the survey instrument. This effort yielded an overall response rate of 52.8%.

4. Analyses. Analysis of the data was performed by the project contractor using Statistical Program for Social Sciences (SPSS) for Windows©. Analysis consisted primarily of frequency distribution and descriptive statistics.

C. Results of the Survey.

1. Providers Responding. Of those providers responding, providers identified themselves as follows:

a. Substance Use Disorder Providers – 28%
b. Mental Health Providers – 21%
c. Providers Delivering Both Services – 43%
d. Others – 8%

It should be noted that, although definitions were provided with the surveys to assist providers in identifying their level of integration, the contractors noted that, in some case, programs identified themselves as delivering both services if they treated persons with co-occurring disorders, even if they arranged for treatment of one of the disorders through a referral process. Since the intent of the question was, in part, to identify those providers who, themselves, provided both services, this interpretation on the part of some programs clearly skews the results. A more accurate assessment would likely result in a lower percentage delivering both services and higher percentages of mental health and substance use disorder providers. Additionally, it should be noted that, of the programs self-identifying as delivering both types of services, approximately 74% were from rural Alaska. The overall distribution of providers, as noted below, has only 58% from rural Alaska.

When asked how providers delivered services to persons with co-occurring disorders, the responses were not surprising. Substance use disorder providers delivered services to persons with co-occurring disorders through direct delivery of substance use disorder treatment and referral out for mental health services. Mental health providers directly delivered mental health services and referred out for substance use disorder services. Finally, the integrated programs report directly delivering both types of services.

Of the providers responding, 42% were from urban centers (Anchorage, Fairbanks, and Juneau), 33% were from hub communities (rural communities with population over 2,000), and 25% were from villages. The following indicates the distribution by region of the state:

- Anchorage – 24%
- North Slope and Northwest Alaska – 2%
- Western Alaska (including Aleutians) – 11%
- Southcentral Alaska (not including Anchorage or Mat-Su) – 15%
- Interior – 17%
- Southeast Alaska – 25%
- Mat-Su Valley – 6%

2. Prevalence of Co-occurring Disorders. One of the questions addressed by the Steering Committee at the beginning of the project was whether there was a difference in the percentage of clients with co-occurring disorders seen by substance use disorder and mental health providers. The following table shows the percentages of clients with co-occurring disorders reported by substance use disorder providers, mental health providers, and providers who deliver both types of services.

Table 1 - Provider Estimates of Co-Occurring Disorder Prevalence

Percentage of Clients with Co-Occurring Disorder	Substance Use Disorder Provider	Mental Health Provider	Provider Delivering Both Types of Services
Less than 25%	50.0%	16.7%	0.0%
25% - 50%	25.0%	33.3%	65.2%
50% to 75%	16.7%	33.3%	21.7%
More than 75%	8.3%	8.3%	13.0%
Do Not Know	0.0%	8.3%	0.0%

From the above table, it is clear that mental health providers perceive that a higher percentage of their clients have co-occurring disorders compared with substance use disorder providers. Half of the substance use disorder providers report that less than 25% of their clients have co-occurring disorders while only 16.7% of mental health providers report such low percentages. By contrast, 67% of mental health providers report that between 25% and 75% of their clients have co-occurring disorders while only 42% of substance use disorder providers report such percentages. The majority (65.2%) of providers who deliver both services report that between 25% and 50% of their clients have co-occurring disorders.

This assessment assumes, of course, that the perceptions regarding the percentages of clients with co-occurring disorders are accurate. There are a number of factors that can impact these perceptions including lack of diagnostic or assessment training, nature of services delivered (long term versus emergency), and organizational policies.

3. Impact of Administrative Barriers. The issue of administrative barriers that impact delivery of services, as the Steering Committee has defined them, applies primarily to those providers who deliver both services within a single organization. These barriers include, for

example, data collection for two state agency data systems, separate grant application and administration processes for the two systems, separate site facility surveys, etc. While issues regarding data collection, grant application, etc., may impact stand alone mental health and substance use disorder providers, it was not the charge of this project to identify and recommend solutions in all of the areas in general. The charge was to identify issues and develop recommendations to barriers experienced by programs delivering both services.

The following table shows the responses by consolidated providers indicating how significant the barriers are for the following issues:

- Data collection;
- Grant application process;
- Site facility surveys;
- Regulation/Oversight;
- Reporting requirements; and
- Overall administration.

Table 2 - Impact of Barriers on Providers Delivering Both Services

Barrier	Greatly Hinders	Slightly Hinders	Neutral	Slightly Enhances	Greatly Enhances
Data Collection	43.5%	34.8%	17.4%	4.3%	0.0%
Grant Application Process	61.9%	4.8%	33.3%	0.0%	0.0%
Site Facility Survey System	34.8%	13.0%	39.1%	13.0%	0.0%
Regulation/Oversight	30.4%	39.1%	26.1%	4.3%	0.0%
Reporting Requirements	30.4%	34.8%	30.4%	4.3%	0.0%
Overall Administration	26.1%	30.4%	34.8%	8.7%	0.0%

4. Funding Sources. We asked respondents to indicate the percentages of their budgets received from various sources. In general, the responses indicated that providers who deliver both services have more diverse funding sources than either mental health or substance use disorder providers. They are less likely to rely on a single funding source as the mainstay of their operations. The following table details the funding source data for substance use disorder, mental health, and integrated programs. The percentages shown indicate the average percentage of the budget per funding source for each type of provider. The percentages in the different columns do not sum to 100% because we are taking averages of the reported values for each funding source for all providers in that category.

Table 3 - Funding Sources

Funding Source	Substance Use Disorder	Mental Health	Integrated
ADA Grants	51.9%	0.0%	28.6%
DMHDD Grants	0.0%	37.9%	22.8%
Medicaid/Medicare Billing	9.2%	35.7%	16.5%
3rd Party Commercial Insurance	4.3%	55.0%	13.3%
Indian Health Service	31.7%	0.0%	36.5%
Federal Grants	20.0%	10.0%	18.1%
Private Grants	3.5%	0.0%	0.5%
Client Self Pay	29.8%	3.1%	13.3%
Other	30.1%	23.0%	12.4%

5. Respondent Level of Integration. All respondents were asked to indicate their level of integration in seven different areas: Treatment planning, delivery of services, grants administration, administrative overhead, program evaluation, staff training/development, and quality assurance. Programs that self-identify as providing both mental health and substance use disorder services report substantially greater integration in all areas than providers of either mental health or substance use disorder services only.

Table 4 – Level of Integration

Area of Integration	Substance Use Disorder	Mental Health	Integrated
Treatment Planning	2.07	1.60	3.88
Delivery of Services	2.20	1.80	3.82
Grant Administration	1.33	1.10	2.94
Administrative Overhead	1.13	2.00	3.65
Program Evaluation	1.53	1.10	3.00
Staff Training and Development	1.73	1.60	4.00
Quality Assurance	1.73	1.20	3.47

Note: Scores are means based on a 5-point scale.

6. Level of Cross-Training. Providers were asked to rate the level of cross-training that exists for their staffs. On a scale of one to five, programs that self-identified as providing both services rated their level of cross-training higher than either substance use disorder or mental health providers, with an average score of 3.83. Substance use disorder providers report an average level of cross training of 3.12 while mental health providers report 2.79. It is again important to note that these data reflect only the self-perception of cross-training levels and are not measured against any standardized specifications.

7. Desire/Need for Additional Cross-Training. Respondents were asked to indicate cross-training subjects from the following list from which they believed their staff could benefit:

a. Mental Health Assessment

b. Crisis Intervention
c. Referral/Resources
d. Substance Use disorder Assessment
e. Pharmacology/Psychotropic Medications
f. Recovery for Dual-Diagnosis Clients
g. Integrated Treatment Planning
h. Integrated Case Management

There was a high interest in mental health assessment by substance use disorder and integrated providers and a corresponding high interest in substance use disorder assessment by mental health and integrated providers. There was high interest from all categories of providers for more cross training in recovery for the dually diagnosed, integrated treatment planning, and integrated case management.

8. Advantages, Disadvantages, and Recommendations for Greater Collaboration. Finally, qualitative responses were solicited regarding the perceived advantages, disadvantages and possible recommendations for greater collaboration or integration of mental health and substance use disorder services. In general, the following response trends were noted:

a. ***Advantages.*** Respondents generally viewed greater collaboration and, in some cases, integrated delivery of services as helping to address all of the presenting problems of clients in an organized and coordinated manner, helping to ensure that problems and clients do not slip through the cracks. Many respondents talked about the efficacy benefits of treating the clients as "whole persons" instead of highly categorizing problems to the extent that there is no coordination in service delivery.

b. ***Disadvantages.*** Despite the potential benefits of greater collaboration, respondents were wary that too much integration could lead to the overriding emphasis of one discipline to the exclusion of the other. Some respondents gave voice to the fear that one or the other of the two disciplines might "swallow" the other, changing the character of the field and reducing treatment efficacy.

c. ***Comments.*** There were a variety of recommendations advanced by respondents. Many suggested special grants for programs that are fully integrated. Other recommendations encouraged the consolidation of administrative functions such as reporting, data collection, and program site visits.

IV. Service Delivery Issues.

A. General. This section will address issues directly related to delivery of services to persons with co-occurring disorders. It will examine the issues from a global, framework perspective and also examine, in more detail, some specific issues such as assessment, treatment planning, case management, and continuing care. This section will also provide a set of working definitions that apply to delivery of services to persons with co-occurring disorders as well as the recommended core values for delivery of such services.

An underlying assumption of all service delivery recommendations is that a highly trained and qualified population of professionals from both the mental health and the substance use disorder fields will be critical. This will require attention to cross-training, adequate compensation, and establishing professional collaborative relationships.

B. Specific Issues.

1. Core Values for Delivery of Services. As with any endeavor, the task of moving from the "here and now" to some improved system or situation involves two major components. The first component is to identify what the definition will look like and how to best get there. The second, and equally important component of this endeavor is to establish a set of core or shared values that will help to define the nature of changes and methods. Early in the process, the Steering Committee, by consensus, adopted the following shared values that should apply to any system delivering mental health and/or substance use disorder services to persons with co-occurring disorders.

a. ***Consumer-Centered.*** Any successful service system must be consumer-centered. A consumer-centered system is one in which the mental health and substance use disorder consumers and their families are actively involved not only in treatment decisions, but also in program design, administration, and evaluation.

b. ***Availability of Services.*** Individuals should have access to a comprehensive array of services appropriate to their needs. Treatment of co-occurring disorders should be individualized to accommodate the needs of different sub-types and different phases of treatment for all established diagnoses.

c. ***Culturally Competent.*** Service systems should observe and respect the values and beliefs of the diverse cultures of our consumers and should be provided by staff that are culturally competent.

d. ***"No Wrong Door."*** Services for persons with co-occurring disorders must be available and accessible where, and whenever, the person enters the service system. The "no wrong door" approach ensures that an individual can be treated, or referred for treatment, whether he or she seeks help for a mental health problem, a substance use disorder, or a general medical condition.

e. ***Administrative Systems.*** Administrative systems and procedures should not

present a barrier to effective delivery of services to persons with co-occurring disorders.

f. ***Respectful Partnership.*** In order to deliver the most appropriate services to persons with co-occurring disorders, substance use disorder and mental health professionals must work together in a respectful partnership that honors the strengths that each sector brings to the table and respects the values, professional standards, and achievements that each sector has developed.

g. ***Resources for Services.*** Any system for delivery of services to persons with co-occurring disorders should have adequate resources to ensure a safe, comfortable physical setting, appropriate program materials, and trained and appropriately compensated staff.

2. The New York Model: A Contextual Framework. At the NASMHPD and NASADAD conference held in Washington, D.C. in 1998, there were various presentations from different states that were active in addressing problems for persons with co-occurring disorders. One presentation and system that drew considerable national attention was the New York Model. More appropriately described as a contextual framework, the New York Model does not prescribe how services will be delivered but rather frames the system for delivery of services based on the type and severity of the diagnoses and presenting problems. The Steering Committee recommends that both DMHDD and ADA adopt the New York Model as a conceptual framework for services to persons with co-occurring mental health and substance use disorders. An important aspect of this model or framework is that it formally recognizes several key factors:

a. ***Different Degrees of Severity.*** There is often a tendency to refer to the multiple diagnoses applied to a person with co-occurring disorders as if the level of severity were basically at some fixed, equal level for all of the diagnoses. This framework recognizes that the different diagnoses present may be at different levels of severity. For example, a client may be diagnosed with a bipolar disorder and alcoholism but the alcoholism may present a more severe problem.

b. ***Fluctuating Levels of Severity and Acuity.*** Another key recognition by this framework is that the presenting problems fluctuate over time with regard to severity and acuity. Problems that may be urgent at a given point in time may be addressed and become less severe over time, giving way to other problems that take on a greater urgency. In addition to fluctuating severity, it is an expectation that persons with co-occurring disorders will also experience variations in acuity over time. This might be manifested by a periods of heightened substance use or mental health disorder symptoms.

c. ***Locus of Care.*** Finally, this framework recognizes that a single agency has primary responsibility for each person. This "locus of care" is tied primarily to the disorder that presents the most urgent need. The framework presumes that the locus of care for any given client can change as the levels of severity and acuity fluctuate for the different disorders present. When a mental health disorder is the most dominant, severe disorder in terms of presenting problems, then the locus of care is likely to be with a mental health provider. As the mental health problem is addressed and substance use the disorder becomes the most prominent or pressing problem, the locus of care shifts to a substance use disorder provider. A key issue

regarding locus of care is the responsibility of the provider that represents the locus of care to ensure that the different presenting problems are addressed, either by directly providing services or by collaborating with other providers to have appropriate services delivered. This becomes critical with heightened levels of acuity that occur with clients. The key point is that accountability for service delivery lies with the locus of care provider.

d. ***Quadrants of Care.*** To better understand the context addressed by the New York Model, the architects of this framework conceptualized four quadrants of diagnosis and problem severity as described below and shown in the chart below.

New York Model – Contextual Framework

Locus of Care **Mental Health** Mental Health Diagnosis (High Severity) Substance Use Disorder Diagnosis (Low Severity)	**Locus of Care** **Collaborative/Consolidated Service Delivery** Mental Health Diagnosis (High Severity) Substance Use Disorder Diagnosis (High Severity)
Locus of Care **Medical /Corrections/Public Safety** Mental Health Diagnosis (Low Severity) Substance Use Disorder Diagnosis (Low Severity)	**Locus of Care** **Substance Abuse** Mental Health Diagnosis (Low Severity) Substance Use Disorder Diagnosis (High Severity)

In this framework, delivery of services is relatively straightforward in the upper left and lower right quadrants, where there is a clear locus of care in either of the two disciplines. For example, the upper left quadrant represents the situation in where the severity of mental health symptoms is high while the substance use disorder symptom severity is low. By contrast, the lower right quadrant represents the opposite situation – substance use disorder severity is high with low severity of mental health symptoms. In these two cases, the locus of care clearly resides with the organization providing care for the disorder with the high level of severity.

In the lower left quadrant, where neither disorder presents with a high degree of severity, the

consumer often does not show up in either system but rather is seen within the corrections system, the medical care system, or even the public safety network. This quadrant represents the opportunity for early and proactive intervention to prevent escalation of symptoms and degraded quality of life. It also represents the opportunity to provide services in the least restrictive and least expensive settings.

The upper right quadrant represents the case in which both mental health and substance use disorders present with equally high levels of severity creating a situation where either discipline could serve as the locus of care. This quadrant also represents the likelihood that neither discipline, operating alone, will be effective in meeting the client's needs. For example, high severity substance use disorder, left untreated, will almost certainly sabotage mental health treatment efforts. Similarly, mental health problems, left unaddressed, will almost certainly sabotage substance use disorder treatment efforts. In order to achieve the greatest probability of success, delivery of services to clients with high severity in both diagnoses needs to be highly coordinated either through the joint efforts of multiple organizations cooperating as a single treatment team or as a single consolidated organization.

This framework has several key assets that make its use attractive. First, it is not prescriptive regarding modality of treatment nor does it advocate for or against consolidating organizations. Second, it identifies the appropriate locus of care in cases where there is a clear difference in severity of symptoms, but it does not imply that the disorder that presents as less severe can be ignored. Rather, it assigns responsibility and accountability for appropriate delivery of services to the organization that serves as the locus of care, whether that organization provides all services or whether it coordinates with other agencies. Finally, for the cases in which both disorders present with equally high severity, the framework specifies that, whether the organizations are formally consolidated or not, the treatment approach must be consolidated. In other words, the client should be treated with a single, consolidated treatment plan by a single collaborative treatment team. The team may be comprised of professionals from various organizations and the coordination of the team efforts may reside in either of the disciplines, but the effort must be consolidated. Generally, this framework focuses on client presenting problems and needs rather than organizational policies. It is completely non-prescriptive in terms of organizational structure and policy.

e. ***Alaskan Issues.*** While the New York Model has many advantages, there are issues particular to Alaska that impact its applicability and will need to be addressed.

(1) Access to Services. In contrast to areas of the United States that are more highly populated, the majority of the communities in Alaska are remote and isolated. Because there are very low population concentrations in these areas, wide arrays of services are not readily available. This causes particular problems in the "high-high" and "low-low" quadrants. Where the symptoms of both disorders are very high, Alaska often has a limited array of services to provide appropriate care. Where symptoms for both disorders are low, the limited array of ancillary services, limited law enforcement, and limited medical services often conspire to prevent the conditions from being recognized until the client's situation deteriorates sufficiently to bring them to the attention of the mental health and or substance use disorder providers.

(2) Differences in Terminology. The New York Model, as published, uses some terminology not currently used by the providers in Alaska. Among these, the term "substance abuse" has been replaced by the term "substance use disorder" and the term "integrated," as used by the New York Model, has been replaced by the term "consolidated." These terminology changes are reflected in the chart of the four quadrants presented above.

3. Proposed Practice Guidelines. One of the recommendations of the Steering Committee is that a set of practice guidelines be developed and implemented that identifies clear standards for organizations, whether mental health or substance abuse, providing services to persons with co-occurring disorders. These guidelines should apply to all state-approved substance use disorder programs (private and public) and to all publicly funded mental health providers. As a minimum, these practice guidelines should include the following elements.

a. ***Accessing Services***. Both consumers and providers are concerned that individuals with co-occurring disorders can access appropriate services. Historically, persons seeking services, whether mental health or substance abuse, sought them from the relevant provider. On occasion, the need for services is identified when the consumer or client accesses other types of services such as medical care. One of the desired characteristics of any system that provides services to persons with co-occurring disorders is the concept of "no wrong door." This concept simply states that, regardless of how or where a person seeks services or interacts with the system, his or her needs will be assessed in all appropriate areas and services provided or referrals and coordination made for service provision. This system characteristic depends heavily on developing collaborative relationships between agencies, as well as implementing screening and assessment requirements (see sub-paragraph 4.b. below).

b. ***Screening and Assessment Issues***. Diagnosis and assessment are critical to service delivery systems. Clients' needs cannot be addressed if organizations are not able to correctly identify those needs. Screening, as previously defined, is the process of determining the likelihood of a condition existing. Diagnosis and the identification of needs and recommended services are products of the assessment process. A full assessment is a process that examines many aspects of a person's situation. Not every organization is qualified or able to provide every element of assessment. Finally, it is important to note that these processes are ongoing. Clients' progress and symptoms are continually assessed throughout the course of treatment. To better understand the issue, the assessment process can be broken down into the following elements:

(1) Screening. Screening, as defined in sub-paragraph B2c(2) above, is the process of examining or considering presenting problems or symptoms to determine the likelihood that a certain disorder does or does not exist. As it is usually a gross process, a specific diagnosis does not result from screening. The result of a screening is a determination that a specific disorder is likely or not likely to exist, which can result in a more formal assessment by qualified professionals, if appropriate, to diagnose the client and identify needed treatment and services. In general, the absence of any symptoms or presenting problems suggesting a particular diagnosis would lead to an assumption that the specific disorder was not present. On the other hand, if a screening indicated that there were signs or symptoms that a disorder existed, the client would either be provided with a more thorough assessment leading to a formal diagnosis by the screening organization or referred for assessment to another organization or professional qualified to diagnose the specific disorder.

There are a wide variety of screening techniques and tools for mental health and substance use disorders. One of the key abilities of any organization providing mental health or substance use disorder services is the ability to screen for either disorder. It is not, however, an expectation that every organization should be able to provide diagnoses for all types of mental health and substance use disorders. The clients' needs can be met if an appropriate screening is conducted and, if indicated, a diagnostic process is undertaken by a qualified organization as indicated. Finally, the specific timing of diagnostic efforts is an issue that is resolved at the clinical level and depends heavily on the clients' situation.

(2) Diagnostic Assessment. Diagnosis is the formal process of determination that a specific disorder does or does not exist. Diagnoses are most often presented within the definitions and designations in the effective edition of the Diagnostic and Statistical Manual (DSM). Within the scope of the diagnostic process, there are several sub-elements.

(a) DSM Diagnosis. Within the mental health field, diagnosis of specific disorders is accomplished through an assessment process in which symptoms and presenting problems are compared with diagnostic criteria found in the effective edition of the DSM. This identification and comparison process can be accomplished through structured interviews, use of formal instruments, and/or review of clinical records and patient history.

(b) Substance Use Disorder Diagnostic Instruments. A number of instruments are currently in use in the substance use disorder field to assist counselors in making diagnoses of substance use disorders. One of the most prominent tools currently used is the Substance Abuse Subtle Screening Index (SASSI), which has versions for both adults and adolescents. Another popular screening tool is the Addictions Severity Index (ASI). Qualified substance use disorder counselors use these and other techniques and tools to arrive at specific substance use diagnoses as defined in the effective edition of the DSM.

In a survey of mental health and substance use disorder providers conducted in 2000 as part of a different project, researchers found that substance use disorder providers used the SASSI extensively as a part of the screening and diagnostic process. By contrast, there was no dominant diagnostic tool used by mental health providers. Some used locally developed instruments; some used nationally developed and validated instruments, while still others used only structured interviews.[6]

(3) *Patient Placement Criteria.* In addition to merely developing a formal diagnosis, the substance use disorder field also has a system for identifying the most appropriate level of services needed. This system was developed by the American Society of Addiction Medicine (ASAM) and is known as the ASAM Patient Placement Criteria. The Alaska Division of Alcoholism and Drug Abuse has mandated this system for use by grantees in determining appropriate levels of care. The system considers presenting problems and past experience and, based on those factors, identifies the most appropriate level of care ranging from outpatient to intensive, hospital-based inpatient care. The patient placement criteria, as they currently exist, do not address co-occurring disorders.

[6] Alaska Mental Health Board, Mental Health Performance Measures – Phase I Report, January 2001, Juneau, AK

The recommendation of the Steering Committee regarding the assessment process is that all substance use disorder providers approved by the Division of Alcoholism and Drug Abuse and all publicly-funded mental health providers be capable of screening for the presence of both mental health and substance use disorders and that, upon indication that a particular disorder may exist, either conduct a formal assessment or refer to a more qualified organization. Additionally, the steering committee recommends that the Division of Alcoholism and Drug Abuse and the Division of Mental Health and Developmental Disabilities develop an index of recommended instruments for screening and diagnosis of substance use and mental health disorders.

c. ***Ensuring that Client Needs are Met.*** For persons with co-occurring disorders, there is a high likelihood, particularly in cases where the primary organizations involved are single-focus, stand-alone providers, that referrals will be necessary in order to ensure delivery of appropriate services. The organization identifying the assessment or treatment needs must accomplish three basic tasks:

(1) Correctly identify assessment and/or treatment needs;

(2) Identify qualified and available resources; and

(3) Ensure delivery and consolidation of assessment and/or treatment efforts that result from the referral through an aggressive follow-up process.

As practice guidelines are developed and adopted, along with required competencies of clinicians, these tasks will become more formalized and effective.

d. ***Treatment Planning Issues***. Treatment planning is the process of formalizing the identification of presenting problems, developing actions and approaches for addressing those problems, and identifying measurable milestones and outcomes for improvement. This is accomplished through the use of a treatment plan. For persons with co-occurring disorders, particularly when receiving mental health and substance use disorder services from different organizations, there have traditionally been multiple treatment plans, each residing in and managed by a different agency or provider. A client receiving both mental health and substance use disorder treatment services would have a mental health treatment plan maintained and managed by the mental health provider. Likewise, they would have a substance use disorder treatment plan that would be maintained and managed by the substance use disorder provider. The need for an integrated treatment plan increases with an increase in severity of both disorders. In addition to the issue of the treatment plan itself, the treatment team involved in the planning and service delivery process is also a critical issue. Traditionally these teams have been organized and coordinated within individual organizations. When providing services to persons with co-occurring disorders, staff from other organizations are sometimes asked to attend meetings of the treatment team to bring their particular expertise to the table.

At the NASMHPD and NASADAD conference held in Washington, D.C. in 1998, the directors of both fields endorsed the need for closer coordination of the treatment planning process. In their identified desirable system characteristics, they identified the need to consolidate treatment teams for delivery of services to persons with co-occurring disorders. This might mean, for two

agencies coordinating services, which members of both organizations would serve on the treatment team. In terms of treatment planning, they recommended that a single consolidated treatment plan be developed and maintained for the persons with co-occurring disorders. This plan can be duplicated and used as a working document in all involved agencies with updates made during multidisciplinary staffings. Both of these recommendations represent a heightened commitment to interagency coordination, with its attendant workload. By contrast, these recommendations are less difficult to achieve for agencies that deliver both services under the same roof.

e. ***Care Coordination/Continuity of Care***. Whether an organization is a stand-alone mental health or substance use disorder provider or a consolidated organization providing both services, delivery of appropriate services for both disorders to persons with co-occurring disorders should be highly coordinated. The mechanics of coordination, as well as for actual delivery of services, will vary with the services needed, availability of services, and the skills and capacity of the organizations. Despite the variations in organizational structure, focus, and capability, there are recognized characteristics that should be present in all organizations if they are to provide appropriate services to persons with co-occurring disorders.

(1) Clinicians and organizations working with persons with co-occurring disorders must add to their clinical skills and organizational capacity. This is particularly true of single-focus organizations providing only substance use disorder or mental health services. They must be able to recognize the signs and symptoms of the disorder for which they do not provide services and engage the necessary resources to provide a coordinated approach.

(2) Agency admission criteria, whether the provider is a single-focus (mental health or substance use disorder) or completely consolidated, should be inclusionary; not exclusionary. Providers must identify ways to bring individuals into the system and provide appropriate services, whether through the use of internal resources or through collaborative partnerships.

(3) Providers should rigorously search for ways to bridge the gaps between the two disciplines in terms of funding, target populations, legal and regulatory mandates, and professional backgrounds and expertise.

(4) Providers should accept the responsibility to provide consolidated treatment for persons with co-occurring disorders. Multi-disciplinary teams and approaches are necessary. This is relatively straightforward in a fully consolidated organization but requires the development of collaborative relationships when multiple organizations are involved.

(5) Regardless of the locus of care or primary focus, treatment should be in the least restrictive and most clinically appropriate setting.

(6) The treatment should be individualized for each client. Treatment provided should be based on client needs and situation rather than the capability of any single organization. Services that exceed the capability and/or capacity of a provider may be provided using a coordinated or collaborative effort with an external resource. The patient should be seen from a holistic, biopsychosocial perspective, which includes consideration not only of treatment

needs but other services such as housing, transportation, culture, community support, etc.

(7) Self-help and peer support are valuable in the recovery process for both mental health and substance use disorders. Ongoing support, relapse management, and prevention are necessary strategies. As with both mental health and substance use disorders occurring independently, relapse and recovery for the person with co-occurring disorders are processes, not single events, and relapse is not synonymous with failure.

(8) Families should be involved in the treatment process, both in terms of planning, service delivery, and ongoing support. In order to fully participate, families need education and support.

(9) Group education and group process are valuable elements of the treatment process for persons with co-occurring disorders.

(10) Organizations providing services to persons with co-occurring disorders, whether fully consolidated or single-focus, as well as the individual caregivers, should be culturally competent.[7]

f. ***Recovery, Continuing Care, and Ongoing Support.*** As noted in the previous sub-paragraph, relapse and recovery are processes. Organizations providing services to persons with co-occurring disorders must recognize and plan for the possibility of acute episodes. The acute episode may or may not include the abuse of psychoactive substances, in either the substance use disorder or the mental health disorder or both. Because there is a high likelihood that a relapse in one disorder, left untreated, will trigger a relapse in the other, organizations must pay attention to the recovery process as it applies to both disorders. When developing ongoing support and continuing care plans, organizations must include provisions for addressing needs associated with both types of disorders. As with treatment planning and coordination, this may take additional effort and vigilance for single-focus organizations. Clinical staff and case managers within these organizations must have extended skills that will enable them to recognize signs of impending relapse in either disorder and provide appropriate intervention through the use of either internal or external resources.

As organizations plan for continuing care and support, they must also work to resolve any conflicts that may exist between the two disciplines. The service delivery system serving persons with co-occurring disorders must resolve these types of issues and not rely on the clients to sort out the different requirements for themselves.

Finally, continuing care and support should be provided in a highly consolidated mode that involves staff from both disciplines. The locus of care in situations where care is provided by several single-focus organizations may rest in either the substance use disorder or the mental health provider, but coordination between the organizations should continue. The responsibility

[7] U. S. Substance Abuse and Mental Health Services Administration, Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse (Treatment Improvement Protocol (TIP) Series 9, 1994, Rockville, MD.

and accountability for ensuring that this coordination continues should rest with the organization within the appropriate locus of care.

C. Service Delivery Recommendations.

1. Core Values. The Steering Committee recommends that the core values identified in this section be adopted by DMHDD and ADA and consolidated into the standards for the providers for which they have oversight responsibility.

2. New York Model Contextual Framework. The Steering Committee recommends that both DMHDD and ADA adopt the New York Model Contextual Framework, particularly as it relates to the designation of locus of care and responsibility for ensuring delivery of appropriate services.

3. Index of Recommended Screening and Diagnostic Tools. The Steering Committee recommends that DMHDD and ADA develop an index of recommended screening and diagnostic tools that can be used by both single-focus, stand-alone providers as well as consolidated organizations. The divisions should also develop and maintain training resources as appropriate for those tools.

4. Practice Guidelines. The Steering Committee recommends that DMHDD and ADA develop and implement practice guidelines for all organizations under their purview regarding services to persons with co-occurring disorders. These guidelines should include, as a minimum, the following elements:

a. Provisions for accessing appropriate services – "no wrong door."

b. Requirements that every provider ensure an appropriate assessment process for clients that includes screening and, as indicated, diagnosis for both substance use and mental health disorders.

c. For single-focus, stand-alone providers, there should be a process for identifying the most appropriate qualified referral for a client whose needs exceed the capability and/or capacity of the organization.

d. Treatment plans for persons with co-occurring disorders should be highly consolidated. The plans should identify client needs based on a holistic, biopsychosocial perspective and mandate specific services based on these needs.

e. Delivery of care should be highly coordinated, regardless of the locus of care, and the responsibility and accountability for this coordination should rest with the organization in the primary locus for cases in which the service providers are single-focus, stand-alone organizations. This element should include case coordination, staffing, scheduling, consistent objectives, and resolution of any programmatic conflicts.

f. Clients should receive continuing care that promotes their recovery. This element should recognize the nature of mental health and substance use disorders, the likelihood

of acute episodes and the concept of recovery as an ongoing process.

V. Administrative Barriers

A. General. In addition to the issue of gaps in service for persons with co-occurring disorders, one of the major issues that served as a catalyst for this project was the issue of administrative barriers that face organizations choosing to consolidate. The organizations affected are, for the most part, located in rural Alaska and consolidate primarily as a means of survival. The scale of operations, given the small population, will usually not support two independent, freestanding providers in small communities. Instead, many of the organizations in small rural communities have elected to offer both substance use disorder and mental health services from within the same organization. The barriers referred to are those created as a result of mental health and substance use disorder services being funded and coordinated by two different divisions within the Alaska Department of Health and Social Services. Such barriers include the necessity for dual grants, two independent, incompatible data collection systems, duplicative quality assurance and regulatory oversight processes, and billing difficulties related primarily to Medicaid.

This issue was brought forward by rural providers at a planning meeting held in Anchorage in the fall of 1999. The barriers were a continued topic of discussion at the Rural Mental Health Conference in the spring of 2000. As a result, the Commissioner of Health and Social Services convened the Steering Committee for this project to examine these barriers, along with other service delivery issues.

B. Specific Barriers.

1. Data Systems and Data Collection. Both the Division of Alcoholism and Drug Abuse (ADA) and the Division of Mental Health and Developmental Disabilities (DMHDD) have data systems and require grantees to collect and submit data to populate these databases. Both systems are designed to collect information on client services without collecting personal identifying information of the client. Unique identifiers prevent duplicate counting but do not reveal the identity of the client. Both systems are designed to produce reports that measure client activity, services received, demographics, treatment outcomes, and program performance. Both systems are designed to produce unduplicated counts of clients system-wide, given appropriate data input from the providers.

For all of their similarities, however, the two data systems are different in many ways, including their basic approach to the task. While the differences and incompatibilities are of little interest to single-focus, stand-alone providers, they pose serious potential problems for the small, consolidated providers. If both divisions insisted upon rigorous collection and reporting of data using their respective systems, these providers would clearly be overwhelmed. The term "potential problems" is used here because, in reality, small consolidated providers are reporting only one set of data. They currently report data to the ADA MIS only. Although they report mental health service provision to this data system, there is currently no way to transfer data from the ADA management information system (MIS) to the DMHDD system, Alaska Recipient Outcome Reporting Application (ARORA). So, while the providers are not directly suffering because of the two disparate systems, DMHDD is not receiving the data that it needs in order to manage and coordinate delivery of services in Alaska.

a. *Division of Alcoholism and Drug Abuse Management Information System (MIS).* The management information system for the Division of Alcoholism and Drug Abuse (ADA) has been in operation since the early 1980s and has served the division well. The system is designed around a proprietary software application that is installed on the computers of all grantees as well as on the computer system within the division. Grantee staff enter data on their own computers and then transfer to the division's in-house system via 3.5" diskettes. The key to success over the years has been that every grantee had the same software application and entered the same set of data. From this system, the division has been able to produce consistent utilization and program performance reports. The system was also designed to allow providers to generate their own management reports directly from their computers. Some providers have taken advantage of this capability while others have not.

In the early 1990s, ADA modified the system to allow for reporting of mental health services by consolidated providers with the concept that this data could then be moved over to the DMHDD system. This capability, however, has never been realized. Although the system has served the division well over the past twenty years, it is now beginning to have problems and ADA is considering replacing it. Currently, it is not clear what the replacement system will look like or when it will be implemented.

In addition to utilization data, ADA also collects outcome data through client follow-up contacts. The data is collected by all providers through the use of a standardized instrument measuring improvement in key life domains. The survey is administered to clients at the point of admission (or shortly thereafter), at discharge, and at periods of six months and one year after discharge.

b. *Division of Mental Health and Developmental Disabilities ARORA System.* Like the MIS for ADA, the data system for DMHDD, Alaska Recipient Outcome Reporting Application (ARORA), implemented in 1997, is the latest version of the mental health management information system with previous versions dating back about twenty years. This application, however, takes a different approach to data collection and has been somewhat problematic. The primary difference stems from the fact that larger urban mental health providers have very intensive internal data needs and most have purchased and implemented their own systems over the years. The two primary applications in use today are from Echo Systems and Community Mental Health Center (CMHC). These applications provide utilization data, billing systems, financial management, and case management functions. The ARORA system is a proprietary system that resides only on the DMHDD computers. Data from the urban providers is "translated" from the format in use (Echo or CMHC) to ARORA format through the use of custom utilities and transmitted to DMHDD. Currently, not all providers have the capability to reliably translate and provide their data to ARORA, which results in incomplete data for DMHDD. Smaller, rural mental health providers submit their data on paper to the DMHDD. Like the ADA, DMHDD is currently investigating the possibility of replacing their system although it is not clear what the new system will look like or when it will be available.

DMHDD is currently conducting a pilot project to measure identified individual client outcomes, similar to the effort of ADA. Like the ADA effort, a standardized instrument is being used that explores improvements in key life domains.

c. *Potential for a Combined System.* With both divisions exploring the possibility of system replacement, the Steering Committee briefly examined the idea of recommending replacement of both with a consolidated system. With closer examination, however, there are significant barriers to this in the short term.

(1) Large, urban mental health providers have significant financial investments in their current proprietary systems.

(2) Mental health providers have data needs that are somewhat different than substance use disorder providers so any new system would have to be flexible enough to meet all providers' needs. These different needs include financial management, patient billing, and patient appointments. Although substance use disorder providers have similar needs, they have elected not to use the ADA MIS for these purposes and have developed other approaches. The larger, urban mental health providers, by contrast have integrated these functions into their management information systems. The rural mental health providers are often components of larger organizations, such as Alaska Native health corporations, and use corporate data systems for these purposes.

(3) Substance use disorder providers must comply with the Federal Confidential Regulations (42 C.F.R. Part 2) with regard to protecting client-identifying information. With a merged dataset, compliance with federal regulations would need to be assured.

Despite these barriers, the Steering Committee recommends developing a consolidated system. In the short term, however, they recommend that small, consolidated providers continue to report to a single system, that efforts be made to develop a method of moving mental health data originating at consolidated providers from the ADA system to ARORA, and that future system replacement planning consider the long-term goal of consolidated data. Finally, the Steering Committee recommends that the divisions explore consolidation of the outcome measurement instruments so that clients with co-occurring disorders served by consolidated providers answer only a single questionnaire.

2. Grant Application/Administration/Reporting. Providers that choose to consolidate mental health and substance use disorder services must face the reality that there are separate funding streams for the two with separate grant application processes. Further, these grants must then be administered separately with separate reporting requirements. For large, urban centers with significant infrastructure, this is merely "the cost of doing business." To the small, rural consolidated provider that offers both services out of necessity, this situation creates considerable burden. The writing of multiple proposals, administration of multiple grants, and multiple reporting requirements create the need for additional administrative staff. Given current budget realities, the additional administrative resources often comes at the expense of direct service resources. Given the already scarce treatment resources in rural Alaska, this is not an attractive solution.

The Department of Health and Social Services recently completed a study designed to identify methods of improving the departmental grant processes. The final report for this project was published in September 2000. Within the final report, seven recommendations were proposed

ranging from simplifying grant applications to improving data collection efforts to improving the proposal evaluation process. The recommendation that presents the greatest opportunity with regard to rural consolidated programs is the recommendation to develop a pilot project for consolidated grants. In this concept, a grantee could apply for a single grant that crosses division boundaries.[8] Grant improvement project staff, in discussions with the Steering Committee, indicated that the concept of the consolidated grant works only when the services are consolidated.

The Steering Committee recommends that the department issue a pilot consolidated grant request for proposals for fiscal year 2004 that would allow consolidated mental health and substance use disorder providers to apply for a single grant. This grant opportunity should be limited to those organizations that are completely consolidated (delivering both services from a single organization). Although the grant improvement project report does not address administration or reporting, the Steering Committee recommends that, for this particular pilot project, that the administration and reporting also be consolidated.

3. Quality Assurance/Oversight Process. Both DMHDD and ADA are engaged in the oversight and quality assurance of mental health and substance use disorder treatment services in Alaska. The two divisions, however, take different approaches due largely to differences in the organization of treatment resources. For providers that offer only one type of service, mental health or substance use disorder, the differences are irrelevant. For those consolidated providers that offer both, however, compliance with the two different oversight systems can be both confusing and cumbersome. This sub-section examines the two different approaches to oversight and quality assurance and offers recommendations for lessening the burden on those programs that choose to consolidate and provide both services.

a. Division of Alcoholism and Drug Abuse Oversight. Providers of substance use disorder services in Alaska are subject to oversight by the Division of Alcoholism and Drug Abuse at various levels of intensity, ranging from no oversight to very rigorous oversight, depending on their circumstances. At the most basic level, there is no absolute requirement that an organization or individual offering substance use disorder services be approved, licensed, or otherwise regulated by the Division of Alcoholism and Drug Abuse. There are, however, a number of different situations that add, at various levels, the oversight requirement.

(1) No Oversight. As mentioned above, there is no absolute requirement for approval, certification, licensing, or any other division oversight for providers offering substance use disorder services. Providers that have no division oversight do not receive grants, do not bill Medicaid or Medicare, are usually not acceptable to third-party insurance payors, and are not eligible to provide services associated with court or legal mandates.

(2) Division Approval – No Grants. The next level of oversight is for providers that voluntarily subject themselves to division oversight but who do not receive grants from the division. In these cases, the division holds providers accountable for compliance with a

[8] Alaska Department of Health and Social Services, Department of Health and Social Services Grant Process Improvement Project Final Report, 2000, Juneau, AK

set of standards, which were derived from the 1974 accreditation standards from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(3) Division Approval – Grant Recipients. The most rigorous level of oversight is for those providers whom the division approves and who receive funding in the form of block grants from the Division. In addition to standards compliance oversight, the division in these cases also checks for compliance with grant conditions.

(4) Independent Program Accreditation. Many substance use disorder providers in Alaska, in addition to being state approved, are also accredited by independent bodies. The two accreditation organizations serving Alaskan providers are the JCAHO and the Commission on Accreditation of Rehabilitation Facilities (CARF). While a very small number of providers may be accredited by both, the vast majority of those providers that are accredited are accredited by only one of the two. Of the two accreditation organizations, CARF is the most common accreditation in Alaska for substance use disorder providers. Providers can request a waiver of state standards based on the results of their accreditation survey. These requests are considered by the division in light of the results of the survey and past division facilities surveys.

A group of surveyors employed by the division in Anchorage provide oversight and visit approved providers every two years. The division practices a concept called "audit by exception" in which surveyors check records, conduct interviews, and observe operations and compare their findings with the standards. Instances in which providers are found to be out of compliance with standards are noted and requirements for correction are issued. The process is an objective one in which a professional surveyor measures observed conditions and performance against written standards and, while the surveyors typically interview clients at the facilities being examined, there is no systematic effort to include consumers as a part of the survey process.

The consequences of the biennial surveys are a list of areas in which improvement is recommended or clear instances in which a program might be found out of compliance and be required to correct the situation. On very rare occasions, providers may be found so far out of compliance that they are placed on probation or provided a conditional certification that is contingent upon correction of problems. These providers can ultimately lose their approval or certification is they fail to correct these deficiencies. Along with this process, there is a process in place that allows providers to appeal or contest the findings of the surveyor.

b. *Division of Mental Health and Developmental Disabilities Oversight.* DMHDD provides oversight for mental health providers using a different approach. First, only grantees of the division are subject to oversight. Providers that do not receive state grant funds are not subject to this process. It should be noted, however, that Alaska Statute does require occupational licensing for many types of professionals offering mental health services such as psychotherapy or counseling. Licenses are not required, however, to provide services such as case management or family support. Each profession has practice and ethical standards. For the most part, these licensing requirements are title restrictions. This means that a person may not hold himself or herself out to have a certain title (social worker, psychologist, etc.) unless they hold that specific license. This is in contrast to a practice restriction, which prevents a person from performing certain services unless they are licensed to provide those services.

Another key difference in the approach to oversight by DMHDD is that the site visit is a collaborative effort. Site visits are coordinated by a division contractor and involve a variety of people including a contractor, professional staff, division representatives, consumers, Alaska Mental Health Board representatives, and others as appropriate. The standards used in this process are the Integrated Standards and Quality of Life Indicators, which were implemented in October 1998. Unlike the ADA standards, these are structured as quality assurance guidelines and do not carry the force of law or regulation. The purpose of the site visits is to assess performance of grantees and identify areas in which improvements are needed. Like the ADA site visits, they are conducted every two years.

In addition to the integrated quality assurance review, DMHDD is responsible for conducting clinical audits on those mental health providers that bill Medicaid. This function is accomplished by DMHDD staff.

c. *Potential for Consolidated Oversight Process.* While there are significant opportunities for collaboration to reduce the burden of duplicative oversight processes, complete consolidation of the substance use disorder and mental health oversight processes may not be the best approach. This is true for several reasons:

(1) *Barriers to Consolidation.*

a) Practically speaking, there are a number of providers in both fields that will remain single-focus, stand-alone providers. The differences in approach, as well as statutory and regulatory requirements for the two systems, would make consolidated oversight for these projects both complicated and unnecessarily burdensome.

b) Despite the fact that many programs offer both types of services, having their operation scrutinized and having to meet the needs of both types of oversight could prove overwhelming for small organizations as scores of professionals in mental health and substance use disorder, as well as consumers, advocacy and planning board members, and other providers all descend at one time. Again, for practical reasons, some organizations may prefer to have these oversight functions separated by time.

(2) *Opportunities for Collaboration and Coordination.* Even though complete consolidation of the two quality assurance and oversight processes may not be desirable, there are ways to reduce the burden by greater coordination and cooperation. Some specific suggestions are:

a) To ensure consistency and continuity across the two processes, particularly for consolidated programs, the site visits for each service (mental health and substance use disorder) could include a professional from "the other discipline," that is, a mental health site visit team could include a substance use disorder professional while substance use disorder site visits could include mental health professionals.

b) Consolidated providers should be given the option for a consolidated site visit if they so choose. While there will be small providers that prefer to keep

them separate simply because of the magnitude of a consolidated visit, some providers may prefer to have the burden of a site visit occur all at once so they can be done with such visits. The provider should have the option to choose.

c) For those providers who prefer to have separate site visits, the two divisions should coordinate the timing of their visits to meet the needs of the providers. This would prevent visits from overlapping or happening in such close proximity that there is insufficient preparation time.

d) Finally, the site review standards for the two divisions should be examined to ensure that there are no conflicts between the two. This should include the development and implementation of standards recommended in the Service Delivery Section of this report.

4. Billing and Funding Streams. The final administrative barrier to be addressed is that of diverse funding streams and difficulties in billing, particularly for services and clients covered by Medicaid. While the issue of funding streams is closely related to issues of grant application and administration addressed in sub-paragraph B.2. above, there are unique issues regarding billing for Medicaid related to funding streams that create administrative barriers.

a. *Billing Organizations must be Grantees.* In order for an organization to bill Medicaid for substance use disorder or mental health services, it must be a grantee of the respective division. While this poses no particular problem for single-focus, stand-alone providers, it does present a barrier to the consolidated program. It requires that the provider be a grantee of both divisions. The awarding of grants, however, is a competitive process in Alaska and it is not always a certainty that an organization, no matter what their preferences for delivery of consolidated services, would be able to receive grants from both divisions. The proposal evaluation processes for the two divisions are separate, independent processes.

b. *Separate Clinical Services.* The billing structure of Medicaid supports billing for either mental health services or substance use disorder services, but there is no provision for delivery of a service that is consolidated. So even when a provider is delivering a consolidated service, such as a group process for persons with co-occurring disorders, the billing for that service would be either mental health or substance use disorder. Because each category has its own limits and authorized services, this forces organizations that can bill for both categories to be familiar with two complicated sets of requirements.

c. *Level of Formal Education and/or Credentials.* Although less of a barrier, the requirement for formal education and/or credentials for persons delivering services can be a problem for the smaller organization. In rural Alaska particularly, many individuals do not hold advanced degrees. In order to bill to Medicaid for mental health services, a master's level professional must directly supervise these individuals.

The problems relating to Medicaid billing are complicated by the fact that there are federal requirements that are beyond the authority of either division to address, there are multiple state agencies that are involved in the Medicaid program, and the nature of difficulties with Medicaid billing varies among providers and regions. In light of these complexities, the Steering Committee recommends that a working group be convened to assess the problems and develop

recommended solutions that can be implemented prior to the pilot integrated grant RFP that is recommended for fiscal year 2004.

C. Recommendations.

1. Data Collection. The Steering Committee strongly supports the move toward an eventual consolidated data system. In the short term, the Steering Committee recommends that consolidated programs continue to report data to only one system and that DMHDD and ADA identify a method of capturing data relating to mental health and substance use disorder services from consolidated providers to the relevant data system (substance use disorder or mental health).

2. Consolidated Grant Pilot. The Steering Committee recommends the issuance of a request for proposals for fiscal year 2004 for consolidated services. This grant opportunity should be available only to organizations that are consolidated and provide both mental health and substance use disorder services to clients needing either or both (not just to clients with co-occurring disorders).

3. Quality Assurance/Program Oversight. The Steering Committee recommends that the two respective systems of program oversight and quality assurance commit to a heightened level of coordination and collaboration. This should include:

a. Inclusion of professionals from both fields in site visits by either division.

b. Offer the opportunity for combined site visits subject to the preferences of the individual providers.

c. Closely coordinate the timing of site visits to minimize the administrative burden for the providers.

d. Carefully review all program and performance standards to ensure that there are no conflicts.

4. Medicaid Billing. The Steering Committee recommends that a working group be convened to assess problems related to Medicaid reimbursement for clients with co-occurring disorders and develop recommended solutions that can be implemented prior to the pilot integrated grant RFP that is recommended for fiscal year 2004.

VI. Staff Recruiting, Training, and Development.

A. Introduction. The inclusion of this section on staff recruiting, training, and development serves two related purposes. First, it provides a snapshot of the existing systems for providing and managing staffing requirements for substance use disorder and mental health services in Alaska. Second, by inclusion of this section the Steering Committee acknowledges that, regardless of any plans or recommendations from this committee or any other, improvements in accessibility, quality, and integration of services to persons with co-occurring disorders will ultimately be accomplished by the staff. The quality of staff training, education, and experience in both disciplines will be a major factor in providing quality services for persons with co-occurring disorders.

This section will include an overview of existing systems for development of professionals in both fields as well as recommendations for system changes to improve services.

1. Mental Health Professionals.

a. ***General.*** The term "mental health professional" is a term that has two distinct applications. One application is a formal designation with a basis in Alaska Statute 47.30.915(11). According to this statute, "mental health professional" means a psychiatrist or physician who is licensed to practice in this state or employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; and a social worker with a master's degree in social work and substantial experience in the field of mental illness.[9] The other accepted usage is that the term "mental health professional" is a general term that describes a wide variety of professionals. This overall grouping includes mental health clinicians, who typically have a master's degree, either in social work, counseling, or a behavioral science. Case managers and mental health associates typically have undergraduate degrees. Clinical psychologists have Ph.D.s, while psychological associates often have master's degrees. On the medical side of the field, there are psychiatric nurses and nurse practitioners that may have masters or bachelor degrees, and psychiatrists, who are medical doctors. There are others who have a variety of training, education and experience, many of them in private practice, who are not easily categorized and who provide specialty services not usually offered in public programs. This diversity of qualifications and backgrounds demonstrates the magnitude of the challenge for improving or enhancing the process ensuring that mental health professionals have appropriate knowledge and skills. Simply put, there is no one "process."

b. ***Recruiting.*** Recruiters of mental health professionals in Alaska face several barriers. First, there is a shortage of trained, experienced mental health professionals in the state. For example, in a study published in 2001 by the University of Alaska Anchorage, just under 10% of the available licensed clinical social worker positions were vacant among the 54 organizations surveyed. Additionally, more than 17% of these positions are expected to turn

[9] Alaska Statute 47.30.915(11)

over annually.[10] Because of this, recruiting efforts often include out of state recruitment, which can be costly and cumbersome. Second, because of the geography and population dispersion, professionals from the lower 48 often experience "culture shock" when recruited into rural positions. They face problems associated with the cultural differences, extreme weather, isolation, and scarcity of support resources that, in most cases, they are not prepared for. Finally, the prevailing pay rates for most mental health clinicians in the public sector are generally considered low for their education and professional level.

c. ***Required Qualifications.*** Most, but not all, of the mental health professionals in Alaska are subject to state occupational licensing requirements. These requirements vary among the different specific occupations but generally all require some combination of education and practical experience for initial licensure and ongoing education credits for continued licensure. These requirements apply to licensed clinical social workers (LCSW), clinical psychologists, licensed professional counselors (LPC), nurses, licensed marriage and family therapists (LMFT) and medical doctors. Mental health associates, who often serve as case managers, are not required to be licensed nor does the state mandate a minimum level of qualifications. In terms of services to persons with co-occurring disorders, some professions are required to have specific training/education on addictions and substance use disorders while others are not. For example, regulations require that LCSWs graduating from post-secondary institutions, other than those accredited by specific accreditation entities, have addictions/substance use disorder course work. In contrast, there is no such requirement for LPCs. From a practical perspective, most professionals with educational credentials in behavioral health or science have been exposed to addiction/substance use disorder coursework, but it is not consistently mandated. In addition to mandated educational and/or experience requirements, most licenses require that the applicant pass an examination that tests for knowledge.

d. ***Continuing Education.*** Once professionals enter the mental health field, there is no apparent systematic training program that serves professionals statewide. Providers develop their own training programs to meet their specific employees' needs, depending on the funds available to the organization. DMHDD and AMHB occasionally sponsor or host statewide conferences or seminars, but there is no ongoing, consistent effort aimed at enhancing or maintaining the knowledge and skill level of mental health professionals.

2. Substance Use Disorder Professionals.

a. ***Introduction.*** In contrast to mental health professionals, substance use disorder professionals have a much more defined path of qualifications. A single process certifies all Alaska substance use disorder professionals regardless of their education, experience, or background.

b. ***Recruitment.*** Recruitment of substance use disorder professionals in Alaska is difficult but not as difficult as recruitment of mental health professionals. One of the primary reasons for this is the diversity of backgrounds that feed the single certification process. While

[10] Alaska Center for Rural Health, Alaska's Allied Health Workforce: A Statewide Assessment, University of Alaska Anchorage, March 2001, Anchorage, AK

there are many individuals who come to the field with undergraduate and graduate degrees, there are also a large number of individuals who come with experience and professional training in lieu of formal education. Organizations offer rigorous on-the-job training programs designed to move individuals from a trainee status to trained, certified counselor status while maintaining their employment. This process is most frequently used with individuals who are recovering alcoholics/addicts. After being in recovery for a period of time, they often begin working as counselor aides or technicians under the supervision of trained, certified counselors while they attend formal training. This system flexibility helps to increase the supply of available counselors. Additionally, the pay expectations in the addictions field is not as high as in the mental health field, although this varies significantly among the diverse groups that come to the field. Despite the greater availability of substance use disorder professionals, there is still a shortage of professionals and programs frequently have to recruit from outside the state. A study conducted by the University of Alaska Anchorage published in 2001 found that just under 10% of the available substance abuse counselor 2 positions among 38 surveyed organizations were vacant and that nearly 17% of the positions are expected to turn over annually.[11] Outside recruitment is more likely for programs serving populations where specialized training is necessary, as is the case for persons with co-occurring mental health and substance use disorders.

c. ***Required Qualifications.*** Qualifications for certification as a substance use disorder professional are set by the Alaska Commission for Chemical Dependency Professional Certification (ACCDPC). ACCDPC is funded through a combination of certification fees and grants from the Division of Alcoholism and Drug Abuse. The commission is comprised of certified counselors from different geographic regions, as well as representatives from substance use disorder agencies. The requirements for certification are stratified by level of certification. The different levels are:

- Traditional Counselor;
- Counselor Technician;
- Counselor Level I;
- Administrator I;
- Counselor Level II;
- Administrator II; and
- Counselor Level III.

Each level has its own training and experience requirements. For Counselor Level II and above, examinations are also required. In addition to total training and experience requirements, ACCDPC specifies that counselors must have certain core competencies. Some of the competencies, such as cultural competence, are assured through a mandatory number of hours of targeted training. Other competencies, such as assessment and record keeping, are merely required to be documented but are not required to be covered in specific training. Mental health subject matter or competence is not required at any level for counselor certification.

d. ***Continuing Education.*** Like the qualification system for substance use disorder professionals, the system for continuing training and education is very well defined.

[11] Alaska Center for Rural Health, Alaska's Allied Health Workforce: A Statewide Assessment, University of Alaska Anchorage, March 2001, Anchorage, AK

The Division of Alcoholism and Drug Abuse funds, through an annual contract, statewide training efforts coordinated by a single training entity. As of the date of this report, this contract is held by the Regional Alcohol and Drug Abuse Counselor Training (RADACT) organization with headquarters in Anchorage. This contractor has an advisory committee to assist with planning and all training is coordinated through local providers. In addition to on-site training efforts, the Substance Abuse Directors Association (SADA) and the Association of Rural and Native Alcohol and Drug Abuse Programs (ARANDAP), using a variety of funding streams, coordinate an annual Addictions School held in May in Anchorage. This event, which lasts three days, typically draws about 400 participants from across the state. Participants, in attending this training event, earn training hours for certification or recertification and receive training on emerging issues.

3. Rural Human Services Staff. Rural Alaska villages rarely have dedicated substance use disorder counselors or mental health professionals. Many villages have, instead, Rural Human Service (RHS) workers who provide "front-line" human services to village residents. RHS workers in villages are among the first to identify mental health or substance use disorders. They provide some help and, in more serious cases, arrange for services by qualified mental health professionals and/or substance use disorder counselors.

The University of Alaska Fairbanks offers a two-year course of study for prospective RHS workers. The course is intended for Alaska Natives who are natural helpers and healers in their communities, and it is designed to meet their needs. The program offers a culturally appropriate training program designed for village-based counselors. Skills and training are provided in services such as crisis intervention, suicide prevention, community development, and counseling in mental health, substance use disorders, interpersonal violence, grief, and healing. A unique aspect of the RHS program is that it uses Alaska Native culture, traditions, and learning styles. Courses blend Native and Western knowledge values, and principles. The program emphasizes cooperative learning and is grounded in the oral tradition.[12] In addition, additional course work can lead to a Bachelor of Social Work or Bachelor of Human Services.

It should be noted that the intent of the RHS program is not to produce mental health professionals or substance use disorder counselors but rather to train individuals to provide help across a wide range of social problems. Serious mental health or substance use disorder problems usually require additional resources beyond the help that can be provided directly by most RHS workers under the current system.

B. Cross Training Needs.

1. General. The provider survey detailed in Section II of this report indicated that cross training of mental health and substance use disorder staffs is critical to the provision of quality services to persons with co-occurring disorders. While some of the existing cross training is accomplished through formal, post-secondary education, most cross training is accomplished at the provider level. This training is usually situational, both in terms of timing and subject matter. It is designed primarily to meet the specific needs of the provider scheduling and/or conducting the training and may be through informal means, such as staff-to-staff instruction.

[12] University of Alaska Fairbanks, "Rural Human Services Program," 2000, Fairbanks, AK

Traditionally, philosophical differences have existed between the substance use disorder and mental health fields. These differences have contributed to less than adequate care for the person with co-occurring disorders who seeks services from providers in either of these fields. Lack of awareness and adequate training to screen, intervene, and refer individuals for specialized care when appropriate have been barriers to treatment and have resulted in less than adequate care for this population. Cross training efforts should address these issues and reflect current research-based best practices in the treatment of those with co-occurring disorders.

2. CMH/ARP Cross-Training. The first and only intensive, organized attempt to provide substantial cross-training relating to services for persons with co-occurring disorders to a wide and diverse audience is being planned and executed by the Community Mental Health/API Replacement Project (CMH/ARP). Through a contract with Akeela, Inc., a needs assessment was conducted in the Anchorage bowl area and, as a result of that assessment, a far-reaching training curriculum has been developed that includes training in dual diagnosis issues, cultural competency, and the specifics of the emerging Anchorage emergency mental health service delivery system. In addition to mental health and substance use disorder professionals, this training is also being offered to other professionals who provide ancillary services to persons with co-occurring disorders in Anchorage. Such professionals include individuals working with domestic violence, homelessness, public safety, and food programs. Because of its wide audience and its rigorous documentation, this project presents a valuable opportunity for either expansion or replication to enhance the level of knowledge and skill statewide.

3. Rural Mental Health Conference. While not intended specifically as a vehicle for cross training, the rural mental health provider conference sponsored by DMHDD and AMHB served as a catalyst for discussion of the issues. During the first conference held in April 2000 and attended by mental health and substance use disorder paraprofessionals, there was a substantial amount of training delivered regarding services to persons with co-occurring disorders. A second conference will be held in November 2001 and will include the co-occurring disorder curriculum from the CMH/ARP Project.

C. Retention Issues. While a rigorous investigation into retention issues for mental health and substance use disorder professionals is beyond the scope of this project, there are some issues that surface consistently and seem to resonate with most professionals. The following brief discussion is not meant to provide an exhaustive assessment but rather to raise relevant issues in need of attention.

1. Support for Professionals in Rural Areas. Substance use disorder and mental health professionals practicing in rural areas face challenges not seen by urban professionals. They are in settings that challenge them both personally and professionally. Frequently, they are called upon to practice in settings with limited access to related services for their clients, few resources for referrals or consultations, and, for some, in little understood cultural settings. Not only are there few related service providers, but frequently rural providers find themselves as solo practitioners, without any peers either within or outside their agencies. Professionals who are on call for 24 hours per day, seven days a week face burn-out, in addition to professional isolation. Low pay compounds the difficulty by further narrowing choices. Some professionals experience a lack of supervision, which could help them through some of the difficulties of rural

practice. All professionals in rural practice encounter boundary issues in daily practice, that is, situations in which clients are in professional and social roles with the practitioner that place stress on confidentiality and other ethics of the professional and which further serve to socially isolate the practitioner. These factors result in high turnover in rural programs. [13]

2. Lack of Training and Educational Opportunities. For professionals in rural areas, and to a lesser extent in urban areas, there are limited opportunities for continuing education and professional growth. While substance use disorder professionals sometimes have the opportunity to attend the Annual Addictions School in Anchorage, mental health professionals have no such event in Alaska. Even for substance use disorder professionals, rural providers must carefully watch expenditures in order to maintain service levels. This sense of stifled growth and lack of opportunities has been cited by several reports as a contributing cause to turnover. [14] [15]

3. Salary Issues. The issue of salaries as a contributor to staff turnover has not been subjected to any intense investigation to date. Several situations exist that indicate that this could well play a role, although they are not thoroughly documented. First, for substance use disorder professionals, most positions in the state are with private, non-profit organizations. These traditionally have lower salaries than private, for-profit companies or government agencies. While the positions do provide a source of income, individuals in these positions often leave in order to take positions with the state in positions such as probation officers or social workers. The State of Alaska offers comprehensive health insurance, retirement, and leave benefits, which many non-profits find difficult to match. The same issues occur for mental health workers who have advanced degrees. Often these degrees have been earned using student loans, which these professionals must repay. Salary levels, therefore, become important to these individuals, who often find better opportunities with the State of Alaska or with employment outside the state. This discussion is based primarily on anecdotal observations and discussions and should be more thoroughly investigated prior to planning any particular course of action.

A comparative analysis of salaries and benefits of Alaskan professionals and professionals from other parts of the country was beyond the scope of this project. In a report published in March 2001, however, the Alaska Center for Rural Health (University of Alaska Anchorage) noted that most human service providers responding to their survey indicated that mental health and substance abuse professionals were "very difficult" to recruit. The second largest group of respondents reported that they were "somewhat difficult" to recruit. The reasons most often given for these difficulties were pay/benefits and required training. [16]

4. Environmental Uncertainty. Finally, a retention issue that hits virtually all professions at one time or another is that of environmental uncertainty. The field of behavioral health, as it is often called, has been in a volatile state of change for the past decade with the onset of managed care, the emerging emphasis on outcomes, and the scarcity of resources. Additionally, projects such as this, while relevant and vitally important, also contribute to a sense of uncertainty.

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[13] Alaska Mental Health Board, Itinerant Consulting Psychiatrist Evaluation, 1999, Juneau, AK
[14] Alaska Division of Alcoholism and Drug Abuse, Consolidated Training Planning Report, 1998, Juneau, AK
[15] Alaska Mental Health Board, Itinerant Consulting Psychiatrist Evaluation, 1999, Juneau, AK
[16] Alaska Center for Rural Health, Alaska's Allied Health Workforce: A Statewide Assessment, University of Alaska Anchorage, March 2001, Anchorage, AK

Professionals struggle to understand what their role will be in the future, what knowledge they will need, and what the service delivery system will look like. All these changes and trends conspire to create a sense of uncertainty and stress among professionals. This is compounded by the previously mentioned problems, creating a situation where high turnover exists.

D. Recommendations. While many staff recruitment, training, development and retention actions could contribute to an overall improvement in the delivery of mental health and substance use disorder services, the discussion here will be limited to those recommendations designed to improve services to individuals with co-occurring disorders. In general, the recommendations can be logically grouped into two categories: (1) Those recommendations regarding staff in all substance use disorder or mental health provider organizations that empower the organization to provide appropriate screening, diagnosis, treatment and/or referral to other organizations for treatment, and (2) those recommendations for staff in consolidated organizations that provide both services. Organizations that are completely consolidated can further segment their professionals into two categories. The first are those professionals in one discipline or the other (mental health or substance use disorder) but who have sufficient training and skill in the other discipline to screen and make appropriate recommendations for services provided by other professionals. The second category consists of those professionals who are trained to provide both mental and substance use disorder services. Given these boundaries, the Steering Committee proposes the following recommendations:

1. Establish Core Competencies.

a. ***Non-consolidated Programs.*** For organizations that are not consolidated, a set of minimum core competencies should be established that require staff to:

- Demonstrate knowledge of the signs and symptoms of the "other disorder" (for example, a substance use disorder provider recognizing signs and symptoms of mental health issues and a mental health provider recognizing signs and symptoms of substance use disorder). This would include the ability to conduct a screening and, if indicated, referral to an appropriate professional for formal assessment and diagnosis.
- The professionals of each discipline must demonstrate knowledge of the treatment system in place to provide services for "the other disorder." This is necessary in order to make appropriate referrals for diagnosis and/or services.
- The professionals of either discipline must demonstrate understanding of the treatment principles and course of treatment for the other discipline. This will allow them to coordinate delivery of services such that the two courses of treatment are complementary rather than conflicting. Examples include an understanding of pharmacology and the use of psychotropic medications, the role of 12-step programs, relapse prevention principles, and recovery concepts.

b. ***Consolidated Programs.*** Core competencies for individuals working in consolidated programsare recommended for two different professional groups. The first group, comprised of professionals who work in an organization that identifies professionals as either

substance use disorder or mental health, would have core competencies similar to those for non-consolidated programs. Those professionals working in programs that are consolidated and in which professionals are expected to provide both services would have a more rigorous set of competencies. Individuals who provide both mental health and substance use disorder services should possess the competencies normally expected of both mental health clinicians and substance use disorder counselors. They should, however, also possess additional special competencies related to services to persons with co-occurring disorders. These competencies should include:

- Demonstrated ability to recognize and diagnose both disorders simultaneously occurring;
- Demonstration of competency in developing treatment plans that appropriately address both disorders as well as the interaction between the disorders;
- Demonstration of understanding of locus of care issues, that is, the primary focus of care at any given time depending on presenting problems;
- Demonstration of understanding the appropriate roles of abstinence, recovery, harm reduction, and other concepts and practices that must be brought to bear in order to provide effective services; and
- Demonstrated ability to develop a plan of continuing care that recognizes the possibility of relapse in both substance use and mental health symptoms.

2. Development of Recruiting Tools. Because much recruiting is done out of state, both fields could benefit from the development of a recruiting tool (video, interactive CD-ROM, short correspondence course, etc.) that would help to prepare a prospective mental health or substance use disorder staff member for many of the issues and problems faced by service providers in Alaska.

3. Consolidated Training Program. Currently, the substance use disorder field provides a very systematic, structured approach to training counselors through the use of a statewide contract training coordinator as well as the Annual Addictions School. This system, in addition to providing critical training, also serves as a forum for discussions and information dissemination regarding key emerging issues. Finally, this system helps to build cohesiveness among the counselors and fosters the growth of professional relationships. With appropriate planning and funding, this concept could be expanded to include mental health professionals or replicated to serve the mental health field. A renewed commitment to coordinated, quality training can also be viewed as a source of support for rural professionals thus helping to reduce turnover.

4. Expansion of CMH/ARP Project Cross Training. The Community Mental Health/API Replacement Project (CMH/ARP) cross-training component is an effort to improve the quality of care and access in the Anchorage area by providing extensive cross training to providers on treating persons with co-occurring disorders, cultural competency, and service delivery system characteristics. The Steering Committee recommends that this concept be expanded to provide similar training opportunities to service delivery providers throughout

Alaska.

5. Rural Human Services Training Expansion. The Rural Human Services program in Alaska has provided trained human service workers in many villages. Because these individuals are often the only local persons with any training in mental health or substance use disorder issues, they are called upon to deliver some level of service to village residents with varied needs. In addition to the core training provided to RHS students, there is a clear need to provide additional training that will enable them to deliver a minimum level of service to persons with co-occurring disorders. This additional training should be provided once the core training is completed. Phasing the training delivery this way will help to prevent the students from being overwhelmed. Finally, the Steering Committee recommends expansion of RHS capacity in Alaska.

6. ACCDPC Certification for Counselors Serving Clients with Co-Occurring Disorders. The Steering Committee recommends that the Alaska Commission for Chemical Dependency Professional Certification (ACCDPC) develop a set of standards and corresponding certification for substance use disorder counselors serving clients with co-occurring disorders.

VII. Steering Committee Recommendations.

A. Service Delivery Recommendations.

1. Core Values. The Steering Committee recommends that the core values identified in this section be adopted by DMHDD and ADA and consolidated into the standards for the providers for which they have oversight responsibility.

2. New York Model Contextual Framework. The Steering Committee recommends that both DMHDD and ADA adopt the New York Model Contextual Framework, particularly as it relates to the designation of locus of care and responsibility for ensuring delivery of appropriate services.

3. Index of Recommended Screening and Diagnostic Tools. The Steering Committee recommends that DMHDD and ADA develop an index or library of recognized and/or recommended screening and diagnostic tools that can be used by both single-focus, stand-alone providers as well as consolidated organizations. The divisions should also develop and maintain training resources as appropriate for those tools.

4. Practice Guidelines. The Steering Committee recommends that DMHDD and ADA develop and implement practice guidelines for organizations providing services to persons with co-occurring disorders. These guidelines should include, as a minimum, the following elements:

a. Provisions for accessing appropriate services – "no wrong door."

b. Requirements that every provider ensure an appropriate assessment process for clients that include screening and, as indicated, diagnosis for both substance abuse and mental health disorders.

c. For single-focus, stand-alone providers, there should be a process for identifying the most appropriate qualified referral for a client whose needs exceed the capability and/or capacity of the organization.

d. Treatment plans for persons with co-occurring disorders should be highly consolidated. The plans should identify client needs based on a holistic, biopsychosocial perspective and mandate specific services based on these needs.

e. Delivery of care should be highly coordinated, regardless of the locus of care, and the responsibility and accountability for this coordination should rest with the organization in the primary locus for cases in which the service providers are single-focus, stand-alone organizations. This element should include case coordination, staffing, scheduling, consistent objectives, and resolution of any programmatic conflicts.

f. Clients should receive continuing care and ongoing support that promotes their recovery. This element should recognize the nature of both mental health and substance use disorders, the likelihood of acute episodes and the concept of recovery as an ongoing process.

B. Administrative Barriers Recommendations.

1. Data Collection. The Steering Committee strongly supports the move toward an eventual

consolidated data system. In the short term, the Steering Committee recommends that consolidated programs continue to report data to only one system and that DMHDD and ADA identify a method of capturing data relating to mental health and substance use disorder services from consolidated providers to the relevant data system (substance use disorder or mental health).

2. Consolidated Grant Pilot. The Steering Committee recommends the issuance of a request for proposals for fiscal year 2004 for consolidated services. This grant opportunity should be available only to organizations that are consolidated and provide both mental health and substance use disorder services to clients needing either (not just clients with co-occurring disorders).

3. Quality Assurance/Program Oversight. The Steering Committee recommends that the two respective systems of program oversight and quality assurance commit to a heightened level of coordination and collaboration. This should include:

a. Inclusion of professionals from both fields in site visits by either division.

b. Offer the opportunity for combined site visits subject to the preferences of the individual providers.

c. Closely coordinate the timing of site visits to minimize the administrative burden for the providers.

d. Carefully review all program and performance standards to ensure that there are no conflicts.

4. Medicaid Billing. The Steering Committee recommends that a working group be convened to assess the problems related to Medicaid reimbursement for clients with co-occurring disorders and develop recommended solutions that can be implemented prior to the pilot integrated grant RFP that is recommended for fiscal year 2004.

C. Staff Recruitment, Training, and Retention Recommendations.

1. Establish Core Competencies.

a. ***Non-consolidated Programs.*** For organizations that are not consolidated, a set of minimum core competencies should be established that require staff to:

- Demonstrate knowledge of the signs and symptoms of the "other disorder" (for example, a substance use disorder provider recognizing signs and symptoms of mental health issues and a mental health provider recognizing signs and symptoms of substance use disorder). This would include the ability to conduct a screening and, if indicated, referral to an appropriate professional for formal assessment and diagnosis.
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- The professionals of either discipline must demonstrate understanding of the treatment principles and course of treatment for the other discipline. This will

allow them to coordinate delivery of services such that the two courses of treatment are complementary rather than conflicting. Examples include an understanding of pharmacology and the use of psychotropic medications, the role of 12-step programs, relapse prevention principles, and recovery concepts.

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- Demonstrated ability to recognize and diagnose both disorders occurring simultaneously;
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D. Implementation. The Steering Committee recommends that the Commissioner of Health and Social Services identify a responsible entity or group with authority to ensure that recommendations made in this report and approved by the commissioner are implemented in a timely fashion.

Appendices.

Appendix A: Directory of Steering Committee Members

Appendix B: Department of Health and Social Services Scoping Document

Appendix C: Other States' Experiences

Appendix D: Provider Survey Instrument

Appendix A: Directory of Steering Committee Members

Name	Representing
Pam Watts (Co-Chair)	Advisory Board on Alcoholism and Drug Abuse
Walter Majoros (Co-Chair)	Alaska Mental Health Board/Division of Mental Health & Developmental Disabilities
Ron Adler	Alaska Community Mental Health Providers Association
Karl Brimner	Division of Mental Health & Developmental Disabilities
Diane Disanto	Department of Health & Social Services, Commissioner's Office
Jane Franks	Rural Mental Health Providers
Mark John	Substance Use Disorder Consumers
Loren Jones	Department of Health and Social Services, Community Mental Health/API Replacement Project
Victor Joseph	Association of Rural and Alaska Native Drug Abuse Programs
Pat Murphy	Mental Health Consumers/Alaska Mental Health Board
Anecia Nanok	Village Rural Human Service Provider
Obed Nelson	Substance Abuse Directors Association
Scot Prinz	Alaska Native Tribal Health Consortium
Janet Schichnes	University of Alaska Fairbanks - Rural Human Services Program
Cristy Willer Tilden	Advisory Board on Alcoholism and Drug Abuse
Ernie Turner	Division of Alcoholism and Drug Abuse
Project Support	
Margo Waring	Alaska Mental Health Board
Steven Hamilton	C & S Management Associates (Contractor Support)

Appendix B: Department of Health & Social Services Scoping Document.

June 1, 2000

PROJECT SCOPING SHEET

Project: Integrated Mental Health & Substance Abuse Services

Lead: Walter Majoros, AMHB
Pam Watts, ABADA

Priority: High: project duration estimated to be nine to twelve months.

Background:
National organizations such as Indian Health Services, Substance Abuse and Mental Health Services Administration, as well as other organizations are supporting the concept of integrated mental health and substance abuse services. However there is no universally accepted definition of "integration" employed in discussing, refining existing service systems or developing new systems of care.

For several years there have been discussions regarding integration of services in Alaska. Successful programs like the Rural Human Services programs have made these efforts seem more achievable. Three key events have led to the formation of an effort to explore further integration of these services. In June of 1999, the Commissioner formally requested the relevant divisions and boards to develop a set of recommendations to further integrate services. This would be done through a stakeholder process.

Secondly, the API 2000 Project represents a significant effort to integrate services for the clients who are mentally ill with a co-occurring substance abuse disorder in the Anchorage area. In small rural communities (i.e. Aniak, McGrath etc) agencies have administered services under one roof for several years. Other rural communities like Bethel, Nome and Barrow are at various stages of planning the integration of mental health and substance abuse services.

Third, in October 1999 the Rural Mental Health Providers Association, the Division of Mental Health and Developmental Disabilities and the Alaska Mental Health Board (AMHB) sponsored a 2-day planning meeting on enhancing rural mental health services. "Integrated mental health and substance abuse services" was one of three major topics addressed in the planning meeting.

The group recommendation from this meeting was for the AMHB and Advisory Board on Alcoholism and Drug Abuse to establish a multi-stakeholder Steering Committee to develop recommendations to move towards more integrated services. The rural mental health providers were primarily interested in reducing duplication and streamlining administrative procedures in such areas as funding, grant applications and oversight, data/reporting requirements, and quality assurance reviews. The group also suggested that the Steering Committee address: training, education and support for rural providers; the interrelationship between mental health/substance abuse and other services in rural communities (child

protection, domestic violence, etc.); and the impact of credentialing and licensing on the provision of integrated services.

Several subsequent meetings have taken place between state representatives of DHSS, the AMHB and ABADA to further develop the scope, composition and structure of the Steering Committee process. In addition to validating the concerns and recommendations from the October 1999 rural mental health planning meeting, the state group identified the following additional concerns to be addressed in a steering committee process:

?? The need to include balanced representation of substance abuse and mental health providers, as well as consumer involvement or representation, on the Steering Committee;
?? The need to recognize the philosophical bases that have separated the substance abuse and mental health fields, and the need to balance mutual respect for these separate disciplines with ways to overcome barriers to collaboration;
?? The need to address the issue of integrating/coordinating services in urban as well as rural environments
?? The need for a commonly accepted definition of integrated mental health and substance abuse services; and
?? The need to address "service provision" issues in addition to "administration and oversight" issues. Important service provision issues include best practices, program standards, increased access to services, training, and coordination with other service systems.

Project Purpose:
The goals of increasing integration of mental health and substance abuse treatment services in Alaska are:
1) improving treatment outcomes;
2) improving accessibility of services and quality of care; and
3) improving efficiency in administration to minimize costs and facilitate greatest use of available funds to support client services.

Why is this project important to us?

Resources for serving persons suffering from mental illness or substance abuse disorders are limited and currently have separate statutory basis, have separate advisory boards which advocate and plan for services and are administered separately at the state level. Significant proportions of the persons served by these fields have co-occurring disorders. Others who do not have a co-occurring disorder sometimes seek treatment through the most readily available service. Clients are often referred to mental health and substance abuse programs only to be told that they cannot effectively address the client's needs. Lack of coordination and integration impedes effective treatment for those with co-occurring disorders and can be a barrier to service for others.

Confidentiality and privacy concerns have precluded efficient collection and effective sharing of critical information needed to facilitate integrated service delivery. Real and perceived barriers to collection and sharing of information have impeded integration of services and posed a barrier to effective planning and service delivery and have prevented implementation of operational efficiencies.

Substantial improvements can be made in service accessibility, treatment outcomes, and efficiency through a systematic effort to improve coordination and integration of the community mental health and substance abuse treatment delivery systems. The advocacy boards in partnership with the Department should provide direction and support to the programs to improve care for persons with co-occurring

disorders. The work group will broadly define "integration of mental health and substance abuse" and define the administrative and practice framework needed to support and promote integration while allowing flexibility to implement services in the most effective way to meet the needs in differing communities.

Steering Committee Structure and Process

The Commissioner of the Department of Health and Social Services is convening a Steering Committee made up of knowledgeable individuals representing various aspects of the fields of mental health and substance abuse. This Steering Committee will be co-chaired by Walter Majoros and Pam Watts, who will report progress directly to the Commissioner. The body of the Steering Committee will be appointed by the Commissioner, and will include a designated representative from each of the following entities:

- Rural Mental Health Providers: Jane Franks, Norton Sound Behavioral Health Services
- Association of Rural and Alaska Native Drug and Alcohol Programs—ARANDAP: Victor Joseph, Old Minto Family Recovery Camp
- Substance Abuse Directors Association—SADA: Obed Nelson, Ernie Turner Center
- Rural Human Services Field Staff: Anecia Nanok, Twin Hills
- Governor's Advisory Board on Alcoholism and Drug Abuse—ABADA: Cristy Willer Tilden, Bristol Bay Area Health Corp.
- Alaska Mental Health Board—AMHB: Susan Humphrey- Barnett, Providence Hospital Mental Health Services
- Division of Alcoholism and Drug Abuse—ADA: Ernie Turner, Division Director
- Division of Mental Health and Developmental Disabilities—DMHDD: Karl Brimner, Division Director
- Department of Health and Social Services—DHSS:
    - Diane DiSanto, Special Assistant
    - Loren Jones, Community Mental Health/API 2000 Project Director
- Alaska Native Tribal Health Consortium—ANTHC: Scot Prinz
- Alaska Community Mental Health Services Association—ACMHSA: Ron Adler, Gateway Center for Human Services
- Consumer representatives
    - Mental Health: Pat Murphy
    - Substance Abuse: Mark John
- University of Alaska: Janet Schichnes, Rural Human Services Program

The project will be sponsored jointly by the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse and the Department of Health and Social Services. It is expected that the Steering Committee will meet for a period of nine to twelve months to achieve the outcomes noted above. Meetings will be conducted in-person and by teleconference. Subcommittees will be formed as necessary to help achieve the group's stated objectives, as listed below.

A contractor will be secured to assist with the Steering Committee effort. The main role of the contractor would be to staff the Steering Committee and subcommittee meetings, conduct research on substantive issues, and write the Steering Committee's draft and final reports. In addition, a small pool of funds will be needed to pay for travel expenses of those Committee members who do not have other funds to cover travel to in-person meetings.

Objectives for the Project:
Produce a final written report for the Commissioner's review that:

1) Establishes a working definition of "integrated mental health and substance abuse" accepted by both fields.

2) Inventories best practice models of integration for mental health and substance abuse services.

3) Addresses philosophical and practice issues which impede integration of the two fields' distinctly different treatment orientations.

4) Proposes actions to facilitate the provision of integrated mental health and substance abuse services addressing the following areas:

?? A survey of providers regarding integration needs
?? Best practice and procedure guidelines for service provision
?? Increased access to services, "no wrong door" and improved service delivery
?? Minimum parameters of service standards
?? Statewide cross-disciplinary training programs utilizing on-site training, distance delivery, and CD-ROM
?? Coordination between mental health/substance abuse services and other systems (child protection, education, criminal justice, etc.)
?? Data collection and coordination
?? Identification of administrative changes that can be accommodated now and those that require longer term development.

5) Develops recommendations regarding processes for planning, advocacy, administration and oversight of mental health and substance abuse services that would facilitate more integrated services. Areas of examination should include:

?? Grant applications
?? Grants for individualized services
?? Funding mechanisms
?? Financial and service reporting requirements (including MIS requirements)
?? Cross-disciplinary Quality Assurance review processes, integrated data collection and assessment/outcome monitoring
?? Licensing and certification of individuals and programs
?? Accountability of providers
?? Changes in statutory and regulatory framework needed to facilitate integration
?? Affiliation with regional/national organizations effecting similar cross-disciplinary changes in rural areas
?? Integration of advocacy and planning efforts.

6) Makes recommendations regarding the barriers to data collection, the statutory differences related to confidentiality, and identify what we need to achieve an effective integrated mental health and

substance abuse system.

Once the recommendations have been reviewed and accepted by the Commissioner, an implementation plan would need to be developed. The implementation plan would include identification of funding sources and responsibilities for action. It would also include a training schedule, and a time line, which would specify strategies to expedite the integration process using best practices and standards of care.

Appendix C: Other States' Experiences.

A. Introduction. While there has been much activity and study at the national level, individual states have addressed the issue of services to persons with co-occurring disorders, each in their own way. The following is a sample of the approaches taken by some other states in an effort to improve access and quality of services to persons with co-occurring disorders.

B. Arizona. Using a grant from the U. S. Substance Abuse and Mental Health Services Administration (SAMHSA), Arizona began a program to improve access and quality of care for persons with co-occurring disorders in 1999. This was a collaborative process involving providers, consumers, and other stakeholders and specifically targeted persons with co-occurring disorders. It provided for integrated assessment, treatment, continuity of care, and recovery drawing primarily upon existing services and programs.

The cornerstone of the Arizona approach was dual primary treatment. This means that each disorder, mental illness and substance use disorder, are considered primary conditions and each has its own associated treatment approach. In the Arizona model, each disorder receives phase-specific treatment. A single individual who, while not actually delivering all treatment, is responsible for ensuring that appropriate care is delivered coordinates all treatment interventions. Treatment is in the most appropriate setting given the presenting problems and resources available. Persons with co-occurring disorders have access to individuals with the appropriate skills. A key feature of the Arizona system is that mental health and substance use disorder treatment is provided by the same team of clinicians (although they may not be from the same organization) in one setting. This provides a sense of stability and consistency for the client who is not being shuffled from agency to agency as they progress or their condition changes. There is a heavy emphasis on family involvement.

The principles adopted by the Arizona project are:

- Empathetic relationships
- Individualized service strategies
- Co-occurring psychotropic medication and substance use
- Unconditional commitment to the client
- Cultural competency
- Outcome-based effectiveness

As the program is implemented, they have identified a series of objectives and strategies to enhance the effectiveness of the effort. These are entitled "Hallmarks of Success."

- Improved quality of life for clients and their families
- Consumer and family involvement in the process
- Safe, consistent, user-friendly treatment environment
- Integrated services are readily available
- The continuum of care is integrated, individualized, and flexible
- The administrative functions are integrated
- The funding is sufficient and staff are qualified

As the Arizona experience progresses, there are a number of issues that remain to be resolved and were in progress at the time of this writing.

- Form statewide implementation structure
- Enhance stakeholder involvement
- Resolve the funding issues
- Establish a framework for evaluation
- Define the continuum of care
- Finalize competencies and implement required training
- Develop an implementation schedule for the future

The Arizona approach is of interest to Alaska because of several characteristics. First, it draws upon existing resources and does not seek to redefine organizations. This has the potential to reduce the likelihood of "turf battles" between agencies. Second, it provides for a single coordinating individual and a treatment team that is consistent, even though the team may be drawn from different agencies. Further it provides for the integrated care to be delivered in a single setting. These three features: consistency of team, consistency of setting, and single point of accountability and coordination provide a sense of stability for the client.

C. Maine. Maine has taken a different approach to improving access and quality of care to persons with co-occurring disorders. Beginning in 1992, Maine set up a series of regional treatment collaboratives. These groups had diverse membership including providers, consumers, family members, and other stakeholders. The purpose and focus of the collaboratives was to:

- Build provider relationships
- Establish a common language about co-occurring disorders
- Provide cross training

The focus of the Maine effort was to build and nurture relationships and use the power of those relationships to solve problems. Some of the specific actions taken included:

- Inviting all relevant agencies to participate in the process
- Using mechanisms such as monthly meetings and joint training sessions
- Ensuring ongoing and meaningful consumer participation
- Nurturing and highlighting one-to-one relationships among provider staff

Using the power of relationships to identify and solve problems, the following issues were successfully addressed:

1. Housing. Despite the best treatment approaches, suitable housing remained a problem for persons with co-occurring disorders. One of the regional collaboratives initiated a joint housing project that was co-staffed by mental health and substance use disorder agencies. This not only provided appropriate housing but also ensured that ongoing support was available.

2. Self-Help Groups. In one of the regions, local substance use disorder support groups seemed unresponsive to the needs of persons with co-occurring disorders. The regional

collaborative helped these clients to start their own 12-step support group that was more responsive to the client needs and situations.

3. Inadequate Emergency Room Psychiatric Services. In one community, the psychiatric services provided in the local hospital emergency room were considered inadequate to meet the needs of the clients. The regional collaborative helped to design a diversion program for this population that provided more appropriate community services.

The Maine approach, while different from Arizona's, is interesting because it harnesses the power of front line collaborative relationships to solve specific problems. Regardless of the effort at the state level to develop and nurture a system that is responsive to the needs of persons with co-occurring disorders, there will always be local situations and problems that require specific solutions. These solutions are best identified and implemented through local collaborative partnerships that include providers, consumers, family members, and other stakeholders.

D. Missouri. Missouri initiated their effort in 1997. The Missouri approach was a complete system re-design. Persons with co-occurring disorders were identified as a special population within the overall client population. The system design was not targeted only at this special population and consumers had a strong voice in the system redesign process. The Missouri effort was based on a recovery concept that included the following principles:

- Client independence, personal responsibility, and belongingness
- Client power and mastery
- Meaning
- Hope

The system design included a single point of accountability for each consumer. Duplicative assessments so common in fragmented systems were eliminated and a single, individualized care plan concept was adopted. An emphasis was placed on providing more consumer treatment and provider choices. New services such as peer support and consumer-run agencies were introduced. A single appeal and grievance procedure was introduced that covered all types of services and a position of consumer advisor and advocate was established to assist in the process. Finally, the system was designed so that consumers do not have to worry about who funds any particular portion of their treatment. Some of the significant features of this system include:

- "No wrong door" for clients seeking treatment
- Single point of accountability for each individual
- Non-duplicative assessments
- Single, integrated care plan
- Consolidated complaint/appeal process
- Greater emphasis on consumer choice
- Appropriate training and qualification of staff

Missouri, unlike other states, completely redesigned their care delivery system and administers the new system as an integrated one. While this approach has the advantage of starting with a "clean page" and designing the system to meet current needs and situations, it is time-

consuming, expensive, and introduces the potential for disruptive "turf battles." The system designed, however, does have some characteristics that are of interest to Alaska. These include the "no wrong door" approach for access to care, single point of accountability for care delivery, and integrated assessments and care plans.

E. New York. Section III of the main body of the report provided a detailed discussion of the New York model or framework. Additionally, the Steering Committee recommended that this framework be adopted for use in Alaska. The New York model is characterized by service delivery that is dependent on the severity and combination of symptoms. Assuming that clients with co-occurring disorders can have mental health and substance use disorder symptoms that vary in intensity from low to high, the treatment system can be viewed as a framework of quadrants:

Quadrant I: Mental Health Symptom Severity Low
Substance Use Disorder Symptom Severity Low

Quadrant II: Mental Health Symptom Severity High
Substance Use Disorder Symptom Severity Low

Quadrant III: Mental Health Symptom Severity Low
Substance Use Disorder Symptom Severity High

Quadrant IV: Mental Health Symptom Severity High
Substance Use Disorder Symptom Severity High

Another key feature of this model is that treatment services for the two types of disorders, while often delivered by separate agencies, are coordinated by a single agency known as the "locus of care." In quadrants II and III, where one of the two sets of symptoms are more severe than the other, the locus of care resides in the domain (mental health or substance use disorder) where the symptoms are the most severe. In quadrant I, where the severity of both sets of symptoms is low, care is often provided in settings other than mental health or substance use disorder treatment agencies. These settings can include corrections systems or the medical community. This is because, with the severity of both sets of symptoms low, it is less likely that the client would come to the attention of a mental health or substance use disorder treatment agency. By contrast, with high severity in both sets of symptoms, aggressive care is needed in both domains.

In quadrants II and III, where there is a clear locus of care, services should be delivered with a high degree of collaboration between the two types of providers. Quadrant IV, with a high degree of severity in both sets of symptoms, care should be delivered in a more consolidated approach.

This framework offers a number of attractive attributes. First, the New York model is not prescriptive with regard to specific treatment modality. It recognizes that the two types of providers use different approaches and does not seek to change that. The framework also recognizes that care for the two types of disorders are often delivered by separate agencies. Finally, this framework acknowledges the reality that levels of severity and acuity in clients with co-occurring disorders can vary and that the approach to treatment will vary with variations in

symptoms.

F. Texas. The Texas approach is noteworthy from the perspective of implementation more than anything else. Texas placed considerable emphasis on access to appropriate care using the concept of "no wrong door." The substance use disorder providers took the lead in this effort although mental health providers have begun to participate to a greater extent.

One of the first steps was to develop requirements for substance use disorder providers to conduct mental health assessments for every client admitted. Implementation included the award of pilot project grants. Using both substance use disorder and mental health funds, providers can offer both services. The program accounting and billing systems are set up to distinguish between the two types of services to ensure proper expense postings. This includes the use of a standardized formula for allocation of overhead expenses to the two funding sources.

In practice, one of the more interesting characteristics of this approach is that, in urban areas the access to care takes the form of "no wrong door." This means that, no matter what type of agency initially admits the client, there is a strong emphasis on ensuring that all needed services are provided, even if provided by another agency. In urban areas, care for the two types of disorders is most often provided by separate agencies. In rural areas, the access to care tends to take the form of "one-stop-shop" where a single agency is most likely to deliver all needed services using internal resources. This differentiation between urban and rural approaches will, based on current trends, likely be reflected in Alaska.

Texas has also placed a strong emphasis on training and staff development. They made use of outside consultants such as Dr. Ken Minkoff and Dr. Robert Drake to assist in this effort.

G. Virginia. Virginia, in its attempt to improve services to persons with co-occurring disorders, has concentrated on funding and training issues. While funding is centrally administered, control of service delivery and local allocation of funds is vested in local mental health boards across the state. These boards oversee mental health, substance use disorder and mental retardation services. There is no statewide mandate to integrate, however, there is a heavy emphasis on cross training of staff.

The actual levels of integration or consolidation at the service delivery level are determined by local needs and preferences. In practice, as with Texas, the two types of services tend to be delivered by independent mental health and substance use disorder agencies in urban areas while rural areas tend to have more consolidated services.

What makes this particular model interesting is the emphasis on local determination. The state focuses on cross training and distribution of funds while local entities determine the level of integration works best in their area.

H. Summary. While each of the states reviewed offers a different perspective, there are some common characteristics.

1. Use of Existing Resources and Expertise. The states reviewed, for the most part, called on existing resources and expertise to deliver care. Although efforts were made to

collaborate, in most cases, the states recognized the reality that the two disorders and usually treated by two different types of providers, each with their own set of skills and competencies. There was little evidence of any attempt to formally merge the two delivery systems into a single system.

2. Coordination of Care. While acknowledging that care for persons with co-occurring disorders may be provided by multiple agencies, the states recognized that coordination and accountability must ultimately lie with one entity. It becomes the responsibility of this entity to ensure that all necessary care is delivered.

3. Access to Appropriate Treatment. Finally, states have taken aggressive steps to ensure that, no matter which type of agency first sees the client, there must be mechanisms in place to ensure that appropriate assessments are conducted, client needs identified, and treatment resources brought to bear.

These common features identified in the different states' approaches have all been addressed in Steering Committee recommendations.

Appendix D: Provider Survey Instrument.

A few minutes of your time…and your thoughts

Thank you for taking the time and effort to complete this survey. Integration of mental health and chemical dependency services is an issue that impacts our consumers and clients, professionals, organizations, and communities. This survey will help us to better understand your ideas and concerns as we consider the issues. If you would like more information on this project, please visit the integration web site www.akintegration.com. Thank you.

1. Organization _____ Community _____

2. Which of the following best describes your organization?

- ✍✍ Substance abuse program only (Go to Question 3)
- ✍✍ Mental health program only (Skip to Question 4)
- ✍✍ Single organization delivering both types of services (Skip to Question 5)
- ✍✍ Substance abuse program – but our parent organization operates a mental health program (Go to Question 3)
- ✍✍ Mental health program – but our parent organization operates a substance abuse program (Skip to Question 4)
- ✍✍ Other _____ (Skip to Question 8)
- ✍✍ If you are a substance abuse only program, what percentage of your clients do you believe also has a serious mental illness (schizophrenia, bi-polar disorder, major depression, etc.)?

- ✍✍ None
- ✍✍ Less that 25%
- ✍✍ 25% to 50%
- ✍✍ 50% to 75%
- ✍✍ More than 75%
- ✍✍ I do not know

Please skip to question 8

4. If you are a mental health only program, what percentage of your clients do you believe also has a substance abuse disorder?

- ✍✍ None
- ✍✍ Less that 25%
- ✍✍ 25% to 50%
- ✍✍ 50% to 75%
- ✍✍ More than 75%
- ✍✍ I do not know

Please skip to question8

5. If you are an integrated program, what percentage of your overall client load do you believe has co-occurring substance abuse disorder and major mental illness?

- ✍✍ None
- ✍✍ Less that 25%
- ✍✍ 25% to 50%
- ✍✍ 50% to 75%
- ✍✍ More than 75%
- ✍✍ I do not know

Proceed to the next question

6. If you are an integrated program, what percentage of your clients has only a substance abuse disorder (no mental health disorders)?

- ✍✍ None
- ✍✍ Less that 25%
- ✍✍ 25% to 50%
- ✍✍ 50% to 75%
- ✍✍ More than 75%
- ✍✍ I do not know

Proceed to the next question

7. If you are an integrated program, what percentage of your clients has only a mental health disorder (no substance abuse disorder)?

- ✍✍ None
- ✍✍ Less that 25%
- ✍✍ 25% to 50%
- ✍✍ 50% to 75%
- ✍✍ More than 75%
- ✍✍ I do not know

Proceed to the next question

8. When a client presents who has co-occurring substance abuse disorder and major mental illness, what is your protocol for providing services?

- ✍✍ We provide consolidated services at our organization
- ✍✍ We treat the mental illness but refer the client to another provider for substance abuse treatment
- ✍✍ We treat the substance abuse disorder but refer the client to another provider for mental health treatment
- ✍✍ We use staff from outside our organization provide substance abuse or mental health services on site.
- ✍✍ We do not provide services to persons with co-occurring disorders

9. Below is a list of administrative functions that are impacted by the working relationship between the Division of Alcoholism and Drug Abuse and the Division of Mental Health and Developmental Disabilities. For each one, please indicate on the scale the extent to which the separation of functions between substance abuse and mental health hinders or enhances your ability to provide quality services to your clients.

Function	Greatly Hinders	Slightly Hinders	Neither Hinders nor Enhances	Slightly Enhances	Greatly Enhances
Data Collection	☐	☐	☐	☐	☐
Grant Application Process	☐	☐	☐	☐	☐
Site Facility Surveys	☐	☐	☐	☐	☐
Oversight/Regulation	☐	☐	☐	☐	☐
Reporting Requirements	☐	☐	☐	☐	☐
Overall Administration	☐	☐	☐	☐	☐

10. From which of the following sources does your program regularly receive funding and roughly what percentage of your funding comes from each?

		Percentage of your budget
??	Division of Alcoholism and Drug Abuse treatment grant	_____
??	Division of Mental Health and Developmental Disabilities grant	_____
??	Medicaid or Medicare	_____
??	Commercial Third Party Insurance	_____
??	Indian Health Service Funds	_____
??	Direct Federal Grant (SAMHSA, OJJDP, etc.)	_____
??	Private Foundation Grants (Robert Wood Johnson, Kellogg, etc.)	_____
??	Client Self-Pay	_____
??	Other _____	_____

11. Which of the following services are provided by your organization (using your own staff) (please check all that apply)?

Substance Abuse	Mental Health
☐ Emergency Services	☐ Emergency Services
☐ Inpatient or Residential Care	☐ Individual Therapy
☐ Intensive or Regular Outpatient Care	☐ Group Therapy
☐ Continuing Care or Aftercare	☐ Case Management
☐ Outreach or Intervention	☐ Crisis Respite or Emergency Housing
☐ Prevention	☐ Supported Housing
☐ Transitional Housing	☐ Psychiatric Care/Medication Management
☐ Other _____	☐ Other _____

12. For each of the functions listed below, please indicate your organization's level of integration between community substance abuse functions and community mental health functions on a scale of 1 to 5 with "1" being "Not Integrated" and "5" being "Highly Integrated."

Function	Not Integrated		Moderate Integration		Highly Integrated
	1	**2**	**3**	**4**	**5**
Treatment Planning	☐	☐	☐	☐	☐
Delivery of Services	☐	☐	☐	☐	☐
Grant Administration	☐	☐	☐	☐	☐
Administrative Overhead	☐	☐	☐	☐	☐
Program Evaluation	☐	☐	☐	☐	☐
Staff Training and Development	☐	☐	☐	☐	☐
Quality Assurance	☐	☐	☐	☐	☐

13. On a scale of 1 to 5, with "1" being "No Cross-Training" and "5" being "Highly Cross-Trained," how would rate the cross-training level of your staff? "Cross-training" refers to training of individuals on both substance abuse and mental health.

Please answer below only for the category of your organization.

Type of Organization	**No Cross Training**		**Some Cross Training**		**Highly Cross Trained**
	1	**2**	**3**	**4**	**5**
Mental Health Providers	☐	☐	☐	☐	☐
Substance Abuse Providers	☐	☐	☐	☐	☐
Integrated MH/SA Providers	☐	☐	☐	☐	☐

14. Please indicate in which of the following topics you would like to have your staff receive more training. (Please check all that apply)

☐ Mental Health Assessment ☐ Substance Abuse Assessment ☐ Integrated Treatment Planning
☐ Crisis Intervention ☐ Pharmacology/Pyschotropics ☐ Integrated Case Management
☐ Referrals/Resources ☐ Recovery for persons with co-occurring disorders

13. What are some of the ways that you believe substance abuse and mental health providers, as well as the Divisions of Alcoholism & Drug Abuse and Mental Health & Developmental Disabilities, can work together more productively?

_____

_____

_____

_____

14. What are some of the benefits that you believe can be realized by greater integration of administrative requirements and services for persons with co-occurring disorders? _____

_____

_____

_____

15. What are some of the dangers or risks in greater integration of administrative requirements and services for persons with co-occurring disorders?_____

_____

_____

_____

Thank you for taking the time and effort to complete this survey!