

Co-Occurring Disorder Service Delivery: Quality Initiative Final Report

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Scot L. Adams, Ph.D., Director
Division of Behavioral Health
Department of Health and Human Services

Co-Occurring Disorder Services Delivery:
Quality Initiative Workgroup

Workgroup Chair: Blaine Shaffer, M.D. Chief Clinical Officer, Division of Behavioral Health

Workgroup 2nd Chair: Sheri Dawson, R.N., Managed Care and Quality Improvement,
Division of Behavioral Health

Facilitator: Mary O'Hare, MEd, MPA, O'Hare Professional Consultation Services, LLC

Workgroup Members

Sue Adams, DHHS/DBH

Diana Meadors, BAART

Susan Boust, BHECN

Judie Moorehouse, Region 1

Kim Carpenter, BHECN

Tara Muir, Metro Area Continuum of Care

Vijay Dewan, LRC

JoAnn O'Connell, Ponca Tribe

Paula Eurek, DHHS/Public Health

Donna Polk-Primm, NUIHC

Renee Faber, DHHS/DBH

Dan Powers, DHHS/DBH

Tamara Gavin, Magellan

Jean Sassatelli, Catholic Charities

Kathleen Grant, Omaha VA

Julie Scott, Probation

Topher Hansen, CenterPointe

Ken Timmerman, Region 6

Julie Hippen, DHHS/CFS

Ann Tvrdik, Region 3

Rick McNeese, First Step Recovery &
Wellness Center

Margaret Van Dyke, DHHS/Medicaid &
Long-Term Care

Cody Manthei, Mental Health Advisory
Committee

Cameron White, NDCS

Linda Witmuss, Region 5

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Introduction

Scot Adams, PhD, Director of Behavioral Health Services appointed Blaine Shaffer, M.D. Chief Clinical Officer and Sheri Dawson, R.N. Managed Care and Quality Improvement to lead a Co-Occurring Disorders (COD) Service Delivery Quality Initiative Workgroup. Consumers, providers, educators, and representatives from a variety of state agencies including corrections, public health and behavioral health were invited to participate. The COD Workgroup adopted the following as mission and goal statement.

Mission Statement: The Co-Occurring Disorders Quality Initiative will improve services to Nebraska adults with co-occurring mental health and substance use disorders and their families.

Goal Statement: The Co-Occurring Disorders Workgroup will produce a Roadmap to a statewide, integrated co-occurring service delivery system.

The impetus for the COD Workgroup originates with work done at the national level by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's initiative is a national initiative to promote integrated, co-occurring services. As a part of the initiative, select states were awarded Federal grants to create action plans for the development of an integrated COD system. In addition, SAMHSA funded the Co-Occurring Center for Excellence (COCE) to develop eight Overview Papers which are anchored in current science, research, and practices in the field of COD service delivery. The concise and easy to read documents are introductions to state-of-the-art knowledge in COD and include the following topics:

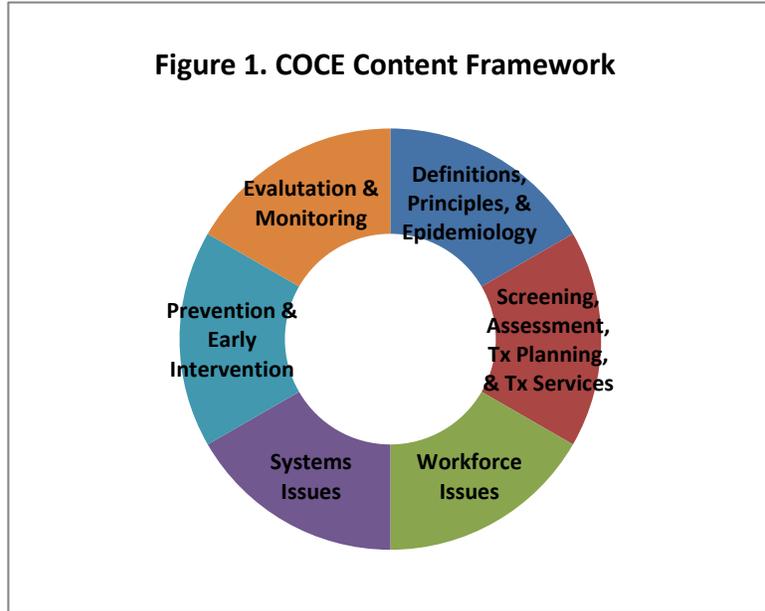
1. Definitions and Terms Relating to COD
2. Screening, Assessment, and Treatment Planning for Persons with COD
3. Overarching Principles to Address the Needs of Persons with COD
4. Addressing COD in Non-Traditional Service Settings
5. Understanding Evidence-Base Practices for COD
6. Services Integration
7. Systems Integration
8. The Epidemiology of COD¹

The COD Workgroup developed Nebraska's Roadmap to guide the transformation of the current system of care. The Roadmap is included in this document along with related background information reviewed and discussed by the COD Workgroup.

¹ Center for Substance Abuse Treatment Overview Papers. (2007). DHHS Publication. Copies may be obtained free of charge electronically at: www.ncadi.samhsa.gov or www.coce.samhsa.gov.

Development of Roadmap

The Nebraska COD Workgroup drew upon the work completed by other states who were involved in SAMHSA's initiative as well as the Overview Papers to create a Roadmap for integrated COD services for Nebraska. In addition, SAMSHA's Co-Occurring Center for Excellence (COCE) Content Framework was utilized as the basis for the COD Workgroup's Roadmap. The Content Framework includes: Definitions, Principles, and Epidemiology; Screening, Assessment, Treatment Planning, and Treatment Services; Workforce Issues; Systems Issues; Prevention and Early Intervention; and Evaluation and Monitoring. (Figure 1.) Subcommittees were formed to develop action plans corresponding to the Content Framework.



The following report provides a description of the content areas and COD Roadmap which resulted from the COD Workgroup discussions.

COD Definitions

It is essential to employ a common language when addressing the needs of persons with COD. The COD Workgroup agreed to use the definitions as described in Overview Paper 1² as common language for their work. The following is taken from Overview Paper 1. These definitions along with others in this document are included in Attachment A.

Substance-Related Disorders

The standard use of the term substance-related disorders derives from the DSM-IV-TR. Substance-related disorders are divided into *substance use disorders* and *substance-induced disorders*.

Substance Use Disorders are further divided into substance abuse and substance dependence as defined below.

- Substance Abuse: "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances."

² Center for Substance Abuse Treatment. Definitions and Terms Relating to Co-Occurring Disorders. COCE Overview Paper 1. DHHS Publication No. (SMA) 07-4163 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

- Substance Dependence: “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems.”

Substance-Induced Disorders include substance intoxication, substance withdrawal, groups of symptoms that are “in excess of the usually associated with the intoxication or withdrawal that is characteristic of the particular substance and are sufficiently severe to warrant independent clinical attention.”

Non-Substance-Related Mental Disorders

Non-substance-related mental disorders definitions also derive from the DSM-IV-TR. The major relevant mental disorders for COD include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and personality disorders. Two other essential definitions-Serious Emotional Disturbance and Serious Mental Illness-are derived from definitions developed by SAMHSA and used to establish Block Grant target populations and prevalence estimates for States but also have an application in the design and delivery of services for persons with COD.

- *Serious Emotional Disorders (SED)* is defined as “persons from birth up to age 18 who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with the DSM-IV that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.”
- *Serious Mental Illness (SMI)* is defined as “persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV, resulting in functional impairment which substantially interferes with or limits one or more major life activities.”

COD

COD refers to co-occurring substance-related and mental disorders. Consumers said to have COD have one or more substance-related disorders as well as one or more mental disorders. At the individual level, COD exist “when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.” Overview Paper 1 provides a more in-depth service definition of COD which includes “pre-diagnosis”, “post-diagnosis” and “unitary disorder and acute signs and/or symptoms of a co-occurring condition” which is relevant to this initiative.

Quadrants of Care and the Integration Continuum

The quadrants of care is a conceptual framework that classifies COD care into four quadrants based on relative symptom severity, not diagnosis. The four quadrants are:

1. Low addiction/low mental illness severity
2. Low addiction/high mental illness
3. High addiction/low mental illness
4. High addiction/high mental illness

The model provides a framework for understanding the range of co-occurring conditions and the level of coordination that service systems need to address them. It provides a

structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every consumer with COD.

Integrated Screening, Assessment, and Interventions

1. *Integrated screening* is the determination of the likelihood that a person has a co-occurring substance use or mental disorder.
2. *Integrated assessment* consists of gathering information and engaging in a process with the consumer that enables the provider to establish the presence or absence of co-occurring disorders, determine the consumer's readiness for change, identify consumer strengths or problem areas that may affect the processes of treatment and recovery, and engage the consumer in the development of an appropriate treatment relationship.
3. *Integrated interventions* are specific treatment strategies or therapeutic techniques in which interventions for all COD diagnoses or symptoms are combined in a single contact or in a series of contacts over time.

Terms Associated with Programs

A program is a formally organized array of services and interventions provided in a coherent matter at a specific level or levels of care in order to address the needs of particular target populations. Some agencies operate only mental health programs; some operate only substance abuse treatment programs and some do both. The following are three program types which derive from American Society of Addiction Medicine (ASAM).

1. Addiction- or mental-health only services refers to programs that "either by choice or lack of resources (staff or financial), cannot accommodate patients" who have co-occurring disorders that require "ongoing treatment, however stable the illness and however well-functioning the patient."
2. Dual diagnosis capable (DDC) programs are those that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment plan, program content and discharge planning."
3. Dual diagnosis enhanced (DDE) programs have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health treatment to consumers who are compared to those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder."

Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders

Overview Paper 3³ outlines 12 overarching principles for working with persons with COD. These principles are intended to "help guide, but not define, systemic, and clinical responses." They can be used as benchmarks to assess whether plans in development, or programs in operation are grounded in the field's best thinking. The COD Workgroup used

³ Center for Substance Abuse Treatment. Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders. COCE Overview Paper 3. DHHS Publication No. (SMA) 07-4165 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

the principles to develop a report card for Nebraska. (Table 1.) Each member was asked to provide a rating that best fits their experience in the ability of the system of care (either local or statewide depending upon their experience) in achieving the principle. The rating scale was as follows: A. Extremely; B. Somewhat; C. No Opinion; D. Not Very; F. Not at All. This was a very unscientific activity designed to solicit discussion more than anything else. The ratings and highlights of the discussion follow.

Table 1. Nebraska's Report Card on Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders

Principle 1: Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.

Nebraska's Grade: Mostly Ds

This statement implies a system and NE doesn't have a co-occurring system. As a system, Nebraska has an expectation that is higher but in practice it is not happening across the state.

Principle 2: An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.

Nebraska's Grade: Mostly Cs

Nebraska has limited resources but providers work hard at quality and continuity of care for the consumers served. Some providers still really struggle at the service-provider level. A desire for continuity and quality exists, but currently there is no integrated system.

Principle 3: The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door) and be perceived as caring and accepting by the consumer.

Nebraska's Grade: Mostly Ds

Professionals have awareness for consumer need, but the infrastructure for an integrated system does not exist. Professionals screen, but a way to follow up is not always available.

Principle 4: The system of care for COD should not be limited to a single "correct" model or approach.

Nebraska's Grade: Mostly As

There are many different approaches that providers use. Some members gave this a D because of a perception that there needs to be more creativity, more integration in services and not just clinical services.

Principle 5: The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence and consensus-based

practices for persons with COD and evaluation of the efforts of existing programs and services.

Nebraska's Grade: Mostly Ds

Some models being utilized are evidence-based, but others are opinion or experience-based. The latter are more often defended vehemently because the clinician is personally attached to the model. Consumers may not always feel welcome, but also providers may not always feel competent to practice and deliver both MH and SA services. It is a culture clash between MH and SA providers. At least right now there is dialogue beginning between the two fields.

Principle 6: Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.

Nebraska's Grade: Mostly Cs

There is an effort by BH systems to work with other areas such as primary care, human services, housing, criminal justice, education and other related fields. There needs to be more case managers working with providers to help connect all of these fields. Problem gambling area does work with legal, housing, finance, etc. State legislation needs to be changed, and/or federal rules need to be changed to better accommodate working together.

Principle 7: Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.

Nebraska's Grade: Mostly Cs.

Some providers are performing better than others. Stigma is a barrier, some people have a substance abuse problem but then when they find out they also have a MH problem it is surprising and upsetting, or vice versa. Some clinicians' training is compartmentalized and they are not adequately trained to meet the needs of a consumer with a co-occurring disorder.

Principle 8: Within the treatment context, both co-occurring disorders are considered primary.

Nebraska's Grade: Mostly Ds

Currently to receive funding for services, providers have to label one diagnosis as primary and the other secondary.

Principle 9: Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.

Nebraska's Grade: C+

Most people do show empathy and respect toward consumers' ability for recovery. Research has shown the relationship between the provider and consumer is the highest determinant of

a successful recovery. On the other hand, many programs are not recovery-oriented.

Principle 10: Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.

Nebraska's Grade: Mostly Ds

Multiple models, for multiple different issues, must be utilized, professionals need better training. Academic providers need to educate clinicians on how to write treatment goals and plans to promote successful consumer outcomes.

Principle 11: The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.

Nebraska's Grade: Mostly Ds

Transition to the adult system is an issue with children that have been involved in the different programs and services. They are aging out and then get lost and don't get the services they need as adults. We must begin to start treating the whole family, children included.

Principle 12: The contribution of the community to the course of recovery for consumers with COD and the contribution of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

Nebraska's Grade: Mostly Bs

Nebraska is starting to have consumers at the table. Many times it is only after years of recovery that consumers can have time or energy to attend meetings to offer input. It can be difficult, time consuming and exhausting just to influence and advocate for your own treatment plan. Therefore, there are many different levels of consumer involvement, not just on an advisory committee level. The workgroup also discussed whether the consumer community is adequately recognized at a policy level or advocacy level in Nebraska.

Conclusion: Chair Blaine Shaffer asked the group if they could adopt the 12 Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders to guide the development of Nebraska's Roadmap. The members agreed.

Epidemiology of COD

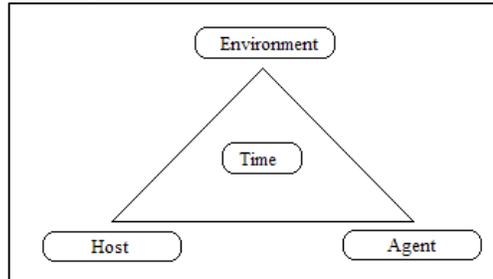
Key Definitions:

1. Prevalence: Denotes the percentage of persons who have a particular disorder at a given time within a specific population.
2. Incidence: Refers to the rate of occurrence or percentage of new cases (e.g. in a 6 month period) within a population

3. Epidemiology: The study of the incidence, prevalence, and distribution of a disease in a population.

Epidemiology Triangle

The Epidemiology Triangle (Figure 2.) helps to inform the public of the parameters of health conditions. It consists of three distinct points: environment, agent, and host, and directs the exploration of the questions who, what, where, when, and how much for a particular disease data points were Workgroup as collect when studying



across time. The following identified by the COD important data elements to COD in Nebraska.

Figure 2. Epidemiology Triangle

Agent (what): Diagnoses by specific categories; four quadrants of COD by severity; substances used; trauma; presenting problem; specific screening or assessment tool utilized; assessor.

Environment (where): State; schools; shelters; hospitals; state institutions; local providers; regional; funding sources; urban; rural; contracts

Host (who): Standard demographics-age, SES, ethnicity; veteran/national guard; employment; housing; onset; family history; sexual orientation; level of severity; medical; current services; prior treatment history; response to treatment; current services; criminological and other risk factors.

Major National Epidemiologic Studies Related to COD

Current national COD epidemiologic data are derived from three major studies. The names of the studies, data collection periods of the studies, data collection tools utilized, and the interview mode are depicted in Table 2.

Table 2. National COD Epidemiology Studies			
Study	Data Collection Period	Data collection tools	Interview mode
National Comorbidity Survey (NCS)	NCS: 1991-1992 NCS-R: 2001-2003	Composite International Diagnostic Interview (CIDI)	CAPI by trained interviewer

Table 2. National COD Epidemiology Studies			
Study	Data Collection Period	Data collection tools	Interview mode
National Survey on Drug Use and Health (NSDUH)	1972 – present (annual)	Questions about substance use and mental health	CAPI by trained interviewer ACASI (self interview)
National Epidemiologic Study on Alcohol and Related Conditions (NESARC)	2001-2001 2004-2005	Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version	CAPI by trained interviewer

COD Treatment Utilization

SAMHSA data in 2006 indicated that adults aged 18 or older with COD included 5.2 million adults. Of those 4.2 million 34.2% received mental health treatment only; 1.9% received specialty substance use treatment; 11.8% received both mental health and specialty substance use treatment and 52.1% received neither mental health treatment nor specialty substance use treatment. (Figure 3.)

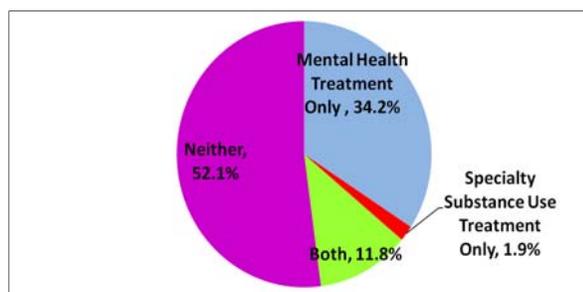


Figure 3. COD Treatment Utilization

University of Nebraska Medical Center (UNMC)/Division of Behavioral Health (DBH) Prevalence Study

Shinobu Watanabe-Galloway from the University of NE Med Center presented on the prevalence of adults with COD in the United States and Nebraska. The following are highlights of her presentation:

- Definitions must be consistent as they affect estimates.
- Prevalence data is often revered in the following two categories: (a) COD with mental illness and (b) COD with serious mental illness. The COD Workgroup is most concerned with those with COD and serious mental illness.
- Prevalence data can be viewed from general population and those participating in behavioral health services.
- Those with behavioral health diagnoses have an average age of death 23/24 years earlier than the general population.

- Three national prevalence data sources were presented: NCS, NSCUH, NESARC. Data is collected from the general population (not necessarily those in service) by non-clinical interviewers.
- General population surveys found the prevalence of COD in the general population of adults to be around 2 to 5% nationally.
- The national prevalence data most relevant to this group is for serious mental illness with co-occurring SUD which is 4 million adults or 2% of the population.
- At a 2.5% prevalence rate, 32,000 Nebraska adults have serious psychological disorders and SUD. (NSDUH 2004-2007)
- COD prevalence is much higher in the clinical population especially among consumers who have chronic/severe mental disorders. 62% of all Nebraska adults admitted to a Regional Center have a serious mental illness and a substance related disorder while 10% of Nebraska adults receiving community-based behavioral health services have a serious mental illness and a substance related disorder. Nicotine dependence is not included in definition of substance use disorder for these studies.
- 42% of those admitted to a NE Regional Center between 1/1/05 and 12/31/09 had a serious mental illness, substance related disorder, and a personality disorder.
- 53% of adults with COD receive neither mental health nor substance use treatment. Potential reasons: under-detection of COD in the general population; limited availability/access to care; lack of coordination between two systems; personal/family reasons for not seeking care.

Nebraska Department of Corrections Data

Cameron White reported that the rate of mental health diagnosis at intake to Nebraska Corrections was from 16% to 40% of all intakes over the past six fiscal years. The past three fiscal years, the percentage ranged from 29% to 40%. There were just over 2200 intakes/admissions per year.

A point of time study revealed 20% of inmates were taking prescribed psychiatric medication. For the last six fiscal years, the percentage for substance related disorders is from 76% to 89% at intake.

DBH Service-Related Data

In 2009, 37,669 consumers received services funded by the DBH. Of those 17,720 or 47% received only mental health services, 5,095 or 14% received only substance abuse services and 14,854 received COD services. (Table 3.)

Table 3. DBH Service-Related Data

FY 2009 Service Numbers	All Consumers Receiving DBH Services	Consumers Receiving ONLY Mental Health Services	Consumers Receiving ONLY Substance Abuse Services ONLY	Consumers Receiving COD Services
Total Number	37,669	17,720	5,095	14,854
Percentage	100%	47%	14%	39%

DBH struggles to coordinate efforts in data collection and analysis. DBH does not have its own data system or claims system. DBH is federally required to report NOMS via electronic submission known as States Outcome Measurement and Management System (SOMMS). Statewide data is also gathered from several other different data sources and for a variety of purposes such as Magellan for data management of service provision; UNMC for block grants, criminal justice projects, and regional center discharges; and Public Policy Center for GAP, grants, and Professional Partners.

The data is stored in variety of places such as at Magellan or on spreadsheets at DBH. DBH has made a concentrated effort to collect more accurate service-related data in the last two years. Magellan is currently working with DBH on provider, region, and statewide NOMS reports. The target date for completion is Dec 2010.

A need exists to create a usable data system by studying state of the art data systems, making recommendations for Nebraska, and determining COD data for those receiving services across all state systems and providers. Efforts need to concentrate on a centralized data location and streamlining data collection.

Evidenced-Based Practices for COD

The advantages of employing evidence-based practices (EBPs) are now widely acknowledged across the medical, substance abuse and mental health fields. EBPs are defined as a practice which, based on research findings and expert or consensus opinion about available evidence is expected to produce a specific clinical outcome (measurable change in client status). The Institute of Medicine (IOM, 2001) suggests a definition of EPBs that reflects the “multiple streams of evidence” approach including the following components: basic research evidence, clinical expertise, patient values. COCE has adopted this “multiple streams of evidence” approach.

A number of terms have been used to describe practices that are expected to produce a specific clinical outcome. These terms are somewhat interchangeable. The terms promising and emerging are consistent with the notion that the strength of evidence varies among practices deemed likely to produce specific clinical outcomes. The COCE avoids

descriptors like 'best' and 'model' because they may imply that there is a single best approach to treating all persons with COD. 'Effective' is also avoided because no hard criterion exists for the level of evidence by which effectiveness is established. The term 'consensus based' refers to a process by which evidence is commonly evaluated and synthesized to determine if a given practice is an EBP. EBP fidelity is the extent to which a treatment approach as actually implemented corresponds to the treatment strategy as designed.

COD is a relatively new field with little development and testing of a large number of EBPs. EBPs developed solely for mental health or substance abuse should be considered in the treatment of people with COD. EBPs for COD should combine both treatment elements, such as motivational therapy, and programmatic elements such as multidisciplinary teams. At the treatment level, interventions that have evidence to support them as EBPs include motivational, behavioral, and psychopharmacological interventions. At the program level, the following models have an evidence base for producing positive clinical outcomes for persons with COD: modified therapeutic communities, integrated dual disorders treatment, and assertive community treatment.

The implementation of EBPs present many challenges including staff resistance to change, commitment to current practices, need for training and supervision, need for organizational changes, and new licensures or certifications.⁴

COD Disorders in Partner Service Settings

Key Definitions:

1. Behavioral Health Service Settings: Agencies, programs, and facilities specifically designed to treat psychiatric and/or addictive disorders.
2. Partner Service Settings: Settings outside of the behavioral health system where persons with COD are likely to be encountered. These can be divided into three categories:
 - a. Health settings, including primary care (e.g., community health clinics, HIV/AIDS treatment programs, family practice locales) and acute care (e.g. emergency rooms, intensive care units, trauma centers) settings.
 - b. Public safety and criminal justice settings, including police encounters, courts, jails, prisons, and community corrections settings.⁵
 - c. Social welfare settings, including income support, entitlement and unemployment offices, homeless shelters (as well as makeshift shelters, parks, and abandoned buildings) and the community (eg. schools and faith and workplace settings).

⁴ Center for Substance Abuse Treatment. *Understanding Evidence-Based Practices for Co-Occurring Disorders. COCE Overview Paper 5.* DHHS Publication No. (SMA) 07-4278. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

⁵ Center for Substance Abuse Treatment. *Addressing Co-Occurring Disorders in Non-Traditional Service Settings. COCE Overview Paper 4.* DHHS Publication No. (SMA) 07-4277. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Individuals with COD are found everywhere in the community and many are not receiving treatment for their disorders. Typical community settings where individuals with COD are likely to be encountered include primary health care/public health care settings, criminal justice settings, educational settings, homeless settings, and social welfare settings. Contacts with professionals working within these settings afford unique opportunities for early identification, initial engagement, and linkage to the COD service delivery system. “The use of specialized techniques appropriate to these settings can increase the likelihood that the persons with COD will access treatment.”⁶

The principle of “No Wrong Door”, whereby every point of entry into a human service agency is seen as an opportunity for outreach, education, and connection to needed services, is embraced by Nebraska’s behavioral health system. This principle can be extended to partner services settings listed above. While these settings should not be expected to provide comprehensive COD services, they do provide opportunities to link their clients with COD to treatment providers.

Continuity of care for the highest at risk and most vulnerable populations across all systems, including partner service systems, is a goal which can be obtained by developing partnerships between the behavioral health system and other service systems. The adoption and integration of COD principles and tenets of integrated treatment and resiliency into partner service systems’ (primary health care/public health care, criminal justice, educational, homeless, and social welfare) strategic/state plans will provide the impetus for increased early identification, initial engagement, and linkage to the COD service delivery system.

Screening, Assessment, and Treatment Planning

Key Definitions

1. **Screening:** Determines the likelihood that a client has co-occurring substance use and mental disorder or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.
2. **Assessment:** Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder. Determines the client’s readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.
3. **Treatment Planning:** Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder. The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.

⁶ Center for Substance Abuse Treatment. *Addressing Co-Occurring Disorders in Non-Traditional Service Settings. COCE Overview Paper 4.* DHHS Publication No. (SMA) 07-4277. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

4. Integrated Screening, Assessment, and Treatment Planning: Screening, assessment, and treatment planning that address both mental health and substance abuse, each in the context of the other disorder.
5. Client-centered: The client's perceptions of his or her problem(s) and the goals he or she wishes to accomplish are central to the assessment and to the recommendations that derive from it.⁷

“Screening, assessment, and treatment planning constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons with COD.”⁸ They are not stand alone processes and may be conducted by different agencies. Formal procedures for information sharing and referral are needed between involved agencies. This can be accomplished by establishing a formal network which utilizes validated screening instruments and protocols; evidence-based assessment tools; and treatment planning processes which are client-centered, integrated, individualized to the client, culturally sensitive, and developed with the client as an equal partner. Subsequent treatment of individuals with COD is implemented by trained professionals according to nationally accepted treatment standards which are specific to the needs and demands of Nebraska's unique demographic and professional condition.

Workforce Development

Key Definition:

COD Workforce: Individuals who are in training or employed to provide prevention and treatment services in settings such as community-based treatment settings; prevention coalitions; psychiatric state and community hospitals; and/or criminal justice settings. The COD Workforce includes individuals with a variety of educational backgrounds including High School; Associate's; Bachelor's; Graduate; and Post Graduate degrees. The workforce includes people in recovery and family members as well as clinicians and support service workers.

For many years, it has been common knowledge, and well-documented that a workforce shortage exists within the behavioral health field in Nebraska. The lack of professionals in rural counties is an especially worrying situation. A brief overview of the behavioral health workforce shortage is presented as a foundation for exploration of other workforce issues. This overview contains data related to licensed practitioners only. Currently, there is no central data depository for the peer support, non-licensed, and prevention workers within the behavioral health workforce.

Nebraska is a predominately rural state with nine of Nebraska's counties being metropolitan counties and of the 34 non-metropolitan counties almost half, 38, are frontier

⁷ Center for Substance Abuse Treatment. Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders. COCE Overview Paper 2. DHHS Publication No. (SMA) 07-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007.

⁸ Center for Substance Abuse Treatment. Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders. COCE Overview Paper 2. DHHS Publication No. (SMA) 07-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007.

counties (less than seven people per square mile). Figure 4. depicts the State-Designated Mental Health Shortage-Psychiatry and Mental Health-Nebraska 2010 map. Three complete counties (Douglas, Sarpy, and Lancaster) are not designated shortage areas. Eight counties are designated partial shortage areas. The remaining 82 Nebraska counties are designated shortage areas.⁹

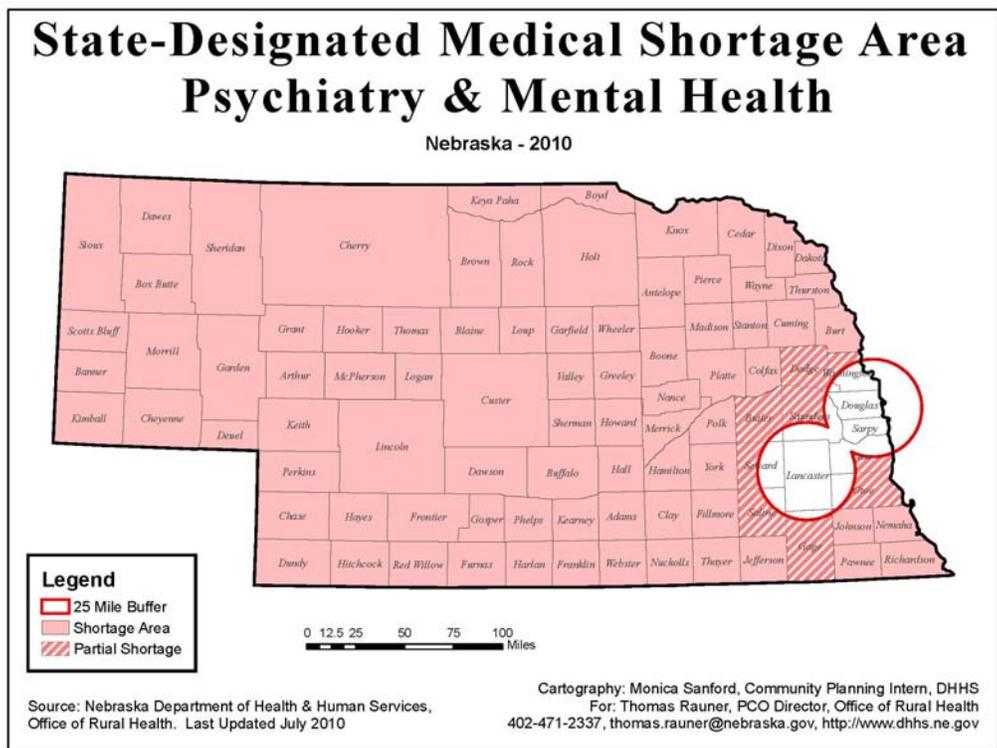


Figure 4. State-Designated Medical Shortage Area Psychiatry and Mental Health. Source: Office of Rural Health

The following statistics are presented to provide an overview of the current state of Nebraska’s actively practicing behavioral health professionals. It is important to note that not all individuals licensed to practice are currently practicing. The information is taken from the UNMC Health Professions Tracking Service 2010 survey and is summarized in the Gap#4: Shortage of Behavioral Health Workforce published by the Nebraska Office of Rural Health.¹⁰

Psychiatrists

- 147 physicians specialize in psychiatry and actively practice in Nebraska.
- Of the 147 Psychiatrists, 114 practice full-time, eight (8) practice part-time (30-39 hours per week) and 25 practice part-time (≤ 29 hours per week) with primary practice locations in 12 Nebraska counties.

⁹ Source: Nebraska Department of Health and Human Services Office of Rural Health, <http://www.dhhs.ne.gov/orh>

¹⁰ Nebraska Department of Health and Human Services Office of Rural Health. *Gap #4: Shortage of Behavioral Health Workforce*. July, 2010.

- The remaining 81 counties do not have a Psychiatrist with a primary practice location.
- Only 23 Psychiatrists; 15 full-time, two (2) part-time (30-39 hours per week) and six (6) part-time (≤ 29 hours per week), have a primary practice location in a State Designated Mental Shortage Area or a partial shortage area.
- Seven (7) Psychiatrists with a primary practice in a State Designated Mental Shortage Area or a partial shortage area are age 61 or older. Only three (3) are age 40 or younger.

Advanced Practice Registered Nurses

- 66 Advanced Practice Registered Nurses (APRNs) specialize in psychiatry and actively practice in Nebraska.
- Three (3) APRNs are dual licensed as an APRN and Licensed Mental Health Practitioner.
- One (1) dual licensed professional practices in a State Designated Mental Shortage Area.
- Fifty-eight (58) APRNs practice full-time, three (3) practice part-time (30-39 hours per week) and eight (8) practice part-time (≤ 29 hours per week) with primary practices in 13 Nebraska counties.
- Twenty-two (22) APRNs have primary practices in a State Designated Mental Shortage Area.
- Four (4) APRNs with a primary practice in a State Designated Mental Shortage Area are age 61 or older.

Physician Assistants

- Ten (10) Physician Assistants (PAs) specialize in psychiatry and actively practice in Nebraska.
- Seven (7) PAs practice full-time and three (3) practice part-time (30-39 hours per week) with primary practices in five (5) Nebraska counties.
- Five (5) PAs have a primary practice in a State Designated Mental Shortage Area.
- No PAs with a primary practice in a State Designated Mental Shortage Area are age 61 or older.

Psychologists

- 315 Psychologists actively practice in Nebraska.
- Two Hundred and Thirty-Six (236) practice full-time, 30 practice part-time (30-39 hours per week) and 49 practice part-time (≤ 29 hours per week) with primary practices in 21 Nebraska counties.
- Twenty-two (22) Psychologists are dual licensed.
- Seventy (70) have a primary practice in a State Designated Mental Shortage Area or partial shortage area.
- Seventeen (17) Psychologists with a primary practice in a State Designated Mental Shortage Area or a partial shortage area are age 61 or older.

Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors and Certified Compulsive Gambling Counselors

- 1,724 behavioral health professionals actively practice in Nebraska.

- One thousand two hundred and fifty (1,250) practice full-time, 173 practice part-time (30-39 hours per week) and 301 practice part-time (≤ 29 hours per week) with primary practices in 55 Nebraska counties.
- Five hundred and eighty-nine (589) have a primary practice in a State Designated Mental Shortage Area or a partial shortage area.
- One hundred and twenty-one (121) behavioral health professionals with a primary practice in a State Designated Mental Shortage Area are age 61 or older.

Dual/Multiple Licensed Practitioners

For the purposes of this report, it is especially critical to examine the number of dual/multiple licensed practitioners actively practicing throughout the state. The percentage per region of the total number of actively practicing individuals with alcohol and drug counselor/mental health practitioner **or** alcohol & drug counselor/independent mental health practitioner **or** psychologist/alcohol and drug counselor licenses are:

- Region 1: 11% of the 71 licensed individuals
- Region 2: 14% of the 80 licensed individuals
- Region 3: 14% of the 273 licensed individuals
- Region 4: 16% of the 157 licensed individuals
- Region 5: 9% of the 623 licensed individuals
- Region 6: 8% of the 1,061 licensed individuals

Certainly, these numbers do not reflect a workforce that is equipped to deal effectively with the number of individuals with COD.

Aging Workforce

Of the actively practicing professionals with a primary practice in Nebraska, approximately ten (10) percent of behavioral health practitioners are 66 years of age and older. An additional 30 percent are between the ages of 56 and 65. Based upon an average retirement age of 65, it is estimated that 40 percent of the behavioral health practitioners will retire within ten (10) years, necessitating the need to recruit more than 40 percent of the current workforce. Only 11 percent of practitioners report being 35 years of age or younger.

Racial/Cultural/Linguistic Disparities

The diversity of Nebraska's workforce does not reflect the diversity of the population. Specifically, African Americans, Hispanics, and Native Americans are underrepresented. However, reliable race/ethnicity data are not available and this could hamper future workforce development activities. Consider the following disparities reported from the data that is available.

- Available data show that African Americans and Hispanics were underrepresented among psychiatrists, making up only 1.4% of psychiatrists who reported race/ethnicity data.
- None of the physician's assistants specializing in psychiatry with race/ethnicity data available identified themselves as Hispanic or African American.

- None of the nurse practitioners specializing in psychiatry with race/ethnicity data available identified themselves as African American or Hispanic.
- The available data show that 2.1% of behavioral health professionals who reported race/ethnicity data in 2008 identified themselves as African American and 1.5% as Hispanic.¹¹

Eighty-five (85) professionals report speaking languages other than English fluently while eight hundred and thirteen (813) professionals report servicing clients who speak languages other than English. Various methods of interpretation are used to communicate with clients: self interpretation, outside interpreter sitting in the session, and phone interpreter.

Nebraska faces many challenges in transforming and developing a behavioral health workforce that can adequately meet the needs of individuals with COD. Workforce needs include shortage of professionals in rural areas; shortage of professionals who can meet the needs of individuals from a variety of cultures and linguistic backgrounds; retention of professionals; need for COD educational opportunities for new students and the existing workforce; limited use of telehealth; lack of coordinated efforts to collect and utilize data in workforce planning; and need for increased emphasis at the state level.

Success in equipping Nebraska's behavioral health workforce to treat and support individuals with COD requires long-term, sustained planning initiatives involving a multitude of change agents/organizations such as Nebraska Health and Human Services, educational institutions, provider organizations, professional organizations, Nebraska Unicameral, Behavioral Health Education Center of Nebraska and advocacy organizations.

Workforce development efforts must address the full spectrum of needs and incorporate sophisticated strategies designed to recruit, retain, educate and train those working in the field. New technologies such as telehealth must be more widely utilized and workforce planning must be active and on-going. Most importantly, the COD workforce initiative must be high on the state agenda. All efforts must address the full spectrum of workers- from clinicians to non-licensed individuals to peer and family support formal and informal networks.

Figure 5. outlines the workforce needs, strategies, outcomes, and change agents needed to transform the behavioral health (COD) system.

¹¹ Mueller, K., et.al. (9/09). *A Critical Match-Nebraska's Health Workforce Planning Project*. (pg. 43) Available at: www.uncm.edu/rural Accessed on 10/12/10.

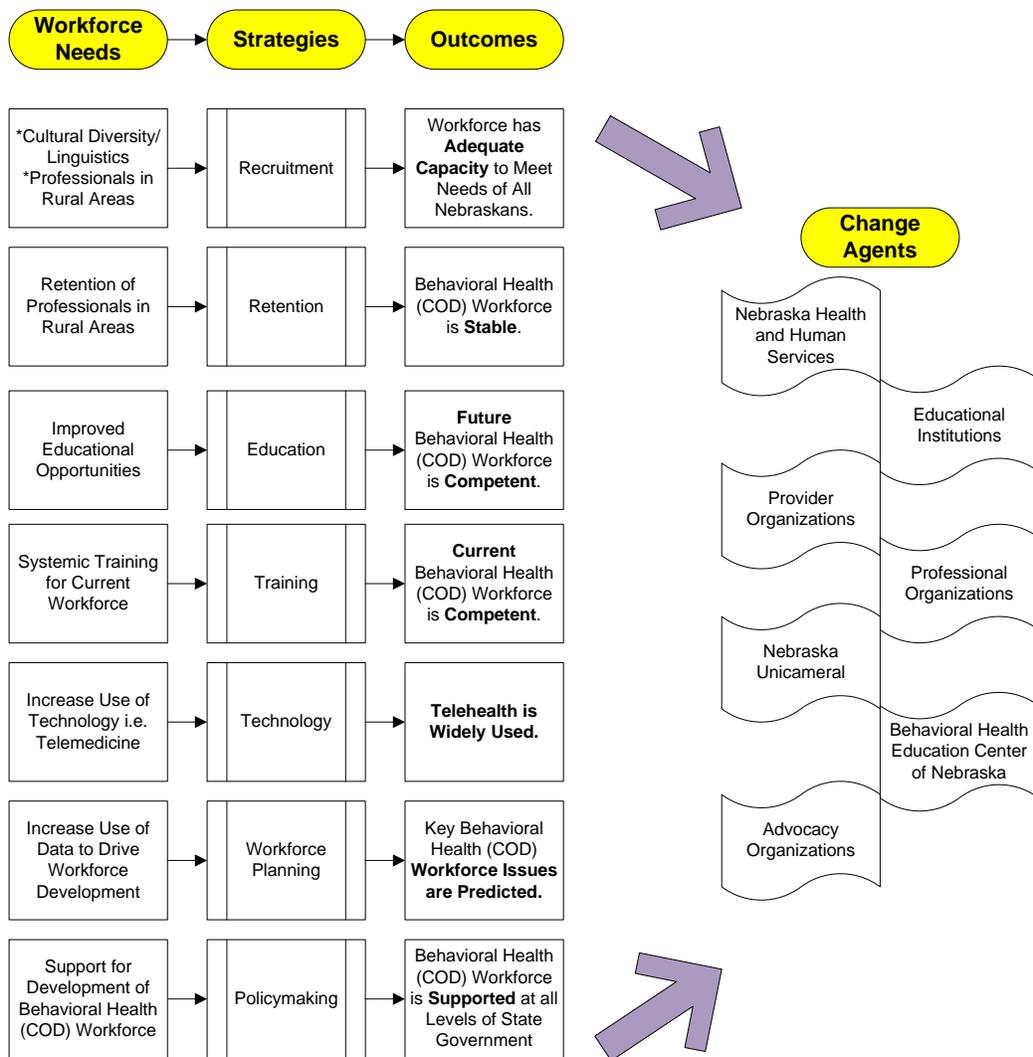


Figure 5. Nebraska Workforce Needs, Strategies, Outcomes

Prevention and Early Intervention

Prevention is the promotion of constructive lifestyles and norms that discourage drug use and prevention of mental illnesses. Prevention is achieved through the application of multiple strategies; it is an ongoing process that must relate to each emerging generation.

Systems Integration

Key Definitions

1. System Integration: Systems or collaborating systems organize themselves to implement services integration to clients with COD and their families.
2. Services Integration: MH and SA services are integrated at the individual client level or between providers or programs serving the individual.

System integration involves the development of the infrastructure within MH and SA systems that support the provision of MH and SA to individuals with COD. Systems Integration may include any or all of the following:

- Integrated system planning/implementation
- CQI
- Financing
- Interprogram collaboration
- Clinical 'best practice' development
- Clinical Licensure
- Competency and Training
- Information Systems
- Data Collection
- Outcome Evaluation
- Regulations and Policies
- Program Design and Certification

Nebraska's COD system is complex, difficult to define, and fluid in nature. However, the workgroup felt it essential to attempt to define the system in an effort to understand the various points of impact which may directly or indirectly influence the services and supports available to consumers with COD. As such, the workgroup defined the system as components of support and within the various components of support lie subcomponents. Consumers of COD services and supports are impacted to varying degrees by the following support categories: natural, living, community, regional, state, and federal. All of these support components and their various subcomponents need to be considered when redesigning a system which will adequately support consumers with COD. Figure 6. displays a diagram which depicts the categories and subcategories of support discussed by the workgroup.

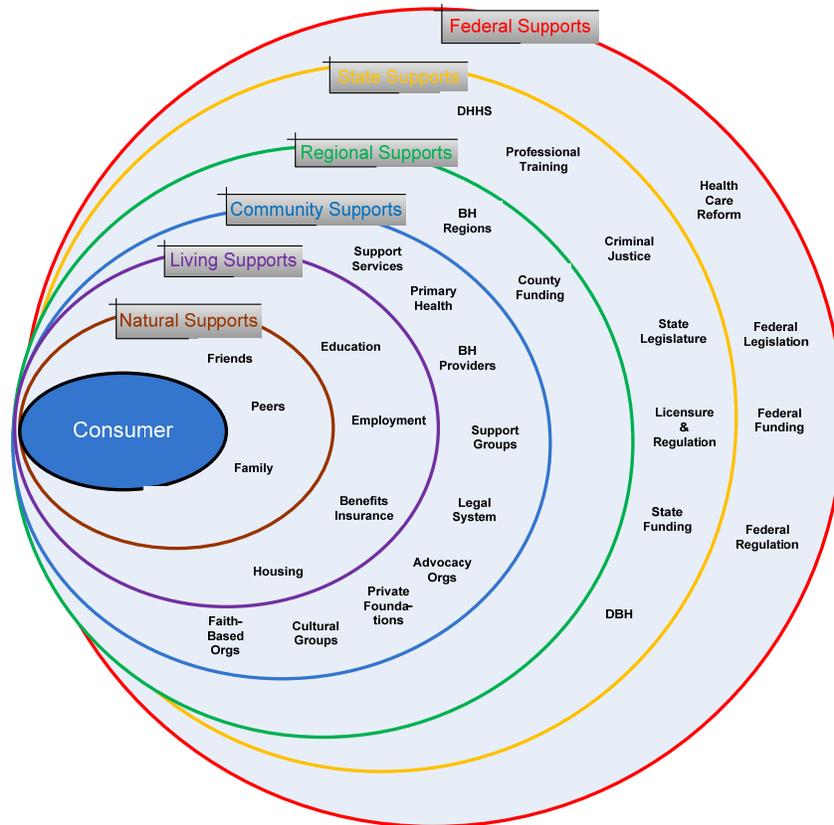


Figure 6. Nebraska's COD System

The Comprehensive Continuous Integrated System of Care (CCISC) Model developed by Minkoff in 2004, is recognized by SAMHSA as best practice for systems implementation. A description of the model follows.

Four Basic Characteristics of the Model

1. System Level Change
 - a. Implementation throughout a system of care
 - b. All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources
 - c. Specific assignment to provide services to a particular cohort of individuals with COD
 - d. Integrates the use of strategically planned system change technology (CQI) with clinical practice technology at the system, program, clinical practice, and clinician competency level to create system change.
2. Efficient Use of Existing Resources
 - a. Designed for implementation within the context of current service resources and emphasizes strategies to improve services to persons with COD within the context of each funding stream, program contract, or service code, rather than *requiring* blending or braiding of funding streams or duplication of services.

- b. Does require additional resources for planning, technical assistance, and training.
 - c. Most basic implementation strategy is exploring regulatory guidelines for any funding stream (e.g. Medicaid) in any program or services and providing a specific set of guidelines and instructions for how to provide and document matched integrated treatment within the context of the already funded service.
3. Incorporation of Best Practices
- a. Important aspect is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of individuals with COD throughout the service system.
 - b. Individuals with COD have a wide range of disorders and needs; best practice treatment involves integrating the provision of best practice treatment for each disorder at the level of the client.
 - c. Need extensive range of best practices for mental health and substance disorders.
4. Integrated Treatment Philosophy
- a. Based on implementation of principles of successful treatment intervention derived from research and incorporated into an integrated treatment philosophy.
 - b. Utilizes common language.
 - c. Model can be used to develop a protocol for individualized treatment matching that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

Minkoff's proposes twelve steps for CCISC Implementation as follows.

1. Integrated system planning process: Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families. The COFIT-100™ (Zialogic, Albuquerque, NM) [30] has been developed by the authors to facilitate this outcome measurement process at the system level.
2. Formal consensus on CCISC model: The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of

implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

3. Formal consensus on funding the CCISC model: CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.
4. Identification of priority populations, and locus of responsibility for each: Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.
5. Development and implementation of program standards: A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stage-wise implementation. Program competency assessment tools (e.g., COMPASS™ Zialogic, Albuquerque, NM) [31] can be helpful in both development and implementation of DDC standards.
6. Structures for intersystem and inter-program care coordination: CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies

and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

7. Development and implementation of practice guidelines: CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination and incremental developmental implementation via CQI processes of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents [32, 33, 34] are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation, (See items 8 and 9).
8. Facilitation of identification, welcoming, and accessibility: This requires several specific steps: 1. modification of MIS capability to facilitate and incentivize accurate identification, reporting, and tracking of ICOPSD. 2. development of “no wrong door” policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible. 3. Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.
9. Implementation of continuous integrated treatment: Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected “scope of practice” for singly licensed clinicians regarding co-occurring disorder [35, 36], and incorporated into standards of practice for reimbursable clinical interventions – in both mental health and substance settings – for individuals who have co-occurring disorders.
10. Development of basic dual diagnosis capable competencies for all clinicians: Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and

licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT™ Zialogic, Albuquerque, NM) [37] can be utilized to facilitate this process.

11. Implementation of a system wide training plan: In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career ladders for advanced certification, and opportunities for experiential learning. Train the trainer curricula have been developed [38] that have been adapted for use in a variety of state and regional systems, and which emphasize that the trainers are actually positioned individually and collectively as “system change agents” to link system managers with front line clinicians in order to appropriately advocate for policy to support good clinical practice, and to transmit that policy in turn to direct care staff.
12. Development of a plan for a comprehensive program array: The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:
 - a. Evidence based best practice: There needs to be a specific plan for identification of any evidence based best practice for any mental illness (e.g. Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g. buprenorphine maintenance), or an evidence based best practice program model for a particular co-occurring disorder population (e.g. Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that facilitates access to co-occurring clients that might be appropriately matched to that intervention..
 - b. Peer dual recovery supports: The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous [39], Double Trouble in Recovery [40]) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports, such as peer outreach and peer counseling.
 - c. Residential supports and services: The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:
 - a) DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs) [41].

- b) Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.
- c) Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
- d) Consumer – choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness. [42]
- e) Continuum of levels of care: All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization. This can often be operationalized in managed care payment arrangements [43] and may involve more sophisticated level of care assessment capacity.

Services Integration

Definitions/Important Points

1. Integrated services can be provided by:
 - a. Individual Clinician
 - b. Clinical Team that assumes responsibility for providing integrated services to the client, or a program that provides appropriately integrated services by all clinicians or teams to all clients. (Services Integration Overview Paper)
2. Integrated Treatment: occurs at the level of the client-clinician interaction. This level of integration might also be called “clinician-level” integration. Integrated treatment can be provided across agencies, within a program or in an individual provider’s office (CSAT, 2005)
3. Integrated Programs: Implemented within an entire provider agency or institution to engage clinicians to provide integrated treatment for COD. A COD-specific integrated program is organized to provide substance abuse, mental health, and sometimes other health and social services to persons with COD.
4. Current programs can be classified as having: Basic, Intermediate, or Advanced Capacity for COD treatment, with the highest level being full integration of addition, mental health, and related services. (CSAT, 2005)
5. The design and implementation of integrated services may depend on the severity of substance abuse and mental disorders in a specific population as well as their additional medical and psychosocial needs.
6. Services integration minimally means providing integrated substance abuse and mental health screening, assessment, treatment planning, treatment delivery, and continuing care, either at the level of direct contact with the client or between providers or programs serving these individuals.
7. Service Change Strategies:
 - Incremental approaches allow treatment facilities and providers to simplify and change licensing and certification requirements for treating COD in the context of different licensing and certification standards.
 - Referral networks (no wrong door), physical and temporal proximity (e.g. services provided by the same clinician or in the same setting), and care coordination (e.g. services provided by a team of providers from different domains who take joint responsibility for the client.)

- With severe disorders, it is clearly advantageous to integrate mental health and substance abuse treatment programs into unified seamless services.
- In programs serving persons with less severe COD, integration may not need to be as comprehensive, as the full array of services may not be indicated for the population served. (SAMHSA, 2005).

Setting the Context for Services Integration

Organizations must support/develop/address the following.

1. Clear articulation of COD principles
2. Wide consensus among stakeholders regarding their importance
3. Articulate client-centered values
4. Remove organizational barriers
 - a. Institute modifications in record keeping to accommodate COD
 - b. Modify facilities to meet additional needs (e.g. space for individual or group counseling)
 - c. Revise staffing patterns and work schedules
 - d. Reconcile differences in confidentiality regulations, policies, and practices between substance abuse and mental health
 - e. Revise policies practices and requirements regarding dispensing and managing medications
5. Establish new relationships
6. Reduce rigidity, bureaucratic restraints, insufficient collegial support, change-averse culture, proactively address staff concerns related to changes in roles and responsibilities, and demoralized staff
7. Workforce development: Identify and respond to gaps in workforce competencies, certifications, licensure
8. Training in integrated screening assessment and treatment strategies for both mental and substance use disorders
9. Training in case management
10. Strong leadership
11. Integrated organizational chart
12. Shared assessment tools
13. Funding for cross-training, incentives for clinicians to cross-train
14. Updated organizational policies that support COD treatment
15. Cost containment that impede the treatment of more severe disorders

At the systems level, services integration is facilitated by regulatory guidelines that allow mental health and substance abuse funds to be combined or that provide specific guidelines and instructions for how to provide integrated treatment within the context of the existing funding mechanisms. (Minkoff & Cline, 2004)

All staff members can provide integrated services consistent with their licenses. For example, although substance abuse counselors in most States cannot treat mental disorders included in the DSM-IV-TR or prescribe medications for these disorders, they can monitor client behavior for signs that medication regimens are being followed and educate and motivate clients regarding the importance of taking their medications.

Nebraska's Co-Occurring Disorder Service Delivery Roadmap



STRATEGIC INITIATIVE I.
NEBRASKA WILL DEVELOP A CO-OCCURRING DISORDER SYSTEM OF CARE WHICH IS CONSUMER DRIVEN AND CONSUMER CENTERED.



STRATEGIC INITIATIVE I. NEBRASKA WILL DEVELOP A CO-OCCURRING DISORDER SYSTEM OF CARE WHICH IS CONSUMER DRIVEN AND CONSUMER CENTERED.

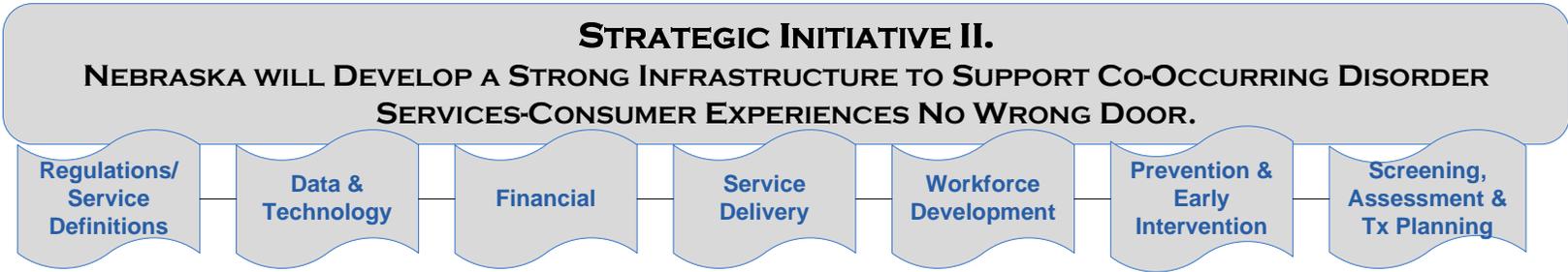
Strategy	Actions	Outcomes	Evaluation
A. State leadership and planning groups adopt the person centered, recovery-oriented vision, definitions, principles, and goals as defined in the <i>Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders</i> ¹² (Overview Paper 3, SAMHSA) and SAMHSA’s 8 Strategic Initiatives. ¹³	1. Establish a steering committee consisting of consumers, families, advocacy groups, DHHS state and other government systems, and education for ongoing planning, oversight, and adoption of SAMHSA’s Overarching Principles and 8 Strategic Initiatives. 2. Establish a marketing plan for communicating/educating stakeholder groups including rebranding the term “co-occurring”. 3. Hold forums with stakeholders to identify obstacles and opportunities to	a. Person centered, recovery- oriented philosophy is evidenced in strategic planning, funding documents, educational curriculum, treatment models, etc. b. Consumers experience no wrong door healthcare service delivery.	i. Evaluate effectiveness of marketing plan. ii. Evaluate results of stakeholder forums and provide recommendations.

¹² Center for Substance Abuse Treatment. *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper 1. DHHS Publication No. (SMA) 07-4163 Rockville, MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services, 2007.

¹³ Substance Abuse and Mental Health Services Administration and Center for Mental Health Services. <http://www.samhsa.gov/about/strategy.aspx>. Retrieved on 7/22/10.

STRATEGIC INITIATIVE I. NEBRASKA WILL DEVELOP A CO-OCCURRING DISORDER SYSTEM OF CARE WHICH IS CONSUMER DRIVEN AND CONSUMER CENTERED.

Strategy	Actions	Outcomes	Evaluation
	improve full adoption of person centered, recovery-oriented COD vision, definition, principles, and goals.		
B. The three Behavioral Health Advisory Committees (Mental Health, Substance Abuse, and Problem Gambling) are coordinated.	<ol style="list-style-type: none"> 1. Create a charge for a collaborative advisory group by researching options of structure that meets the needs of all groups. 2. Develop steps needed to form the collaborative advisory group. 	<ol style="list-style-type: none"> a. Coordinated administrative approach (single voice to the Division). 	<ol style="list-style-type: none"> i. Monitor effectiveness of cooperation and collaboration between the three Behavioral Health Advisory Committees.
C. Consumer involvement in COD planning and service delivery.	<ol style="list-style-type: none"> 1. Leaders at all levels work closely with consumers for involvement in service planning, delivery, and evaluation of services. 2. Develop an infrastructure which mandates participation from consumers. 	<ol style="list-style-type: none"> a. Services developed are reflective of consumer needs. b. Consumers play an active, valued role regarding COD services. 	<ol style="list-style-type: none"> i. Through consumer participation, evaluate that COD services are reflective of consumers' needs.



STRATEGIC INITIATIVE II. NEBRASKA WILL DEVELOP A STRONG INFRASTRUCTURE TO SUPPORT CO-OCCURRING DISORDER SERVICES-CONSUMER EXPERIENCES NO WRONG DOOR.			
Strategy	Actions	Outcomes	Evaluation
<u>Regulation/Service Definitions</u> A. Revise regulations and service definitions to support COD services & supports.	1. Further enhance language and intent of regulations and service definitions to reflect a COD system. 2. Develop a list of all existing professional and facility licensure regulations and identify co-occurring language. 3. Develop a comparison table of necessary enhancements or changes in the regulations. 4. Complete cost benefit analysis of identified changes. 5. Seek public input for recommended regulation changes. 6. Initiate regulation changes.	a. Fully operational COD regulations and service definitions.	i. Develop a systematic mechanism for evaluating and measuring fidelity to service definitions, EBP's and compliance with regulations. ii. Monitor national research on co-occurring disorders and develop evaluation protocols. iii. Evaluate costs of recommended changes as well as costs for ongoing monitoring and evaluation iv. Evaluate effectiveness system change via measures such as access, consumer satisfaction, length of stays, etc.
<u>Data & Technology</u> B. Increase the use of telehealth in the delivery of	1. Provide/Develop COD telehealth providers. 2. Develop a telehealth support system. 3. Expand telehealth use.	a. Telehealth is widely used to deliver COD services and	i. DBH to assess: <ul style="list-style-type: none"> • satisfaction with provider telehealth training yearly;

STRATEGIC INITIATIVE II. NEBRASKA WILL DEVELOP A STRONG INFRASTRUCTURE TO SUPPORT CO-OCCURRING DISORDER SERVICES-CONSUMER EXPERIENCES NO WRONG DOOR.

Strategy	Actions	Outcomes	Evaluation
<p>COD services in all areas of the state.</p>		<p>supports.</p>	<ul style="list-style-type: none"> • # providers providing telehealth care to persons with COD yearly; • # of telehealth encounters to persons with COD yearly; • satisfaction with care provided to persons with COD via telehealth.
<p>C. Use data to plan for the future development of COD workforce.</p>	<ol style="list-style-type: none"> 1. Increase the use of data to track, evaluate, and manage key COD workforce issues on a statewide and local basis. 2. Consolidate COD workforce data in one repository. 3. Make COD workforce data available to the public. 	<p>a. Key COD workforce issues are predicted and addressed.</p>	<p>i. DBH in collaboration with stakeholders is to complete Needs Assessment and develop plan to address identified needs. DBH to identify priority needs from plan and complete yearly report on efforts to address these needs. Yearly report is publicly available.</p>
<p>D. Develop more expertise in the field in measuring outcomes.</p>	<ol style="list-style-type: none"> 1. Develop evaluation training curriculum for providers. 2. Provide technical assistance to providers in measuring program outcomes, in interpreting and utilizing outcomes to improve programs, and in assisting consumers to review their personal progress. 	<ol style="list-style-type: none"> a. Providers will collect data to measure desired outcomes. b. Outcomes will be utilized to improve programs. c. Providers will 	<p>i. Monitor technical assistance and evaluation training to make sure they reflect the needs of providers.</p>

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Strategy	Actions	Outcomes	Evaluation
		<p>share progress with consumers on a regular basis.</p> <p>d. Consumers will utilize outcomes to improve their treatment progression.</p>	
<p>E. Develop strategies to assist behavioral health providers to participate in health information exchanges (HIE) and technology-electronic health records (EHR)/enterprise practice management (EPM).</p>	<p>1. Provide technical assistance to behavioral health providers to institute HIE, HMR, and EPM with adequate privacy and confidentiality considerations.</p> <p>HIT= Health Information Technology. HIT is the overall framework for comprehensive management and secure exchange of information electronically. Broad term incorporates telemedicine, etc.</p> <p><u>HIE</u>= Health Information Exchange. Exchanges integrate information from a variety of sources. Partners agree to participate. Two of Nebraska largest exchanges are Nebraska Health Information Initiative (NeHII) and</p>	<p>a. Providers have up-to-date information technology systems.</p>	<p>i. Develop an evaluation tool for selecting EHR. The tool should include review of federal, state, and local data exchange standards; privacy of consumer data (HIPAA) ; Interoperability; Efficiency; ICD codes; meaningful use.</p> <p>ii. Identify metrics and methodology to evaluate cost effectiveness and efficiency of practice with EHR.</p>

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Strategy	Actions	Outcomes	Evaluation
	<p>Electronic Behavioral Health Information Network (eBHIN). <u>EHR</u> = Electronic Health Record. EHR integrates information in a given system with a broader system. Links across clinical practice areas such as BH, primary care. EHR provides complete, accurate and searchable information. <u>EPM</u> = Enterprise Project Management. EPM in the IT world provides network administration of multidomain, multiprotocol, multiplatform systems.</p>		
<p>Financial F. Create a flexible reimbursement system that adequately supports a COD service delivery system.</p>	<ol style="list-style-type: none"> 1. Explore providers' challenges with the current reimbursement system. 2. Explore reimbursement systems that support a flexible co-occurring service delivery system by studying other states' reimbursement systems. 3. Work with legislative representatives to design needed legislative changes. 4. Explore a reimbursement system to reflect incentives for dually licensed professionals and facilities credentialed to provide COD services. 5. Develop unified service definitions. 6. Complete a professional rate 	<ol style="list-style-type: none"> a. Implementation of a flexible reimbursement system that adequately supports COD delivery system. 	<ol style="list-style-type: none"> i. Evaluate identified unit costs and service definitions. ii. Ongoing monitoring of wage and benefits for COD workforce.

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	<p>methodology study to determine fair and equitable unit costs for the delivery of COD services and supports.</p> <p>7. Assist providers to determine wage and benefits for COD workforce which are commensurate with education, experience, and levels of responsibility.</p>		
<p>Service Delivery</p> <p>G. Build a foundation for the implementation of Evidence/Consensus based practices in COD in Nebraska.</p>	<ol style="list-style-type: none"> 1. Identify and disseminate EBP in COD. 2. Identify and disseminate practice principles for COD, including integrated treatment. 3. Identify EBP in COD currently implemented in Nebraska. 4. Develop a registry of EBP for COD in Nebraska and place on system websites or a directory of COD competent programs. 5. Survey treatment facilities/level of care to understand capabilities and current activities in serving clients with COD. 6. Clarify the characteristics of those clients with COD for whom MH or SA treatment alone is not sufficient to achieve significant improvement in the 	<ol style="list-style-type: none"> a. System is willing and able to welcome and serve persons with COD. b. Stakeholders are on the same page regarding COD best practice principles. c. Registry of COD competent services in Nebraska. d. Defined characteristics of 	<ol style="list-style-type: none"> i. Evaluate current system using tools such as Minkoff’s Comprehensive Continuous Integrated System of Care (CCISC) to define COD service capabilities. ii. Conduct an ongoing evaluation of the effectiveness of the system to serve COD through best-practice services. iii. Evaluate, through measurement of relevant practices, incorporation of evidence-based, COD practices. Provide measurement feedback with training as updated best-practices are researched. iv. HHS to compile and systematically update, through evaluation and monitoring of services, COD competent registry.

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	<p>MH or SA disorders.</p> <p>7. Define scope – focus on a particular quadrant to improve outcomes.</p> <p>8. Hold forums with providers and consumers for dialogue and decisions on COD issues.</p>	<p>population to be served.</p> <p>e. Defined scope – quadrant of focus for the plan.</p> <p>f. Feedback/input from providers and consumers on dialogue and decisions on COD issues.</p> <p>g. Survey data of current system capacity and capability to serve clients with COD.</p>	<p>v. Evaluate the impact and implementation capacity of each quadrant to determine a focused plan.</p> <p>vi. Create a focus group of COD competent providers and consumers to specifically provide systemic input regarding COD issues.</p> <p>vii. Evaluate resources such as financial, workforce, service delivery, etc. to determine system capacity to serve the COD population.</p>
<p>H. Dissemination of up-to-date COD evidence and consensus based practices.</p>	<p>1. Develop a dissemination plan which includes a variety of activities (webinars, website resources, learning experiences, etc.) dedicated to providing access to providers on up-to-date COD evidence and consensus based practices and principles.</p>	<p>a. Dissemination Plan is implemented.</p>	<p>i. Monitor ongoing education for both new and established COD providers for inclusion of up-to-date COD evidence and consensus-based practices and principles.</p> <p>ii. Evaluate areas of change within licensure to incorporate co-occurring</p>

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I. Develop a state consensus policy on screening and treatment of COD.	<ol style="list-style-type: none"> 1. Develop a policy (similar to trauma informed policy). 2. Secure stakeholder feedback on policy. 3. Prepare barriers/opportunities to be addressed with implementation of policy. 	<ol style="list-style-type: none"> a. Draft & final policy. b. Consensus on policy. 	<p>provider registry education.</p> <ol style="list-style-type: none"> i. Conduct ongoing evaluation of policy to reflect current, up-to-date COD best-practices. ii. Develop a systematic mechanism for implementation of measurement feedback by stakeholders in securing consensus on policy.
J. Explore protocols for adopting promising and evidence-based practices.	<ol style="list-style-type: none"> 1. Hold forums with providers. 2. Consider TA on protocol. 3. Explore use of Fidelity toolkits. 	<ol style="list-style-type: none"> a. Protocols for adopting promising and evidence-based practices are created. 	<ol style="list-style-type: none"> i. Evaluation of promising practices to see where protocols are the most applicable. ii. Develop a systematic mechanism for monitoring protocol; updating as research releases “newer” promising principles.
<p>Workforce Development</p> <p>K. Build a system of care with providers who are competent and comfortable in meeting consumers’</p>	<ol style="list-style-type: none"> 1. Showcase model programs to providers & professional organizations. 2. Work with educational systems to adapt curriculum designed to teach healthcare professionals to work with consumers with COD issues, and catalog professional training. 3. Review professional licensure requirements to better reflect ability of 	<ol style="list-style-type: none"> a. Utilization of evidenced and consensus based practices in the delivery of COD services throughout the state. b. Professional 	<ol style="list-style-type: none"> i. Develop a systematic mechanism for evaluating all EBP which includes fidelity and consumer outcomes. ii. Develop a comparative analysis of existing curriculum to adopted standards. Analyze gaps. iii. Develop an evaluation mechanism such as the CODECAT and aggregate results to identify areas of change for

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<p>health care needs and adhere to the Overarching Principles as defined in SAMHSA's Overview Paper 3.</p>	<p>professionals to work with consumers with COD including specific populations.</p> <p>4. Provide technical assistance to providers to deliver culturally competent, linguistically appropriate, and trauma-informed services to persons with COD.</p>	<p>licensure is modified as needed.</p>	<p>training and licensure requirements and training improvement.</p> <p>Comparative analysis of existing professional licensure standards (see Regs and Service Defs)</p> <p>iv. Through stakeholder meetings, develop systematic mechanism for evaluating and measuring culturally competent, linguistically appropriate, and trauma informed care.</p> <p>v. Evaluate effectiveness of system change through identified measures such as improved access, consumer satisfaction, etc.</p>
<p>L. Implement systematic recruitment strategies at the state and local level across the full spectrum of the COD workforce.</p>	<p>1. Develop an agreed upon definition of the COD workforce so that recruitment strategies can be targeted to all categories of COD workforce members.</p> <p>2. Disseminate information and technical assistance in effective recruitment and retention strategies.</p> <p>3. Select, implement, and evaluate recruitment strategies tailored to the unique needs of each behavioral health region. (Rural Health Education</p>	<p>a. The COD workforce has the capacity to meet the needs of all Nebraskans with COD.</p>	<p>i. Identify metrics and methodology for measuring recruitment effectiveness and demographics of workforce verses demographics of persons served.</p> <p>ii. Consider using measures such as new employee turnover, employee satisfaction metrics or average position vacancy time. Consider qualitative evaluation thru management and employee surveys.</p> <p>iii. Evaluate overall costs and return on</p>

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	<p>Network, Rural Health Opportunities Program)</p> <p>4. Expand state financial incentives such as training stipends, tuition assistance, and loan forgiveness to increase recruitment. (National Health Service Corps, Nebraska Student Loan and Loan Repayment Program)</p> <p>5. Implement a comprehensive public relations campaign to promote behavioral health as a career choice. (Area Health Education Centers)</p> <p>6. Expand the use of “grow-your-own” recruitment strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.</p> <p>7. Increase the cultural and linguistic competence of the COD behavioral health workforce with outreach efforts such as low-cost training opportunities.</p>		<p>investment from an HR perspective.</p>
<p>M. Implement systematic retention strategies at the</p>	<p>1. Identify and evaluate current statewide retention strategies.</p> <p>2. Select, implement, and evaluate retention strategies, such as mentoring,</p>	<p>a. The COD workforce is stable.</p>	<p>i. See above, but include exit interviews in the qualitative measures.</p>

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state and local level.	tailored to the unique needs of each behavioral health region. 3. See F 6 & 7 for financial retention strategies.		
N. Increase the relevance, effectiveness, and accessibility of educational opportunities that improve the provision of COD services and supports and/or prevention.	1. Survey educational programs to explore current curriculum related to COD being employed. 2. Explore and identify barriers that determine curriculum content and inhibit the on-going need to improve training curriculum. 3. Develop a set of core competencies for the COD workforce (clinical, non-clinical, peer support) which reflect nationally recognized tools such as the Compass/CODECAT=-EZ. 4. Increase the capacity of Nebraska’s educational programs to meet the market need for COD providers. 5. Identify and recommend modifications to eligibility requirements for professionals supervising provisionally licensed individuals. 6. Develop and implement competency-	a. The future COD workforce has essential competencies to meet the needs of Nebraskans with COD.	i. From the core set of competencies, develop a set of metrics and methodology for initial and ongoing competencies. Analyze competency data by workforce category (clinical, etc.), licensure, training source, and other variables to identify educational improvements. ii. Evaluate the impact of information technology in terms of cost effectiveness and competency improvements.

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	<p>based curricula.</p> <p>7. Use technology to increase access to and the effectiveness of education.</p> <p>8. Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.</p> <p>9. Extend current successful, innovative educational initiatives to COD behavioral health professions for statewide training programs such as Rural Health Opportunities Program, UNMC's Family Practice Training Program, UNMC Nursing Programs, Munroe Meyer.</p> <p>10. Promote the inclusion of consumers in the development and provision of COD educational curriculum.</p>		
<p>O. Increase the relevance, effectiveness, and accessibility of training opportunities for those working in</p>	<p>1. Launch a statewide initiative to ensure that members of the behavioral health workforce develop basic competencies in the identification of COD and assessment/ treatment of substance use disorders and co-occurring mental and addictive disorders as appropriate to</p>	<p>a. The current COD workforce has the competencies to meet the needs of all Nebraskans with</p>	<p>See above recommendations.</p>

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the field of COD.	<p>their role as service/support providers.</p> <ol style="list-style-type: none"> 2. Implement and sustain the use of newly acquired skills in practice settings. 3. Develop communities' infrastructure to support COD workforce continuing education efforts. 4. Promote the increased availability and use of information technology to support the COD workforce for training and supervision. 5. Promote the inclusion of consumers in the development and provision of COD continuing education opportunities. 	COD.	

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<p>P. State government policies support the development of expanded COD workforce to include professionals, non-licensed professionals, and peer specialists.</p>	<ol style="list-style-type: none"> 1. Ensure that the COD workforce is a top state priority. 2. Consolidate activities related to the development of COD workforce. 3. Examine ways to provide sustained funding for education and continuing education. 4. Educate legislators and other state officials on the need for an increased ability to treat individuals with COD. 5. Work closely with higher education institutions to support educational and marketing campaigns. 6. Explore all avenues of licensure for COD clinical providers. 	<p>a. The COD workforce is supported at all levels of state government.</p>	<p>i. Develop and implement agreed upon metrics/measures and methodology which will be linked to the DBH strategic plan and illustrate consumer and service demographics, utilization data, workforce data, costs clinical outcomes and identified need (unserved individuals via capacity and waiting list data). (See Strategy A.2.)</p>
<p>Q. Individuals in care or recovery and their families receive COD education.</p>	<ol style="list-style-type: none"> 1. Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other. 	<p>a. Individuals in care/recovery and their families are better equipped to direct/support their own or a family member's</p>	<p>i. Ongoing monitoring of information and education to individuals and families to enhance their COD support and care/recovery.</p>

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<p><u>Sustainable System of Prevention & Early Intervention</u> R. Training and educational activities for providers and the general public regarding prevention of and early intervention related to co-occurring disorders.</p>	<ol style="list-style-type: none"> 1. Using resources such as but not limited to "SAMHSA Report to Congress on the Prevention and Treatment of Co-Occurring Substance abuse Disorders and Mental Disorders - November 2002, Chapter III Prevention of Co-Occurring Disorders," develop informational resources for stakeholders and the general public. 2. Create a coalition or link existing coalitions of substance abuse prevention specialists, early childhood specialists, trauma care providers, adolescent and elder services, BH therapists, consumers, certified compulsive gambling counselors, and advocacy groups to promote and disseminate information 3. Develop and deliver training programs for behavioral health students and for behavioral health providers on prevention strategies, trauma-informed care, cultural competency, and linkages with applicable prevention programs. 4. Develop and deliver training programs 	<p>care/recovery.</p> <ol style="list-style-type: none"> a. Stakeholders and the general public have greater awareness of co-occurring disorders and the value of prevention and early intervention; b. Stakeholders and general public support the development of prevention and early intervention programming in their communities c. Behavioral health workforce has the 	<ol style="list-style-type: none"> i. DBH to measure community prevention needs and priorities every two years and assess via community input these needs and priorities yearly. ii. DBH to identify key priority groups for training and formulate a plan to provide such training. iii. DBH to complete yearly report of prevention and early intervention training provided. This report to be publicly available. iv. Measure efficacy of prevention/early intervention activities yearly by accessing national surveys of substance use and mental health promotion by state.

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	<p>for providers in a variety of settings, including primary care, early childhood care and education, secondary and post secondary education, community-based organizations, and correctional facilities; training to include prevention strategies that include promoting protective factors, screening & referral, and linkages with behavioral health providers.</p>	<p>knowledge, skills and abilities to incorporate prevention and early intervention strategies.</p> <p>d. Behavioral health providers routinely incorporate prevention and early intervention strategies in their work settings</p> <p>e. Key providers have knowledge, skills and abilities to incorporate prevention and early intervention</p>	

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		strategies, such as promoting protective factors and screening and referral f. Protective factors promoted; screening and referral routinely done.	
S. Strategic planning focused on identifying, promoting, and implementing evidence-based practices for prevention of and early intervention related to co-occurring	1. Conduct literature search to identify risk factors for the development of mental illness and substance abuse disorders (such as low socioeconomic status, family conflict, exposure to violence, and life changes in older adults). 2. Identify Nebraska populations at greatest risk for the factors identified in S.1. (homeless, incarcerated, victims of abuse/domestic violence, adolescents in transition, racial/ethnic groups, members of the military, etc.).	a. Agreed upon template for developing systems of prevention and early intervention b. Prevention and early intervention programs in place, utilizing	i. Ongoing monitoring of risk factors, high risk populations, protective factors, and evidence-based interventions.

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<p>disorders (universal, selected or indicated)</p>	<ol style="list-style-type: none"> 3. Conduct literature search to identify protective factors and evidence-based interventions to promote these factors, including but not limited to models such as peer-to-peer support. 4. Select evidence-based interventions based on feasibility and acceptability, in coordination with key stakeholders; determine funding strategies to support these interventions. 5. Investigate strategies related to prenatal drug exposure. 6. Complete plan based on S.1 through S.5 and utilize in program development, grant seeking, policy development, and setting priorities for funding regional co-occurring disorders initiatives. 7. DBH performs ongoing monitoring of risk factors, high risk populations, (to include infants exposed to drugs) protective factors and evidence-based interventions. 8. DBH to generate a plan to develop programs and policies to address these factors, populations and interventions. 	<p>evidence-based practices.</p> <p>c. Lower incidence of COD and/or earlier treatment and reduced morbidity.</p>	

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	<p>9. DBH to produce a plan for grant submission to address COD prevention and early intervention in at-risk populations.</p>		
<p>T. Establish administrative policies and practices that promote a systematic approach to prevention and early intervention, using integrated models across behavioral health, public health, child protective services, adult protective services, domestic</p>	<p>1. Inventory and assess existing prevention and early intervention programs and practices, identifying gaps and opportunities across agencies.</p> <p>2. Develop self-assessment tool and utilize to determine administrative practices that may be barriers to or promoters of establishing a system of prevention and early intervention (referral and screening practices that are not criminally focused, collection and use of data, funding streams, etc.).</p> <p>3. Using the strategic plan completed in S. 6. and the assessments completed in T.1. and T.2. applicable agencies, divisions, and programs create or revise policies that are supportive of a system of prevention and early intervention.</p> <p>4. DBH will complete report with identified self-assessment tool and revised</p>	<p>a. Greater awareness among policy makers of the value of prevention and early intervention and the steps needed to incorporate systematically.</p> <p>b. Policies in place that support a systematic approach to prevention of and early intervention related to co-occurring</p>	<p>i. Evaluate the prevention and early intervention system of care and make recommendations to decrease incidence of COD.</p>

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violence programs, community corrections, corrections, and judicial system.	policies. 5. DBH to identify national datasets to assess and track longitudinal incidence, treatment and morbidity of COD in Nebraska.	disorders. c. Sustainable system of prevention and early intervention resulting in lower incidence of COD and/or earlier treatment and reduced morbidity.	
<u>Screening, Assessment, Treatment Planning</u> U. Identify definitions of Screening, Assessment, and Treatment Planning.	1. Review literature for definitions relating to COD such as those found in SAMSHA COCE Screening, Assessment, and Treatment Planning for Persons with COD disorders, Overview Paper 2. 2. Adopt common COD definitions at a statewide level and incorporate into regulations, service definitions, etc.	a. Common COD definitions are acknowledged and utilized throughout the state.	i. Through stakeholder meetings, develop a systematic mechanism for ongoing evaluation and measurement of fidelity to common COD definitions.
V. Screening for COD will occur	1. Decide who and in what settings to perform COD screening based on a	a. Individuals are screened for	i. Monitor and evaluate the comprehensive training curriculum to

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<p>across a broad range of individuals in a variety of settings.</p>	<p>review of current literature on screening of individuals for COD.</p> <ol style="list-style-type: none"> 2. Identify existing validated mental health and substance abuse screening instruments. 3. Cross-train individuals on screening instruments and processes of administration. 4. Develop referral protocols that must take place once the client scores in the positive range. 5. Develop protocol for minimum standards of recording the results of the screening, other relevant client information, and the disposition of the case. 	<p>COD with validated instruments by trained individuals; referred for COD treatment when appropriate; and minimum standards for recording are adhered to by screening entities.</p>	<p>ensure best practices are applied to screening, assessment, client placement criteria, treatment planning and implementation when working with COD clients.</p> <ol style="list-style-type: none"> ii. Develop a systematic mechanism for evaluating and measuring fidelity in the administration of the screening instruments, providing opportunities for mentoring when needed. iii. Ongoing monitoring of referral protocols for COD screening and critical scores. iv. Through stakeholder meetings, identify a protocol for the capturing of critical client data results related to COD scores. v. Ongoing monitoring of protocols for minimum standards of COD screening results.
<p>W. Assessments will be used to identify or rule out presence or absence of COD,</p>	<ol style="list-style-type: none"> 1. Identify evidence-based assessment tools. 2. Train clinicians on the use of evidence-based assessment tools and techniques that promote treatment engagement. 	<ol style="list-style-type: none"> a. Individuals will be assessed by trained clinicians using evidence-based 	<ol style="list-style-type: none"> i. Monitor and evaluate the comprehensive training curriculum to ensure best practices are applied to screening, assessment, client placement, treatment planning and

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<p>determine client readiness for change, strengths and problems impacting recovery, and begin to engage the client in a treatment relationship.</p>		<p>assessment tools.</p>	<p>implementation when working with COD clients. ii. Develop a systematic mechanism for evaluating and measuring clinician fidelity in providing an evidence-based assessment. Mentoring opportunities to be provided when needed.</p>
<p>X. Implement treatment planning as a set of client centered, staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to</p>	<ol style="list-style-type: none"> 1. Educate providers about COD treatment planning processes which are client-centered, integrated, individualized to the client, culturally sensitive, and developed with the client and/or family as an equal partner. 2. Obtain evidence that above described COD treatment planning is utilized. 3. Promote peer support in a variety of types and forms that are supportive of long-term recovery. 	<p>a. Individuals with COD are involved with treatment providers in the development of their treatment plan which is client-centered, integrated, individualized, and culturally sensitive.</p>	<ol style="list-style-type: none"> i. Monitor the comprehensive training curriculum to ensure best practices are applied to screening, assessment, client placement criteria, treatment planning and implementation when working with COD clients. ii. Develop a systematic mechanism, which may include consumer satisfaction surveys, length of stay, successful completion of treatment, etc., for evaluating and measuring clinician fidelity in providing client-centered, integrated COD treatment. Mentoring

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<p>take into account issues related to the other disorder. The treatment plan is matched to the individual needs, readiness, preferences, and personal goals of the client.</p>			<p>opportunities to be provided to the clinicians when needed.</p> <p>iii. Ongoing monitoring of consumer involvement in treatment planning.</p> <p>iv. Ongoing monitoring of peer support involvement in consumer long-term recovery.</p>
<p>Y. Implement nationally accepted standards of treating COD specific to needs and demands of Nebraska’s unique demographic profile and professional capacity.</p>	<ol style="list-style-type: none"> 1. Collect and review Federal agencies (SAMHSA, NIDA, etc.) and national professional organizations’ professional publications and literature on COD treatment standards. 2. Adopt COD treatment standards which employ a recovery perspective that provides standards for areas such as peer support, community support, medication assisted treatment, medication compliance, continuity of care over time, specific tasks faced at each stage of the treatment process, and 	<p>a. Individuals receive quality COD treatment.</p>	<ol style="list-style-type: none"> i. Evaluate and Monitor the comprehensive COD treatment standards based on evidence-based research, which employ quality recovery orientated services, and are adapted to meet the needs of the Nebraska COD population. ii. Monitor the comprehensive training curriculum to ensure best practices are applied to screening, assessment, treatment planning and implementation when working with COD clients. Access to training needs to be available to all

STRATEGIC INITIATIVE II. NEBRASKA WILL DEVELOP A STRONG INFRASTRUCTURE TO SUPPORT CO-OCCURRING DISORDER SERVICES-CONSUMER EXPERIENCES NO WRONG DOOR.

Strategy	Actions	Outcomes	Evaluation
	<p>wraparound services which address the array of mental health, medical, substance abuse, family, housing, and other social problems in a comprehensive manner.</p> <p>3. Train professionals on COD treatment standards.</p>		<p>regions of Nebraska to dispel lack of access in certain geographic areas.</p> <p>iii. Develop a systematic mechanism, which may include consumer satisfaction surveys, length of stay, successful completion of treatment, etc., for evaluating, monitoring and measuring clinician fidelity in providing COD treatment according to the approved treatment standards. Mentoring opportunities to be provided to the clinicians when needed.</p>

**STRATEGIC INITIATIVE III.
NEBRASKA WILL DEVELOP STRONG PARTNERSHIPS ACROSS ALL SYSTEMS TO ENSURE AN EXPANDED CONTINUUM OF CARE.**



STRATEGIC INITIATIVE III: NEBRASKA WILL DEVELOP STRONG PARTNERSHIPS ACROSS ALL SYSTEMS TO ENSURE AN EXPANDED CONTINUUM OF CARE.			
Strategy	Actions	Outcomes	Evaluation
A. Broaden the strategy to include a vision for service provision of multiple, complex health and social issues beyond co-occurring mental health and substance use disorder.	1. Identify and develop a comprehensive report of this committee’s work, so it can be shared and replicated by a similar group charged with developing an integrated behavioral health and primary health care system.	a. Road map to integrated behavioral health and primary health care service delivery system. b. Increased number of consumers will be screened for multiple complex health issues.	i. Ongoing monitoring of COD services for integration of behavioral health and primary health care.
B. Create continuum of care across all systems (no wrong door concept), including settings such as primary health care	1. Identify potential partners and introduce COD principles and tenets of integrated treatment and resiliency. 2. Develop formal partnerships with a variety of state agencies and community agencies to expand efforts of the COD service provision system. 3. Identify and address barriers to COD early	a. An expanded continuum of care for the highest at risk and most vulnerable populations in need of COD services will exist across a variety	i. Ongoing monitoring of COD population to make sure all key stakeholders are engaged. ii. Ongoing monitoring of eligibility practices

STRATEGIC INITIATIVE III: NEBRASKA WILL DEVELOP STRONG PARTNERSHIPS ACROSS ALL SYSTEMS TO ENSURE AN EXPANDED CONTINUUM OF CARE.

Strategy	Actions	Outcomes	Evaluation
<p>providers, social services agencies, criminal justice system, homeless providers, and educational settings for the highest at risk and most vulnerable populations in need of COD services and supports.</p>	<p>identification, engagement, and linkages to the COD services delivery in cooperating partnership settings.</p> <p>4. Assist partners to include COD practices (screening, assessment, and/or referral) in daily operations whenever appropriate.</p> <p>5. Review and revise eligibility practices and reimbursement strategies to support integrated treatment for COD continuum of care.</p> <p>6. Integrate health care reform requirements into the COD continuum of care as new initiatives unfold.</p>	<p>of settings.</p> <p>b. Early identification, engagement, and linkage to appropriate care pathways will be incorporated in a variety of settings.</p>	<p>and reimbursement strategies to support integrated treatment.</p>
<p>C. Criminal Justice Settings Strengthen capacity of and improve coordination in every criminal justice setting.</p> <p>Criminal justice settings include but are not limited to: Courts, Department of Corrections,</p>	<p>1. Identify and develop activities aimed at diverting individuals with COD from the criminal justice system as described in the <i>Sequential Intercepts for Change: Criminal Justice/Mental Health Partnership</i>.</p> <p>2. Create, enhance, and coordinate current DBH and Criminal Justice initiatives and strategic/state plans to improve Criminal Justice workforce skills in recognizing signs and symptoms of COD, improving engagement with individuals with COD, and responding with appropriate referrals and linkages to behavioral health services and supports.</p> <p>3. Develop strategies to ensure consistency in</p>	<p>a. Individuals with COD are diverted from the criminal justice system when appropriate.</p> <p>b. Individuals with COD in the criminal justice system receive adequate care and treatment for their disorder.</p>	<p>i. Evaluate the number of individuals appropriately diverted from Criminal Justice System.</p> <p>ii. Ongoing monitoring of collaboration with Criminal Justice in COD continuum of care.</p>

STRATEGIC INITIATIVE III: NEBRASKA WILL DEVELOP STRONG PARTNERSHIPS ACROSS ALL SYSTEMS TO ENSURE AN EXPANDED CONTINUUM OF CARE.

Strategy	Actions	Outcomes	Evaluation
<p>Probation, Parole, Problem Solving Courts, Law Enforcement, Jails.</p>	<p>treatment, continuity of care, medication management, and/or referral for individuals with COD in the criminal justice system.</p>		
<p>D. Primary Health Care including Public Health Departments and Federally Qualified Health Centers Strengthen capacity of and improve coordination across the continuum of providers and stakeholders in primary health care.</p>	<ol style="list-style-type: none"> 1. Develop formal partnerships with primary health care partners. 2. Identify and address barriers to COD early identification, engagement, and linkages to the COD services delivery in primary health care settings. 3. Create, enhance, and coordinate initiatives and strategic/state plans to improve primary health care workforce skills in Screening, brief interventions, referral and treatment (SBIRT). 4. Develop strategies to ensure consistency in treatment, continuity of care, medication management and/or referral for individuals with COD receiving primary care services. (National Council on Behavioral Health Quadrants of Care.) 	<p>a. Individuals with COD are identified, engaged, and adequately treated within the primary care setting or referred to more intensive behavioral health setting when appropriate.</p>	<p>i. Ongoing monitoring of collaboration with primary health care in COD continuum of care.</p>

STRATEGIC INITIATIVE III: NEBRASKA WILL DEVELOP STRONG PARTNERSHIPS ACROSS ALL SYSTEMS TO ENSURE AN EXPANDED CONTINUUM OF CARE.

Strategy	Actions	Outcomes	Evaluation
<p>E. Educational Settings (School systems including pre-school through professional school systems) Strengthen capacity of and improve coordination across the continuum of providers and stakeholders in education.</p>	<ol style="list-style-type: none"> 1. Create, enhance, and coordinate DBH and Educational provider initiatives and strategic/state plans to improve workforce skills in recognizing signs and symptoms of COD, improving engagement with individuals with COD, and responding with appropriate referrals and linkages to behavioral health services and supports. 2. Develop strategies to ensure consistency in referrals of individuals with COD utilizing educational services to COD services and supports. 3. Seek to create awareness and prevention of COD among children, families, educators. 4. Look at National models that work. 	<p>a. Individuals with potential COD in educational systems are identified and engaged by educational providers and linked with COD services and/or resource information.</p>	<p>i. Ongoing monitoring of collaboration with education in COD continuum of care.</p>
<p>F. Homeless Settings (Shelters, soup kitchen, ministries, domestic violence settings, etc.) Strengthen capacity of and improve coordination across the continuum of providers and stakeholders in homeless settings.</p>	<ol style="list-style-type: none"> 1. Create, enhance, and coordinate DBH and homeless initiatives and strategic/state plans to improve workforce skills in recognizing signs and symptoms of COD, improving engagement with individuals with COD, and responding with appropriate referrals and linkages to COD services and supports. 2. Develop strategies to ensure consistency in treatment, continuity of care, medication management and/or referral to COD services and supports for individuals with COD in homeless settings. 	<p>a. Individuals with potential COD in homeless settings are identified and engaged by homeless providers and linked with COD services and/or resource information.</p>	<p>i. Ongoing monitoring of collaboration with homeless agencies in COD continuum of care.</p>

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Strategy	Actions	Outcomes	Evaluation
<p>G. Human Service Settings (Public support and private nonprofit settings)</p>	<ol style="list-style-type: none"> 1. Create, enhance, and coordinate DBH and human service settings initiatives and strategic/state plans to improve workforce skills in recognizing signs and symptoms of co-occurring disorders, improving engagement with individuals with COD, and responding with appropriate referrals and linkages to COD services and supports. 2. Develop strategies to ensure consistency in referrals of individuals with COD utilizing human services to appropriate COD services and supports. 	<p>a. Individuals with potential COD in human service settings are identified and engaged by human service workers and linked with COD services and/or resource information.</p>	<p>i. Ongoing monitoring of collaboration with human services in COD continuum of care.</p>

SAMHSA's Eight Strategic Initiatives

SAMHSA has identified eight strategic initiatives to focus its work on improving lives and capitalizing on emerging opportunities. These initiatives are referenced in Nebraska's COD Roadmap and include the following.

Prevention of Substance Abuse and Mental Illness: Create Prevention Prepared Communities where individuals, families, schools, faith-based organizations, workplaces, and communities take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This initiative will include a focus on the Nation's youth, Tribal communities, and military families.

Trauma and Justice: Reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral health care systems and by diverting people with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

Military Families: Support America's service men and women – Active Duty, National Guard, Reserve, and Veterans – together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

Health Care Reform Implementation: Broaden health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions.

Housing and Homelessness: Provide housing and reduce barriers to accessing effective programs that sustain recovery for individuals with mental and substance use disorders who are homeless.

Health Information Technology: Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of Health Information Technology (HIT).

Data, Outcomes, and Quality: Realize an integrated data strategy that informs policy, measures program impact, and results in improved quality of services and outcomes for individuals, families, and communities.

Public Awareness and Support: Increase understanding of mental and substance use disorder prevention and treatment services and activities to achieve the full potential of prevention and assist people in accessing/getting help for these conditions with the same urgency as any other health condition.

Attachment A. Definitions

Addiction- or Mental-Health Only Services: Programs that “either by choice or lack of resources (staff or financial), cannot accommodate patients” who have co-occurring disorders that require “ongoing treatment, however stable the illness and however well-functioning the patient.”

Assessment: Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder. Determines the client’s readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.

Behavioral Health Service Settings: Agencies, programs, and facilities specifically designed to treat psychiatric and/or addictive disorders.

Client-centered: The client’s perceptions of his or her problem(s) and the goals he or she wishes to accomplish are central to the assessment and to the recommendations that derive from it.¹⁴

COD: Co-occurring substance-related and mental disorders. Consumers said to have COD have one or more substance-related disorders as well as one or more mental disorders. At the individual level, COD exist “when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.” Overview Paper 1 provides a more in-depth service definition of COD which includes “pre-diagnosis”, “post-diagnosis” and “unitary disorder and acute signs and/or symptoms of a co-occurring condition” which is relevant to this initiative.

Dual diagnosis capable (DDC) Programs: Programs are those that “address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment plan, program content and discharge planning.”

Dual diagnosis enhanced (DDE) Programs: Programs have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health treatment to consumers who are compared to those treatable in DDC programs, “more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder.”

Evidence-Based Practices: A practice which, based on research findings and expert or consensus opinion about available evidence is expected to produce a specific clinical outcome (measurable change in client status)

¹⁴ Center for Substance Abuse Treatment. Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders. COCE Overview Paper 2. DHHS Publication No. (SMA) 07-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007.

Epidemiology: The study of the incidence, prevalence, and distribution of a disease in a population.

Incidence: Refers to the rate of occurrence or percentage of new cases (e.g. in a 6 month period) within a population

Integrated Programs: Implemented within an entire provider agency or institution to engage clinicians to provide integrated treatment for COD. A COD-specific integrated program is organized to provide substance abuse, mental health, and sometimes other health and social services to persons with COD.

Integrated Assessment: Consists of gathering information and engaging in a process with the consumer that enables the provider to establish the presence or absence of co-occurring disorders, determine the consumer's readiness for change, identify consumer strengths or problem areas that may affect the processes of treatment and recovery, and engage the consumer in the development of an appropriate treatment relationship.

Integrated Interventions: Specific treatment strategies or therapeutic techniques in which interventions for all COD diagnoses or symptoms are combined in a single contact or in a series of contacts over time.

Integrated Screening, Assessment, and Treatment Planning: Screening, assessment, and treatment planning that address both mental health and substance abuse, each in the context of the other disorder.

Integrated Screening: Determination of the likelihood that a person has a co-occurring substance use or mental disorder.

Integrated Treatment: occurs at the level of the client-clinician interaction. This level of integration might also be called "clinician-level" integration. Integrated treatment can be provided across agencies, within a program or in an individual provider's office (CSAT, 2005)

Non-Substance-Related Mental Disorders: Non-substance-related mental disorders definitions also derive from the DSM-IV-TR. The major relevant mental disorders for COD include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and personality disorders. Two other essential definitions-Serious Emotional Disturbance and Serious Mental Illness-are derived from definitions developed by SAMHSA and used to establish Block Grant target populations and prevalence estimates for States but also have an application in the design and delivery of services for persons with COD.

- *Serious Emotional Disorders (SED)* is defined as "persons from birth up to age 18 who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with the DSM-IV that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities."

- *Serious Mental Illness (SMI)* is defined as “persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV, resulting in functional impairment which substantially interferes with or limits one or more major life activities.”

No Wrong Door: Every point of entry into a human service agency is seen as an opportunity for outreach, education, and connection to needed services

Partner Service Settings: Settings outside of the behavioral health system where persons with COD are likely to be encountered. These can be divided into three categories:

1. Health settings, including primary care (e.g., community health clinics, HIV/AIDS treatment programs, family practice locales; and acute care (e.g. emergency rooms, intensive care units, trauma centers) settings.
2. Public safety and criminal justice settings, including police encounters, courts, jails, prisons, and community corrections settings.¹⁵
3. Social welfare settings, including income support, entitlement and unemployment offices, homeless shelters (as well as makeshift shelters, parks, and abandoned buildings) and the community (eg. schools and faith and workplace settings).

Prevalence: Denotes the percentage of persons who have a particular disorder at a given time within a specific population.

Prevention: The promotion of constructive lifestyles and norms that discourage drug use and prevention of mental illnesses. Prevention is achieved through the application of multiple strategies; it is an ongoing process that must relate to each emerging generation.

Program: Formally organized array of services and interventions provided in a coherent matter at a specific level or levels of care in order to address the needs of particular target populations. Some agencies operate only mental health programs; some operate only substance abuse treatment programs and some do both.

Quadrants of Care and the Integration Continuum: The quadrants of care is a conceptual framework that classifies COD care into four quadrants based on relative symptom severity, not diagnosis. The four quadrants are: Low addiction/low mental illness severity; Low addiction/high mental illness; High addiction/low mental illness; High addiction/high mental illness. The model provides a framework for understanding the range of co-occurring conditions and the level of coordination that service systems need to address them. It provides a structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every consumer with COD.

¹⁵ Center for Substance Abuse Treatment. *Addressing Co-Occurring Disorders in Non-Traditional Service Settings. COCE Overview Paper 4*. DHHS Publication No. (SMA) 07-4277. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Screening: Determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.

Substance-Related Disorders

The standard use of the term substance-related disorders derives from the DSM-IV-TR. Substance-related disorders are divided into *substance use disorders* and *substance-induced disorders*.

Substance Use Disorders are further divided into substance abuse and substance dependence as defined below.

- Substance Abuse: “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.”
- Substance Dependence: “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems.”

Substance-Induced Disorders include substance intoxication, substance withdrawal, groups of symptoms that are “in excess of the usually associated with the intoxication or withdrawal that is characteristic of the particular substance and are sufficiently severe to warrant independent clinical attention.”

System Integration involves the development of the infrastructure within MH and SA systems that support the provision of MH and SA to individuals with COD. May include any or all of the following: Integrated system planning/implementation; CQI; Financing; Interprogram collaboration; Clinical ‘best practice’ development; Clinical Licensure; Competency and Training; Information Systems; Data Collection; Outcome Evaluation; Regulations and Policies; Program Design and Certification.

Treatment Planning: Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder. The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.