MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

1300 17th Street, Suite 1000
Sacramento, CA 95811
(916) 445-8696
FAX: (916) 445-4927

MHSOAC Services Committee
Status Update
MHSOAC Report on Co-Occurring Disorders (COD)
(June 9, 2011)

The purpose of this document is to provide an update on the status of implementation of the recommendations of the Mental Health Services Oversight and Accountability Commission (MHSOAC) Report on Co-Occurring Disorders adopted by the Commission on November 20, 2008.

In November 2007, the MHSOAC authorized a 19-member Workgroup on Co-occurring Disorders (COD). The MHSOAC charged the COD Workgroup with developing comprehensive recommendations to address the needs of individuals with co-occurring mental illness and substance abuse. The COD Workgroup, which met from November 2007 through June 2008, heard briefings by state leaders and experts on the status of the treatment of co-occurring disorders in California. A report was developed which summarized the COD Workgroup's key findings and recommendations to improve the capacity of state and county policy makers and program administrators to address the needs of individuals with co-occurring disorders under the Mental Health Services Act.

The following chart provides the enumerated recommendations from the COD Report. The chart also includes an analysis of each recommendation, with possible action taken or to be taken. As of this analysis, 44, or 80% of the 55 recommendations are complete. The remaining recommendations would require long-term action by the Commission.

Recommendations	Analysis	Done
1.1: MHSA-component programs should be reviewed for consistency in emphasizing co-occurring disorders competency, including policies that support "whatever it takes" and "no wrong door" approaches.	The INN and PEI trends reports provide analyses on COD inclusion in programs. LONG-TERM: Continue inclusion of COD competency and integrated service delivery as applicable in MHSOAC policy papers; and for future regulations, guidelines, or	Done

	best practices.	
1.2: The MHSOAC should work with the Department of Mental Health (DMH) and Alcohol and Drug Programs (ADP) to ensure that MHSA guidelines support flexible funding to allow development of integrated programs. Reporting requirements should not be a barrier to flexible funding for "whatever it takes" services.	LONG-TERM: If Integrated Plans move forward, look at opportunities for doing this with Integrated Plan discussions.	Long-term
1.3: MHSA-component programs that serve individuals with COD shall be culturally and linguistically competent as required by MHSA.	Cultural Competence is required of all MHSA plans.	Done
2.1: The MHSOAC should commission a work group on the Integrated Treatment of Youth.	There is not a lead agency looking at fragmented children's services. LONG-TERM: Revisit when discussing 2012 Work Plan and consider whether this is a priority for inclusion in the 2012 Work plan.	Long-term
2.2: The MHSOAC will commission a work group on the Treatment of Offenders.	In May 2009, the Services Committee convened a stakeholder group and wrote a report to the Administrative Offices of the Court on, "Facilitating Better Outcomes for Persons with Co-occurring Disorders in the Courts" Several of the recommendations of the report were incorporated into the Task Force Paper. LONG-TERM: Follow-up on status of recommendations incorporated in the Task Force Paper.	Done
2.2.1: The MHSOAC will convene a panel forum to educate the MHSOAC and the public about current public policy issues regarding the treatment of offenders within the scope of the MHSA.	The November 2010 Commission meeting focused on Criminal Justice.	Done

2.3: The MHSOAC will promote partnerships with the Department of Public Health, the Department of Health Care Services, Health Plans, Public and Community Health agencies, and California Hospitals and State medical associations to promote behavioral health screening, prevention, and treatment in medical settings. In concordance with SAMHSA's recommendations, mental health services should be more accessible in primary care settings, including "encouraging flexibility in state [Medi-Cal] benefit designs to cover mental health services in primary care settings". Behavioral health care should be co-located in primary care settings.	California's County Medical Services Program (CMSP) enhanced benefits within 14 pilot sites to provide integrated physical and behavioral health screens and care in primary care settings. An analysis of the results of the CMSP Behavioral Health Pilot Project (February 2011) shows promising effort, which can be utilized by other counties.	Done
2.4: The MHSOAC should continue to give priority focus to individuals who are homeless or at-risk for homelessness. The MHSOAC should continue to support full-service and supportive housing partnerships that serve individuals who are homeless or at-risk for homelessness.	The MHSA places a priority on this population in statute. County Plans support this through Full Service Partnerships. This is being measured and tracked in evaluation.	Done
2.5: The MHSOAC should work with DMH, ADP and the Department of Veterans Affairs to clarify California's response to increased PTSD and substance abuse among veterans.	As a result of DMH's interagency agreements with DVA and ADP, activities are focusing on co-occurring issues among veterans. Examples include outreach to discharged veterans and screening for co-occurring issues; and increasing COD providers' knowledge, awareness, and capacity of veterans' issues. Note: DMH posts progress reports of work plan	Done

	activities of MOUs with ADP and DVA on DMH website that includes activities on trauma and substance abuse among veterans.	
2.6: The MHSOAC should work with DMH's Office of Multicultural Services, ADP, CMHDA's Ethnic Services Manager and community-based organizations (CBOs) that primarily serve racial, ethnic and culturally diverse communities to identify culturally competent approaches and programs that show promise for individuals with COD.	LONG-TERM: Recommendation for 2012 CLCC Committee Charter.	Long-term
2.7: The MHSOAC will commission a work group on the Integrated Treatment of Older Adults that would be advisory to the MHSOAC and DMH.	There was an Older Adults presentation at the January 2011 Commission Meeting.	Done
2.8: When working with non-mental health systems and diverse communities, MHSA component efforts must promote culture change by focusing on stigma reduction; cross-training for non-mental health personnel or training of "embedded" mental health personnel in non-mental health settings; increased links between mental health and non-mental health systems and services; continuity of care; and opportunities to leverage resources.	The recently approved Statewide PEI plan includes Stigma Reduction priorities and focus on training. INN Learning chart indicates counties in which this is happening. LONG-TERM: Continue to monitor in PEI statewide programs.	Done
2.9: MHSA guidelines must permit counties to identify local priority populations with high public health needs who are negatively affected by co-occurring disorders. Guidelines must also support the development of	Local planning process determines how MHSA local dollars are spent in the County Plan and guidelines allow partnerships.	Done

partnerships to meet those needs.		
3.1: COJAC and its member organizations should seek opportunities to leverage MHSA program funds to implement the COD State Action Plan. Areas of potential leveraged funding include use of MHSA funding to implement elements of the COD State Action Plan, including joint training of substance abuse and mental health staff, interagency collaboration, and implementation of screening tools and universal charts. Where possible, training and screening tools should be tailored to the groups or racial, ethnic or culturally diverse communities they serve.	MHSOAC staff requested a status on this recommendation via letter to COJAC. Note: COJAC is currently validating the "COJAC Screening Tool" (CST) over a 2-year period	Done
3.1.1: Local collaboration to implement elements of the COD Action Plan must include commitment and participation of both the County Alcohol and Drug Administrators and County Mental Health Directors.	MHSOAC staff requested a status on this recommendation via letter to COJAC.	Done
3.1.2: An assessment of countywide COD services, staffing capacity and competency, and adequacy of treatment and program standards to address the needs of individuals with COD, should be considered when undertaking the Community Planning Process for Integrated Plans under the MHSA.	The Alcohol & Drug Policy Institute (ADPI) conducted a survey of counties in 2003, but an updated survey may be beneficial. MHSOAC staff requested a status on this recommendation via letter to COJAC.	Done

3.1.3: DMH and ADP should review California Codes and Regulations to promote effective collaboration, including a review of HIPAA and 42CFR confidentiality restrictions, documentation requirements for universal charts, licensing requirements to provide integrated residential treatment and guidelines to promote joint activities by Mental Health and Alcohol and Other Drugs Advisory Boards.	A review by the Health Policy Institute for the U.S. Dept. of Health and Human Services points out that California codes and statutes are not a barrier. Federal regulations are the barrier. The Legal Action Center offers a "work around" for this federal barrier.	Done
3.2: DMH and ADP should examine alternatives to maximize flexible funding for COD treatment under Medi-Cal, as recommended by SAMHSA.	MHSOAC staff requested a status on this recommendation via letter to COJAC.	Done
3.2.1: DMH and ADP should seek opportunities to partner and leverage resources with health plans and health maintenance organizations, who are mandated to provide expanded parity-level mental health and substance abuse treatment benefits in California under the Federal Mental Health and Addiction Equity Act provisions in the Emergency Economic Stabilization Act of 2008.	MHSOAC staff requested a status on this recommendation via letter to COJAC.	Done
3.3: DMH and ADP should extend their commitment to fund the Office for Co-occurring Disorders.	Positions were funded at ADP with MHSA to address COD.	Done
3.4: COJAC should participate as a partner in the MHSOAC's collaborative discussions with non-mental health agencies.	COJAC presented at January 2011 meeting.	Done

3.5: MHSOAC staff and/or commissioner(s) should attend COJAC meetings to provide collaboration.	Commissioner David Pating attends.	Done
4.1: (Stigma Reduction) The MHSOAC should promote the use of Statewide Stigma Reduction funds to reduce the stigma and discrimination of individuals and families with mental illness and substance abuse in the criminal justice system, hospitals, schools, foster care, and other non-mental health systems.	The MHSOAC approved PEI funding to be set aside for statewide projects for Stigma and Discrimination Reduction. Guidelines for Statewide Programs (DMH Information Notice No.: 10-06, Guidelines for Prevention and Early Intervention (PEI) Statewide Programs) were issued March 29, 2010. Plan approved at January 2011 Commission meeting. LONG-TERM: Monitor PEI statewide programs outcomes.	Done
4.2: (Workforce Training) The MHSOAC, in conjunction with the Mental Health Planning Council and DMH, should promote the use of Statewide or Local Workforce Education and Training funds to increase co-occurring competency in mental health and substance abuse providers, as well as other non-mental health personnel (e.g. law enforcement, prison guards, school teachers, property managers) who interact with individuals with COD.	MHSOAC has worked with DMH to ensure that statewide or local WET dollars were spent to incentivize the capacity of a behavioral health workforce, which may have included co-occurring competency. Examples include the following: - All stipend recipients must, as a condition of receiving their award, be educated in an MHSA-funded curriculum which includes co-occurring competency in mental health and substance abuse as well as how to work with non-mental health personnel. - Twenty-six counties and one city have approved WET programs in place to increase co-occurring competency. These local programs include trainings for law enforcement, consumers, staff, community members, teachers, and primary care providers. These counties include: Monterey, Stanislaus, Kern, Orange, Riverside, Santa Barbara, El Dorado, Placer, Los Angeles, Marin,	Done

	Alameda, Solano, Modoc, Contra Costa, Glenn, Sierra, San Luis Obispo, San Joaquin, Yolo, Nevada, Humboldt, San Diego, Fresno, Mendocino, City of Berkeley, Siskiyou, and Amador.	
4.2.1: (Workforce Training) The MHSOAC should promote the use of Workforce Education and Training Funds to train mental health staff in practices which promote effective discharge and transition planning from hospitals and emergency departments and other institutions or agencies with newly identified individuals with co-occurring disorders, severe mental illness or who are homeless or at-risk for homelessness.	WET funds were intended for the development and expansion of the local public mental health workforce, and this recommendation may be more appropriate for CSS funding. Counties were not required to specify the content of trainings funded by WET. Two counties (Santa Cruz and Marin) out of 56 have approved WET programs in place to train mental health staff in practices which promote effective discharge and transition planning from hospitals and emergency departments and other institutions or agencies.	Done
4.2.2: (Workforce Competency) DMH and ADP should work with academic institutions and licensing boards to integrate co-occurring disorders competency into academic curricula and licensing standards.	MHPC informed the MHSOAC that co-occurring services and issues are typically addressed in the context of supervision and internship and residency experiences. The Board of Behavioral Sciences (BBS), in partnership with DMH and other mental health stakeholders such as the Department of Alcohol and Drug Programs (ADP), developed SB 788 and SB 33 which requires that the education of Licensed Professional Clinical Counselors (LPCCs) and Marriage and Family Therapists (MFTs) include: 1) A orientation to wellness and prevention 2) Working with multidisciplinary teams 3) Client career development 4) Multicultural counseling 5) Co-occurring disorders.	Done

	These requirements will go into effect on August 12, 2012.	
4.2.3: (Workforce Competency) The MHSOAC should promote the use of Workforce Education and Training to train mental health and substance abuse providers in culturally competent care for individuals with COD.	MHSOAC worked with the DMH Office of Multicultural Services to review county plans for cultural competency. Note: All MHSA county plans must be culturally competent.	Done
4.2.4: (Workforce Capacity) DMH should increase the allocated state-administered Workforce Education and Training funds designated to increase rural and community mental health internships and residencies for psychiatrists and other mental health professionals who are committed to serving in the public sector. All MHSA-funded residencies and internships should teach skills that promote culturally competent care for individuals with co-occurring disorders.	DMH has funded distance learning programs at various levels, assisting rural and geographically remote regions of the State to "grow their own" mental health professionals. DMH is working with the Board of Behavioral Sciences (BBS) and CSU Chico to develop a guide for how to conduct supervision at a distance, enabling rural and geographically remote communities to retain mental health professionals in a more cost-effective manner. DMH also partnered with OSHPD and BBS to assist rural and geographically remote regions of the state become eligible for federal funding and to help them draw down federal funds for various programs, including treatment that promotes culturally competent care for individuals with co-occurring disorders.	Done
4.3: (Prevention) The MHSOAC should promote the use of MHSA Prevention and Early Intervention Training and Technical Assistance funds to improve the effectiveness of outreach and engagement for racial, ethnic and culturally diverse communities to enhance	In the past, this item was supported through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	Done

participation in community program planning, enhance service utilization and foster collaboration with community-based organizations serving these communities.		
4.3.1: (Early Intervention) The MHSOAC should promote the use of MHSA Prevention and Early Intervention Training and Technical Assistance funds to provide statewide technical assistance to improve referrals by early responders, hospital emergency departments, law enforcement and others in a position to intervene early and effectively with individuals who may be at risk for developing co-occurring disorders, including people who are homeless or at risk for homelessness.	In the past, this item was supported through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	Done
4.4: (Clearinghouse) The MHSOAC should work with partners to develop a clearinghouse to disseminate "best practice" programs and training for COD. These may also include cultural and linguistically appropriate approaches to work more effectively with individuals and families from racial, ethnic and culturally diverse communities.	ADP publishes the "COD E-Circular" to provide information on best practices on its website. MHSOAC linked this webpage on its website. http://www.adp.ca.gov/COD/documents.shtml Note: A PEI and INN clearinghouse is being implemented through CIMH contract (many PEI and INN plans include a focus on COD).	Done
5.1: The MHSOAC should encourage the use of MHSA Capital Improvement and Technology or Community Services and Supports funds to develop voluntary residential crisis-stabilization units, alternative peer-run crisis or wellness centers, and integrated mental	Guidelines for the Capital Facilities Technology Needs and Community Services and Supports support these activities. Going forward, the Local Planning Process determines how funds are spent locally.	Done

health and substance abuse multi-service centers. Detoxification services should be integrated with crisis stabilization.		
5.2: The MHSOAC should encourage the use of MHSA Prevention and Early Intervention program funds to implement voluntary Screening and Brief Intervention and Treatment (SBIRT) for Substance Abuse or pilot behavioral-health screening in Emergency Departments, Primary Care and other public health programs, and related systems such as Child Welfare and Aging Services.	Only a few counties included SBIRT or other screenings in their PEI or INN programs. LONG-TERM: Possible recommendation for future regulations, guidelines, or best practices.	Done
5.3: Statewide Suicide Prevention guidelines should include protocols and trainings for SBIRT interventions targeting individuals at risk for suicide.	No statewide initiative is focusing on this specific effort although co-occurring issues are addressed as a risk factor in individual trainings on suicide prevention. LONG-TERM: Possible recommendation for future regulations, guidelines, or best practices.	Done
5.4: DMH and ADP should develop joint certification of COD-competent residential treatment programs.	MHSOAC staff requested a status on this recommendation via letter to COJAC.	Done
6.1: The MHSOAC should encourage the development of client-centered services and treatments for individuals with COD that offer consumers real and meaningful choices about treatment options, including peer-provided and peer-run services which are culturally and linguistically appropriate.	In the past, this item was supported through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	Done
6.1.1: The MHSOAC should	In the past, this item was supported	Done

specifically encourage the broad use of peer-run Warm and Crisis lines and peer-run crisis-alternative respite centers and crisis residential programs. Sites for peer-run services should be expanded to include non-mental health community settings, such as Community Wellness Centers or Recreation Centers.	through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	
6.1.2: The MHSOAC should encourage use of MHSA Innovation funds to study the effectiveness of endemic treatment programs (e.g. The Red Road to Sobriety or Faith-based mental health and recovery alternatives) in partnership with racial, ethnic and culturally diverse communities.	MHSOAC Staff review approved PEI and INN plans and works with CIMH to highlight county programs which specifically address COD and include in the CIMH maintained PEI Clearinghouse as a resource for other counties.	Done
6.2: The MHSOAC should encourage training for consumers and providers to increase consumers' ability to successfully cope with life's challenges, foster recovery and build upon resilience, instead of just managing symptoms. Training should support the provision of services in the least restrictive environment.	In the past, this item was supported through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	Done
6.3: The MHSOAC should encourage the employment of peers at all levels of the mental health system in the wide range of roles for which individuals are qualified, including, but not limited to, ambassadors, cultural brokers, trainers and providers of peer-based wellness and	In the past, this item was supported through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	Done

recovery services.		
7.1: The MHSOAC should support community partnerships with client, peer and family organizations.	In the past, this item was supported through plan approval. Going forward, the Local Planning Process determines how funds are spent locally.	Done
7.2: The MHSOAC, DMH and ADP should collaborate to enhance state information systems—both phone and website—to assure that consumers and family members can easily find information and resources in multiple languages for both mental illness and substance abuse.	Counties have Network of Care websites listing available mental health, substance use, and veteran services in threshold languages in their county. http://networkofcare.org/index2.cfm?productid=2&stateid=6 MHSOAC included this link on its website.	Done
7.3: The MHSOAC should promote the use of MHSA Workforce Education and Training funds to train mental health and substance abuse providers to engage, collaborate with and support families as an essential resource. Training should include instruction to assess and refer families to collateral services when needed.	LONG-TERM: Possible recommendation for future regulations, guidelines, or best practices.	Long-term
7.4: The MHSOAC should include family members of individuals with COD as a priority population for PEI programs. In addition, mental health and ADP programs should provide referrals for family members to recovery services, including co-dependency and trauma services specifically for families.	LONG-TERM: Possible recommendation for future regulations, guidelines, or best practices.	Long-term
8.1: The MHSOAC should create a panel to educate the MHSOAC and the public about current public policy issues regarding trauma, including its impact on people with mental health and	LONG-TERM: Potential panel for future Commission Meeting.	Long-term

substance-use disorders.		
8.2: The MHSOAC should establish a workgroup to inform and guide policy on the needs and perspectives of individuals who have experienced trauma, and create a plan to facilitate the implementation of core competency to recognize and address trauma.	LONG-TERM: Recommendation for 2012 CFLC Committee Charter.	Long-term
8.3: The MHSOAC should promote the use of MHSA Workforce Education and Training funds to educate and train mental health and substance abuse treatment providers in the identification, assessment and treatment of individuals suffering from trauma and a substance-use and/or mental disorder.	LONG-TERM: Possible recommendation for future regulations, guidelines, or best practices.	Long-term
9.1: The MHSOAC should direct DMH and ADP to improve data collection systems to better measure prevalence, treatment and outcomes for co-occurring disorders.	ADP reported that its data set with DMH is not comparable. LONG-TERM: Possible recommendation for future regulations, guidelines, or best practices.	Done
9.2: The MHSOAC should work with COJAC and its members to define standards for “successful” COD treatment, including staffing standards and measures of program effectiveness.	Commissioner Pating attends COJAC meetings.	Done
9.3: The MHSOAC should develop appropriate “process” indicators to measure progress towards systemic transformation, cultural competency and co-occurring disorders competency.	Staff included language in current draft of the MHSOAC Policy Paper, “Transformation of the Mental Health System through Client and Family Leadership,” to address these indicators.	Done
9.4: The MHSOAC should promote the use of MHSA Workforce Education and Training to train	LONG-TERM: Possible recommendation for future	Long-term

and educate mental health and alcohol and drug treatment staff to improve accuracy of screening, assessment and diagnostic coding for COD and other serious mental illnesses.	regulations, guidelines, or best practices.	
9.5: DMH and ADP should inventory by county the availability of integrated adolescent mental health and/or substance abuse treatment services.	Under COJAC leadership, there are 2 committees investigating information related to this question.	Done
9.6: DMH should support statewide implementation of HUD's Homeless Management Information System, including identifying chronic homeless and housing-related outcome measures.	In the past year, the DMH State PATH Contact (SPC) has communicated with County Mental Health Departments that data entry into HMIS will become a requirement of the program within five years. Federal Guidance for the State PATH Application requires the state to: • Migrate PATH data into HMIS within the next 3-5 years, • Participate in and initiate HMIS technical assistance and training activities to ensure a successful implementation of HMIS; and • Develop actions to facilitate flexible use of PATH administrative funds to support HMIS activities.	Done
10.1: The MHSOAC should encourage the use of MHSA funds and strategies to incentivize transformative processes at the county level, including 1) quality improvement activities that foster integrated care, 2) efforts to establish and encourage non-mental health partnerships, and 3) activities that promote client and family wellness and recovery.	Supported through plan approvals. Local Planning Process determines how funds are spent locally. LONG-TERM: Possible recommendation for ways to incentivize transformative practices through future regulations, guidelines, or best practices.	Done
10.2: The MHSOAC should publicly acknowledge and celebrate	The MHSOAC posts Innovation Plans on the Website and a matrix of plans	Done

innovative best practices developed by counties and partners that advance the ability to provide culturally competent and comprehensively integrated care for COD.	approved to date. LONG-TERM: Possible recommendation for future best practices.	

Staff reviewed the Evaluation Indicators for Phase II of the Evaluation and found that none of the selected indicators specifically address outcomes for individuals with COD.

In the MHSOAC 2011 PEI Trends Report, approved county PEI programs were assessed for the inclusion of individuals with co-occurring mental health and substance-use risk factors or disorder. In 36% of the programs analyzed, program features or program outcomes addressing COD were specifically mentioned. This report analyzed 485 programs in 59 approved PEI plans.