Mental Health Services
Oversight and Accountability Commission
Report on Co-Occurring Disorders

Transforming the Mental Health System
Through Integration

Adopted by the
Mental Health Services
Oversight and Accountability Commission
11/20/08

MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

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Dear Commissioners:

In November 2007, the California Mental Health Services Oversight and Accountability Commission (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. This report summarizes 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 central finding of the COD workgroup is that co-occurring disorders are pervasive and disabling, yet individuals with co-occurring mental illness and substance abuse are among California's most underserved. If we want people with co-occurring disorders to recover, we must promote systemic recovery. From the ground up, our mental health system must be transformed to instill hope, create and support partnerships, build on strengths and celebrate small changes for individuals and families living with mental illness and substance abuse. As noted by the President's New Freedom Commission on Mental Health, "to achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services."[1]

In a transformed mental health system, co-occurring disorders must be the expectation. Individuals with co-occurring disorders touch every part of our system. They have more medical problems, poorer treatment outcomes, more negative social consequences and lower quality of life. They are disproportionately represented among arrestees, foster care placements, veterans, hospitalizations and the homeless. The enormous social consequences of untreated COD prompted the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify the treatment of co-occurring disorders as our nation's highest priority.[2]

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[1] The President's New Freedom Commission on Mental Health, "Achieving the Promise: Transforming Mental Health Care in America," http://www.mentalhealthcommission.gov/reports/reports.htm, 2003
2. SAMHSA, Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders, 2002. http://www.samhsa.gov/reports/congress2002/index.html

The COD Workgroup believes that integrating care to provide appropriate treatment for co-occurring disorders will simultaneously improve our mental health system to efficiently and effectively meet the complex needs of individuals with mental illness. The Mental Health Services Act envisions a transformed mental health system. Our charge is to ensure that 1) individuals receive comprehensive treatment delivered in a culturally competent integrated system of care; 2) mental health services are delivered in collaboration with non-mental health partners; and 3) peers and families foster "client-centered" and "family-centered" wellness and recovery. Achieving these goals will require the use of multiple tools to promote system development in counties, including ample technical assistance, appropriate identification of outcomes to measure progress, and incentives to encourage competency and transformation. It is our intention that the recommendations for developing an integrated system of care for co-occurring disorders provide the template for integrated services under the Mental Health Services Act.

An overarching goal is to integrate the system of mental health prevention and treatment so that there is no "wrong door" to enter the system, whether it be through a mental health clinic, a substance abuse clinic, the public health system, child welfare and foster care, or any number of social service agencies or community-based organizations. Right now, many people enter through the criminal justice or juvenile justice systems. We envision that as a result of integrating all systems, eventually even people entering through criminal justice or juvenile justice will receive appropriate treatment. In a transformed mental health system, the whole community will work towards integrating the whole system to treat the whole person.

Another overarching goal is to address the mental health needs of other people who are unserved and underserved in California. The COD Workgroup supports the Co-occurring Joint Action Council's vision of integrated treatment under the concept of "One Person, One Team, One Plan."[3] This includes providing services in a culturally competent manner.

Lastly, after hearing six months of personal testimony, the COD Workgroup has learned that successful recovery for individuals with co-occurring disorders requires a focus on the whole person. We must not only appreciate the risks that affect individuals with serious mental illnesses and/or substance abuse, but also their strengths, including connections to friends, family and community. If we fail to understand the whole person, we will further stigmatize individuals with co-

[3] In response to SAMHSA's call for national action to improve the care for individuals with co-occurring disorders, the Co-Occurring Joint Action Council (COJAC) and the Co-Occurring Office for Co-Occurring Disorders were established under the joint auspices of the Department of Mental Health and the Department of Alcohol and Drug Programs in 2005. COJAC and the Office for COD have been charged with developing a COD State Action Plan for California to promote integrated services for shared populations.

occurring disorders as “downtrodden” and “underachieving,” rather than appreciate their resiliency and potential to achieve wellness and recovery.

Thank you for your interest in the report of the MHSOAC’s COD Workgroup. We will soon have available a Resource Guide summarizing the key research that we used to develop the recommendations in this report. We recognize that acting on the recommendations that follow will be a long-term, collaborative effort. We look forward to this work together.

David Pating Beth Gould

Co-Chairs, Workgroup on Co-occurring Disorders

The Mental Health Oversight and Accountability Commission
Report on Co-Occurring Disorders

Transforming the Mental Health System
Through Integration

The Mental Health Services Oversight and Accountability Commission (MHSOAC) was created to provide oversight, accountability, and leadership on issues related to mental health including all components of the Mental Health Services Act (MHSA)[4]. Voters passed the MHSA in 2004 as Proposition 63.

Two key tenets of the Mental Health Services Act are: 1) effective services for people living with serious mental illnesses must include "whatever it takes" for recovery, and 2) those services must be integrated. "Whatever it takes" refers, in part, to flexible funding[5] for a wide array of clinical and supportive services beyond traditional mental health care, often including housing, employment and treatment for co-occurring conditions (COD). This MHSA mandate builds on and expands Assembly Bill 2034 (Chapter 518, 2000), an approach to integrated services for homeless mentally ill adults with proven success in lowering hospitalization, incarceration and homelessness. "Integrated" refers to services that are concurrently delivered by a coordinated team of caregivers, often sharing a single site. Among the most important services to be provided integrated with mental health services is treatment for alcohol and other forms of drug abuse.

Building upon findings of a previous MHSOAC COD workgroup, a reconstituted 19-member COD Workgroup met from November 2007 through June 2008 to hear presentations on relevant COD topics. These topics included: a) review of national best practices; b) updates on existing state and county activities on COD; c) review of the social impact of COD in California; and d) exploration of contributions and concerns of peers and families.

The following are the key findings and recommendations of the MHSOAC Co-occurring Disorders Workgroup.

Key Findings: Global Concerns

1. *Co-occurring disorders are pervasive.* Approximately one half of the people who have one of these conditions - a mental illness or a substance abuse disorder - also have the other condition.[6] The proportion of co-occurrence may be even higher in adolescent populations. The onset of a diagnosable mental disorder often precedes the onset of a substance-use disorder, with

[4] Mental Health Services Act, Section 10, Part 3.7, 5845a.
[5] Flexible funding allows use of funds for a wide array of clinical services and supports beyond what is normally allowed in categorical funding. These funds should meet the needs of individuals in order to achieved identified priority outcomes.
[6] SAMHSA, Report to Congress on Co-occurring Disorders, op. cit.

substance-use disorders developing typically 5-10 years later in late adolescence or early adulthood.[7] Co-occurring disorders are the norm, not the exception.

2. *Co-occurring disorders are disabling*. Individuals with COD have more medical problems, poorer treatment outcomes, greater social consequences and lower quality of life.[8] They have more relapses, re-hospitalization, depression and suicidality, interpersonal violence, housing instability and homelessness, incarceration, treatment non-compliance, HIV, family burden and service utilization. These problems arise from risks associated with biological vulnerability, alcohol and drug interactions, deferred or delayed treatment, and lifestyle and environmental conditions,[9] including discrimination, community violence and poverty.

3. *Individuals with co-occurring mental illness and substance abuse are among California's most underserved*.[10] Numerous studies demonstrate that integrated care is necessary for successful treatment of co-occurring disorders (COD). To meet the needs of individuals with COD, there can be "no wrong door" to access treatment.[11] Availability of comprehensively integrated treatment for mental health and substance abuse problems is currently the exception rather than the rule. The unmet need for integrated mental health, alcohol and drug abuse treatment in underserved racial and ethnic communities is even greater.[12]

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[7] Kessler, RC, The epidemiology of dual diagnosis. Biological Psychiatry, *56*, 730-7. 2004.

[8] The breadth of COD-associated consequences is documented in SAMHSA, Report to Congress on Co-occurring Disorders, op cit; President's New Freedom Commission on Mental Health, op cit; Institute of Medicine, "Improving the Quality of Health Care for Mental and Substance Use Conditions: Quality Chasm Series," Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2006; Center for Substance Abuse Treatment, Treatment Improvement Protocol 42, "Substance Abuse Treatment for Persons with Co-occurring Disorders," SAMHSA, 2005.

[9] Drake RE, McHugo GJ, Xie H, Fox M, Packard J, Helmstetter B."Ten-year recovery outcomes for clients with co-occurring schizophrenia and substance use disorders."Schizophr Bull. 2006 Jul; 32(3):464-73. Epub 2006 Mar 8; Buckley PF. "Prevalence and consequences of the dual diagnosis of substance abuse and severe mental illness." J Clin Psychiatry. 2006; 67 Suppl 7:5-9.; Havassy BE, et al, "Comparisons of patients with comorbid psychiatric and substance use disorders: implications for treatment and service delivery," Am J Psychiatry. 2004 Jan;161(1):139-45.

[10] In California, up to 60% of clients seeking community mental health services have co-occurring substance use disorders, reported Stephen Mayberg, PhD, Director, California Dept. of Mental Health in appearance before COD Workgroup on 1/23/08; see also California's Little Hoover Commission, "Addressing Addiction: Improving & Integrating California's Substance Abuse Treatment System," March, 2008.

11 "No Wrong Door," means mental health and non-mental health agencies must effectively detect, screen, engage and transition or refer individuals with COD to appropriate community-based treatment which is designed and implemented for COD.

[12] Wells K, Klap R, Koike A, Sherbourne C.," Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care.", Am J Psychiatry. 2001 Dec;158(12):2027-32.; For California-specific data, see Grella, C., Greenwell, L.,"Treatment needs and completion of community-based aftercare among substance-abusing women offenders." Womens Health Issues. 2007 Jul-Aug;17(4):244-55.

4. *Insufficient support for integrated COD programs leads to a paucity of treatment facilities and properly trained clinicians.* Both are essential to provide the full spectrum of necessary care. The lack of such facilities and expertise restricts access to service not just for outpatient care, but also for inpatient mental health units with COD capability.

5. *Disproportionate public funding for treatment of CODs.* While only 20 percent of individuals in California are uninsured, the public health system serves 40 percent of Californians with substance abuse or mental illness. This creates a significant burden on the public health system. Private funding is inadequate to treat mental illness and substance abuse as chronic diseases. Many health plans have day and dollar limits that curtail both outpatient and inpatient treatment for individuals with co-occurring disorders.

6. *Adolescents and Transition-Aged Youth with co-occurring disorders are at significant risk.* Fifty percent of 12th graders have tried an illicit drug and one in four is a current user.[13] Of youth identified with substance use disorders, up to 75 percent have co-occurring mental health disorders.[14] These youth are disproportionately represented in the foster care and juvenile justice systems and among school dropouts largely as the result of a lack of prevention, early intervention and appropriate treatment. Common risk factors precipitate both mental illness and substance abuse in susceptible youth. Ethnic and gender differences may increase susceptibility to risks.[15] Of major concern are the decrease in the age of onset of adolescent drug use and the increase in severity of early drug use, particularly prescription drug use, among youth.[16] The earlier children use alcohol or drugs, the more likely they are to become alcoholic or drug-dependent as adults.

7. *Older Adults with co-occurring disorders have increased risk* of cognitive impairment, poor health, hospitalization, and increased suicidal ideation and attempts, compared to individuals having either a mental health or substance use disorder alone. Depression and alcohol are the most commonly cited co-occurring disorders in older adults.[17]

8. *People with co-occurring disorders are disproportionately represented in the criminal justice system* largely as a consequence of the lack of access to mental health and substance abuse services. Nationally, 40 percent of adults

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[13] Johnston, L.D., O'Malley, P.M., Bachman, J.G. & Schulenberg, J.E, (December 19, 2005)., "Teen drug use down but progress halts among youngest teens." University of Michigan News and Information services: Ann Arbor, MI. [on-line] Available: www.montoring the future.org.

[14] Greenbaum P., et al, "Co-occurring addictive and mental disorders among adolescents: prevalence research and future directions," Am J of Orthopsy 66:52-60, 1996.

[15] Grella, C., Stein JA, Greenwell, L., "Associations among childhood trauma, adolescent problem behaviors, and adverse adult outcomes in substance-abusing women offenders.", Psychol Addict Behav. 2005 Mar;19(1):43-53.

[16] Johnston, op cit

[17] SAMHSA, "Prevention of Co-Occurring Substance Abuse in Older Adults," Older Americans-Substance Abuse and Mental Health Technical Assistance Center, 2006; http://www.samhsa.gov/OlderAdultsTAC/docs/Co_Occurring_Booklet.pdf

with mental illness will come into contact with law enforcement,[18] 16 percent of the jail population is incarcerated for offenses related to mental illness or substance abuse.[19] Once in prison, people with mental illness do not receive adequate or appropriate care. Prison health officials are not sufficiently trained in offering rehabilitative and recovery-oriented services that would prepare an individual with mental illness for success after release. People with untreated co-occurring mental illnesses and substance abuse have high recidivism rates. Pilot programs in California show that offering appropriate care to parolees with severe mental illnesses reduces the recidivism.[20]

9. *Co-occurring disorders are disproportionately prevalent among those who are homeless.* Co-occurring disorders reduce employability and challenge an individual's ability to sustain housing. The precipitants of homelessness are many and evidence demonstrates that supportive housing is effective and cost-effective. While it costs on average $16,000 annually per person to provide full-service supportive housing, these costs easily offset the $61,000 in annual emergency medical, hospital, law enforcement and other services provided per person to those who are not housed.[21]

10. *Mental Health Service to veterans is poorly coordinated between states and the federal government.* Posttraumatic stress disorder, major depression, traumatic brain injury and substance abuse are common among veterans. Treatment for veterans is cost-effective; if untreated, these individuals experience more homelessness, loss of productivity, suicide, domestic violence and strain on families. Treatment for veterans must be offered in integrated settings and include mental health, substance abuse, housing, vocational rehabilitation and employment services.[22]

11. *Hospital care, particularly acute psychiatric inpatient services, is in crisis.* In California, 26 hospitals closed between 2001-2005. Since 1990, 70 emergency departments have closed and 30 of our 58 counties currently do not have psychiatric hospital beds.[23] Access to hospital care for patients in their home communities, especially for individuals with co-occurring disorders, is at times non-existent. There is an inadequate supply of crisis alternative care options, such as crisis stabilization and acute diversion units, resulting in hospital emergency departments being the only available care for individuals in psychiatric crisis, including psychosis or suicide. There is also an inadequate supply of community-based medical detoxification units. Individuals in crisis

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[18] Cowell., A., et al, "A Cost Analysis of the Bexar County, Texas, Jail Diversion Program," Dec 2007
[19] ibid
[20] CDCR: Division of Adult Parole Operations Report: Mentally Ill Parolee Population, March 28, 2008.
[21] Culhane, D., et. al., (2002) Public Service Reductions Associated with Placement of Homeless Persons with Severe mental Illness in Supportive Housing," Housing Policy Debate V 13, Issue 1 p 107-163.
[22] Tanielian, T., Jaycox, L. eds., "Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences, and Services to Assist Recovery," Sponsored by the California Community Foundation, RAND Corp, 2008.
[23] California Data Source: Office of State Health Planning and Development (OSHPD)--data for acute psychiatric hospitals include city and county hospitals, but not state hospitals-- provided by Center for Behavioral Health, updated 2008.

with co-occurring disorders are unable to receive "the right care at the right time and in the right place." Due to the increase in methamphetamine use, demands on emergency departments continue to grow.[24]

12. *MHSA Full-Service Partnerships (FSP) programs are the only significant publicly funded programs that offer integrated mental health and substance abuse treatment.* Virtually all other programs provide treatment for only mental health or substance abuse. Most private insurance coverage and other funding mechanisms for treating mental illness or substance abuse are similarly separated. Recently, limited funding was approved for integrated mental health and substance abuse treatment under California's Substance Abuse and Crime Prevention Act (Proposition 36).
13. *Families provide important support for individuals with co-occurring disorders,* yet they have difficulty finding information and connecting with treatment and support resources. There are even fewer resources for families from culturally diverse communities. Families of individuals with co-occurring disorders also have their own needs, [25] yet, services for families, including co-dependency treatment, are not widely available due in part to inability to bill for family services. The needs and strengths of families were unfortunately omitted in the National Treatment Improvement Protocol on Co-occurring Disorders.
14. *The prevalence of co-occurring disorders in underserved racial, ethnic and culturally diverse communities is presumed high* based on the prevalence of single diagnosed mental illness and substance abuse. Yet, specific mental health research on COD in these diverse communities is sparse. SAMHSA-endorsed guidelines for the treatment of COD promote cultural competency as a desirable goal but do not identify specific culturally relevant best practices. In California, counties that piloted SAMHSA's Integrated Dual Diagnosis Treatment (IDDT) protocol were required to address the unique concerns of California's diverse communities, including the need to translate written materials, as a prerequisite for IDDT implementation.[26]
15. *Trauma is ubiquitous among individuals and families with severe mental illness and/or substance abuse.* Post traumatic stress disorder is common among individuals with COD.[27] Substance abuse greatly increases the risk of sexual or physical assault, injury or violence. Early substance abuse and trauma are co-factors in the development of adolescent mental illness.[28]

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[24] Cermak, T., "Recommendations to Improve California's Response to Methamphetamine," Special Report to the California Senate Select Committee on Methamphetamine, California Society of Addiction Medicine 2005.

[25] Ray GT, Mertens JR, Weisner C., "The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems," Med Care. 2007 Feb;45(2):116-22.

[26] SAMHSA-Center for Mental Health Services (CMHS), "Co-occurring Disorders: Integrated Dual Diagnosis Treatment – Statement on Cultural Competence," see website http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTCCsectionAJ1_04.pdf

[27] Mueser, K. T., Goodman, L. B., et al, "Trauma and Posttraumatic Stress Disorder in severe mental illness", Journal of Consulting & Clinical Psychology, 1998, *66*(3), 493-499.

[28] Jennings, A., "The Damaging Consequences of Violence and Trauma: Facts, Discussion Points and Recommendations for the Behavioral Health System," National Association of State Mental Health Program Directors (NASMHPD), 2004; see also Centers for Disease Control and Prevention, Kaiser

Key Findings: Systemic Strengths

1. Nationally, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides strong leadership in developing national best practices, disseminating training and technical assistance and funding demonstration pilots, despite various limits, such as insufficient focus on the needs and contributions of families and the needs and strengths of culturally diverse individuals and communities.[29]

2. In California, the Department of Mental Health (DMH) and Alcohol and Drug Programs (ADP) sponsored the Co-occurring Joint Action Council (COJAC)[30] to improve integration of COD services provided by state and county DMH and ADP. DMH and ADP also signed a memorandum of understanding, which authorized MHSA funds to staff an Office for Co-occurring Disorders, to assist COJAC with the development and implementation of a COD State Action Plan. Under the rubric, "One Person, One Team, One Plan," COJAC created an action plan to increase the availability of integrated care for COD in California. This plan endorses the development of a COD screening tool and templates for universal charts; explores alternative funding, program licensure and certification; and provides guidelines for training. The current COD Workgroup recommendations to the MHSOAC support and build upon the action plan recommendations of COJAC to DMH and ADP.[31]

3. Nationally recognized model programs demonstrate cost-effective strategies, which have been proven to reduce the financial impact of co-occurring disorders (and other serious mental illnesses) and simultaneously improve overall quality of care and clinical outcomes among high-risk populations. Among these model programs are: 1) Bexar County's (Texas) Mental Health Diversion Program,[32] 2) Allegheny County (Pennsylvania) Mental Health Courts,[33] 3) California's Screening and Brief Intervention for Substance Abuse Treatment (CASBIRT) pilot program in San Diego,[34] 4) California's Full-

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Permanente, "The Adverse Child Experiences (ACE) Study: Prevalence of Individual Adverse Childhood Experiences, 1995-1997," retrieved from hppt://www.cdc.gov.nccdphp/ace/prevalence.htm; and Rothman EF, et al, "Adverse childhood experiences predict earlier age of drinking onset: results from a representative US sample of current or former drinkers." Pediatrics. 2008 Aug;122(2):e298-304.

[29] Center for Substance Abuse Treatment, Treatment Improvement Protocol 42, "Substance Abuse Treatment for Persons with Co-occurring Disorders," SAMHSA, 2005 (see website http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073)

[30] COJAC membership includes the California Institute for Mental Health, California Alcohol and Drug Policy Institute, California Mental Health Directors Association, County Alcohol and Drug Program Administrators' Association of California, Departments of Mental Health and Alcohol and Drug Programs and representatives from other community-based organizations and agencies.

[31] Charter for the California Co-Occurring Joint Action Council (COJAC) As revised, February 22, 2006. See website: http://www.adp.ca.gov/cojac/pdf/State_Action_Plan.pdf

[32] Cowell, A., op. cit.

33 Ridgley, M Susan, Engberg, J, et al, "Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court," Sponsored by the Council of State Governments, RAND Corp, 2007 (see web: http://www.rand.org/pubs/technical_reports/TR439/)

[34] Office of National Drug Control Policy, "Screening and Brief Intervention Factsheet," 2008 at http://www.whitehousedrugpolicy.gov/publications/pdf/screen_brief_intv.pdf ; and personal

Service Mental Health Partnerships, which were developed under AB34 and incorporated into MHSA Community Services and Supports, 5) Supportive Housing programs for the Homeless Mentally Ill[35] and 6) California's Substance Abuse and Crime Prevention Act (Proposition 36) program.[36] Each of these programs demonstrates cost-offset savings for every dollar invested. Among private insurers, data from Kaiser Permanente indicate that integrated medical, mental health and substance abuse treatment results in medical savings from emergency, medical and other cost offsets within six months of entering treatment.[37]

4. Many California counties, in collaboration with community-based service partners, have taken steps to become co-occurring competent counties. Seven of these counties have followed the Comprehensively Continuous Integrated System of Care (CCISC) model of Minkoff and Cline;[38] six counties have adopted SAMHSA's Integrated Dual Diagnosis Treatment model.[39] Many community-based organizations have developed effective programs to deliver integrated care. These counties and programs demonstrate that integrated treatment is both feasible and doable.

5. The MHSOAC has supported substance abuse or co-occurring disorders as an issue deserving recognition but inclusion of a COD focus in MHSA policies has been inconsistent: A) Community Supports and Services guidelines recommend COD as a priority focus and many Full Service Partnerships plans endorse activities that integrate care for COD. B) Prevention and Early Intervention policies and guidelines do not specify substance abuse or COD for priority focus. PEI funds, however, can be used to address co-occurring substance abuse in the underserved or in other priority populations, such as children in stressed families, individuals who have experienced trauma, or individuals at high risk for suicide. The Department of Alcohol and Drug Programs has distributed supplemental resource material to guide county MHSA planners when considering prevention efforts to reduce the impact of substance abuse on mental health. The Suicide Prevention guideline strongly endorses screening for co-occurring substance abuse when assessing suicide. C) Workforce Education and Training Policy and Guidelines do not emphasize COD, but state that "All training and technical assistance provided

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communication, Raymond DiCiccio, Project Director, CASBirt—Principal Investigator, San Diego State University Research Foundation

[35] Culhane, D., op. cit.

[36] Douglas Longshore, Elizabeth Evans, Darren Urada, Cheryl Teruya, Mary Hardy, Yih-Ing Hser, Michael Prendergast, and Susan Ettner, "Evaluation of the Substance Abuse and Crime Prevention Act: 2002 Report (Los Angeles, CA: UCLA Integrated Substance Abuse Program, 2003); and "Evaluation of the Substance Abuse and Crime Prevention Act: Final Report (Los Angeles, CA: UCLA Integrated Substance Abuse Program, 2007)

[37] Parthasarathy S, Weisner CM., "Five-year trajectories of health care utilization and cost in a drug and alcohol treatment sample," Drug Alcohol Depend. 2005 Nov 1;80(2):231-40

[38] SAMHSA, CSAT TIP 42, op cit

[39] SAMHSA, Evidence-Based Practices: Shaping Mental Health Services Toward Recovery, Co-occurring Disorders Integrated Dual Disorders Treatment, see website: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/cooccurring/

with MHSA funding must increase a county's ability to promote recovery, wellness and resiliency by...assessing and treating co-occurring disorders,"[40] among other goals. D) Innovation Policy (in development) does not reference substance abuse or co-occurring disorders, but COD is not excluded as long as the identified innovation project focus is developed within communities and contributes to significant learning and development of model approaches.

6. Many effective state and local collaborations among agencies and departments demonstrate the feasibility of integrating services. Building collaborative partnerships with non-mental health systems requires high-level commitment and broad-based stigma reduction.[41] Mental health and substance abuse issues may need to be redefined into terms relevant to "non-mental health systems." School communities, for example, under the pressure to meet learning objectives of "no child left behind," may be more willing to consider mental health interventions when framed as efforts to reduce truancy or improve school performance rather than increase well-being or resiliency.

7. While separated (siloed) funding has been often cited as a major barrier to providing integrated treatment for co-occurring disorders—and real barriers exist, for example the fact that programs licensed as mental health cannot receive drug Medi-Cal reimbursement and vice versa—nevertheless, numerous funding sources are available. One commonly underutilized funding source for the treatment of children and adolescents with co-occurring mental illness and substance abuse are EPSDT (Early and Periodic Screening Diagnosis and Treatment) funds. Technical assistance may reduce the perception that funding of integrated programs is impossible. SAMHSA supports the use of flexible funding, while assuring that requirements are met for the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Services Block Grant (CMHSBG).[42]

8. Research, technology and our understanding of how to treat mental illnesses support services and treatments for individuals with co-occurring disorders and other serious mental illnesses that are culturally competent and consumer- and family-centered. Built around a consumer's needs, treatment must be seamless, convenient and promote recovery, resiliency and wellness[43] within the context of an individual's world view and culture. Recovery refers to the process by which people are able to participate fully and productively in their lives despite a disability. Resiliency refers to efforts that support mastery, competence and hope. Wellness refers to optimal

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[40] MHSA Workforce Education and Training Component of the Three-Year Program and Expenditure Plan, Fiscal Years 2006-07, 2007-08, and 2008-09, p. 25.
[41] President's New Freedom Commission Report on Mental Health, op cit.
[42] SAMHSA, February 11, 1999 letter "SAMHSA Position on Use of SAPTBG and CMHSBG Funds to Treat People with Co-Occurring Disorders," as cited in the Little Hoover Commission Report, "Addressing Addiction: Improving & Integrating California's Substance Abuse Treatment System," 2008
[43] Flaherty, Michael, "A Unified Vision for the Prevention and Management of Substance Use Disorders: Building Resiliency, Wellness and Recovery—a Shift from an Acute Care to a Sustained Care Recovery Management Model," Institute for Research, Education and Training in Addictions, May 2006.

physical or mental health with a balance of mind, body and spirit, a result of recovery.[44] Services and treatment that are culturally competent and consumer- and family-centered have better outcomes and enhanced utilization.

9. Model peer programs provide alternative crisis services, including peer-run crisis residential programs, peer-led support groups, community outreach and engagement, harm reduction education, wellness centers, warm lines and peer-managed housing. Peers bring many unique perspectives to mental health care and can help engage and motivate individuals with co-occurring disorders to recover.

10. Model family programs that educate and support family members, clients, mental health providers and others help break down stigma about co-occurring disorders; these programs are available through family and client organizations and are offered free to community members.

Key Recommendation:

Consistent with the Mental Health Services Oversight and Accountability Commission's overarching goal to transform the mental health system through strategic implementation of the Mental Health Services Act, the Co-occurring Disorders Workgroup offers a single global recommendation:

COD Recommendation

The MHSOAC should promote "Co-occurring Disorders Competency" as a core value in implementation of the MHSA and this value should be reflected in the Commission's Annual Strategic Plan.

By adopting co-occurring disorders competency as a core value, the MHSOAC provides policy direction that facilitates the achievement of the following 10 key goals necessary to improve the treatment of co-occurring disorders, as well as transform the mental health system in California.

Transformative Goals for the Mental Health Services Act

Goal 1: Create a Comprehensive Culturally Competent Integrated System
Goal 2: Establish Systemic Partnerships
Goal 3: Encourage DMH and ADP Collaboration
Goal 4: Provide Ample Training and Technical Assistance
Goal 5: Close Gaps in the Continuum of Care
Goal 6: Expand Peer-based Wellness and Recovery Services
Goal 7: Support Families to Enhance Recovery
Goal 8: Effectively Recognize and Treat Trauma
Goal 9: Use Outcomes to Measure Progress
Goal 10: Provide Incentives to Promote Transformation

The adoption of co-occurring disorders competency as a core value does not alter nor mitigate the MHSOAC's commitment to other core values of the MHSA. Addressing co-occurring disorders effectively involves consumers and families in decision-making, promotes cultural and linguistic competency and provides focus on underserved communities in addition to people with COD. The COD Workgroup believes that the core value of effectively addressing COD offers strategic direction to guide the activities of the MHSOAC and its partners toward achieving the goals of the MHSA.

In a Co-occurring Disorders-Competent System…

The following recommendations facilitate the transformative goals that are foundational to a co-occurring disorders-competent system. Achieving these goals will require collaboration and sustained effort among agencies, consumers and their families. Implementation of these recommendations will make best use of available resources and stimulate other needed changes in the mental health environment.

Goal 1: Comprehensive Integrated Care

Mental Health Care in California will be provided through a comprehensively integrated continuum of care that is culturally competent, client-friendly, family-friendly, and capable of meeting the behavioral health needs of individuals with both mental illness and substance abuse.

- Recommendation 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.[45]
- Recommendation 1.2: The MHSOAC should work with DMH and 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.[46]
- Recommendation 1.3: MHSA-component programs that serve individuals with COD shall be culturally and linguistically competent as required by MHSA.[47]

Goal 2: Systemic Partnerships

Mental Health Care in California will reflect a public health perspective, which results in the development of collaborative partnerships among mental health and non-mental health agencies to reduce the negative consequences of COD in high-risk populations.

- Recommendation 2.1: The MHSOAC should commission a work group on the Integrated Treatment of Youth.[48]
    - This workgroup will advise the MHSOAC and DMH on how to integrate MHSA activities targeting children and youth into ongoing activities covered under the DMH Children's System of Care, Child Welfare System, State Department of Education programs and Juvenile Justice.

[45] SAMHSA, Report to Congress on Co-Occurring Disorders, op. cit.
[46] Ibid.
[47] National Association of State Mental Health Program Directors (NASMPD), "Cultural Competency: Measurement as a Strategy for Moving Knowledge into Practice in State Mental Health Systems-FINAL REPORT," September 2004; http://www.nasmhpd.org/general_files/publications/cult%20comp.pdf
[48] Little Hoover Commission, "Addressing Addiction: Improving & Integrating California's Substance Abuse Treatment System," March, 2008; Schwab Foundation, "The Need to Invest in Adolescent Treatment- Policy Recommendations for Adolescent Substance Abuse Treatment," 2004.

- The workgroup will explore means to increase representational participation of Adolescents and Transition-Age Youth in MHSOAC planning activities, including individuals from diverse racial, ethnic and cultural communities.
- The workgroup will explore means to realize the goal of an integrated system of care for children and adolescents, including ways to expand the availability and accessibility of treatment services and staff necessary to meet the behavioral health needs of children and youth.
- The workgroup will highlight the significant gaps in alcohol and drug treatment for adolescents and seek ways to blend and leverage MHSA funding to fill those gaps.
- The workgroup will address the coalescing of risk factors among youth, including trauma, as a target of primary prevention.

- Recommendation 2.2: The MHSOAC will commission a work group on the Treatment of Offenders.[49]
  - This workgroup will advise the MHSOAC on how to create a statewide collaboration with the California Department of Corrections and Rehabilitation (CDCR), county jails, law enforcement and the courts.
  - Efforts will be made to increase the participation of law enforcement, parole or probation officers, judges, the courts and district attorneys in the MHSA local planning process.
  - The workgroup will explore cost-effective diversionary and post-release programs, with the opportunity to leverage MHSA funds for training and services.
  - The workgroup will identify means to measure baseline impact of COD on jails and prisons and measure progress towards reducing this impact.[50]
  - The workgroup will clarify the rules for utilizing MHSA funds and encourage programs to braid allowable funds to better serve individuals mandated to treatment under the SACPA (Proposition 36) guidelines.[51]

[49] Little Hoover Commission, op. cit.
[50] Measures of effective service delivery in jails and detentions prisons may include arrest rates, pre- & post-incarceration data, jail days and treatment rates for individuals with mental illness or substance abuse in jails or prisons, personal communication, R Conklin, Chief Mental Health Services, San Diego Sheriff's department.
[51] Little Hoover Commission, op. cit.

- Recommendation 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.

- Recommendation 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.[52] 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"[53]. Behavioral health care should be co-located in primary care settings.

- Recommendation 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.[54]

- Recommendation 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.[55]

- Recommendation 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[56] to identify culturally competent approaches and programs that show promise for individuals with COD.

- Recommendation 2.7: The MHSOAC will commission a work group on the Integrated Treatment of Older Adults that would be advisory to the MHSOAC and the Department of Mental Health (DMH).

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[52] Institute of Medicine, "Improving the Quality of Health Care for Mental and Substance Use Conditions: Quality Chasm Series," Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2006

[53] SAMHSA, Reimbursement of Mental Health Services in Primary Care, 2008; see website http://nmhicstore.samhsa.gov/cmhs/ManagedCare/pubs.aspx

[54] President's New Freedom Commission on Mental Health, op cit

[55] Tanielian, T , op. cit.

[56]CBOs serving diverse communities may include community clinics, family resource centers and faith-based programs, among others.

- Recommendation 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.

- Recommendation 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 partnerships to meet those needs.

Goal 3: DMH & ADP Collaboration

The Departments of Mental Health and Alcohol and Drug Programs will collaborate to support integrated treatment as outlined in the Co-occurring Joint Action Council's "One Person, One Team, One Plan" workplan.

- Recommendation 3.1: COJAC and its member organizations[57] 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.
- Recommendation 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.
- Recommendation 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
- Recommendation 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

[57] See footnote 30

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.

- Recommendation 3.2: DMH and ADP should examine alternatives to maximize flexible funding for COD treatment under Medi-Cal, as recommended by SAMHSA.[58]
- Recommendation 3.2.1: DMH and ADP should identify and leverage non-MHSA funding for the treatment of individuals with less serious mental illness (not seriously mental ill or SMI) who currently receive AOD treatment. These individuals do not qualify for MHSA services since MHSA exclusively prioritizes individuals with SMI.
- Recommendation 3.2.2: 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.[59]
- Recommendation 3.3: DMH and ADP should extend their commitment to fund the Office for Co-occurring Disorders.
- Recommendation 3.4: COJAC should participate as a partner in the MHSOAC's collaborative discussions with non-mental health agencies.
- Recommendation 3.5: MHSOAC staff and/or commissioner(s) should attend COJAC meetings to provide collaboration.

Goal 4: Training and Technical Assistance

MHSA Training and Technical Assistance will be available to support ongoing training, workforce development and quality improvement to strengthen co-occurring disorders competency and to increase competencies to move toward an integrated behavioral health system.

- Recommendation 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.

[58] SAMHSA, February 11, 1999 letter, op. cit.
[59] Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act provision in the "Emergency Economic Stabilization Act of 2008," (HR1424); see website for full text at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h1424enr.txt.pdf

- Recommendation 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.

- Recommendation 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[60] with newly identified individuals with co-occurring disorders, severe mental illness or who are homeless or at-risk for homelessness.

- Recommendation 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.

- Recommendation 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.[61]

- Recommendation 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.

- Recommendation 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 participation in community program planning, enhance service utilization and foster collaboration with community-based organizations serving these communities.

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[60] Other institutions and agencies may include prisons, county jails, and parole or probationary services.
[61] SAMHSA, CMHS op cit.

- Recommendation 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.

- Recommendation 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.

Goal 5: Closing Gaps in Continuum of Care

Individuals with co-occurring disorders will receive the "Right Care at the Right Time and in the Right Place" and MHSA funds will be directed to create a comprehensive, accessible, integrated, culturally competent and consumer-friendly and family-friendly system of care, *with special priority to fill gaps to prevent overutilization of crisis services*[62].

- Recommendation 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 health and substance abuse multi-service centers. Detoxification services should be integrated with crisis stabilization.

- Recommendation 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.[63]

[62] Crisis services, in this context, refer to acute or urgent psychiatric care delivered in an emergency department, inpatient psychiatric or medical hospital, or institution for mental disease (IMD). While these services provide life-saving stabilization for psychiatric emergencies, including psychosis or suicide, they are costly, restrictive and remove clients from their natural support.
[63] Office of National Drug Control Policy, op cit

- Recommendation 5.3: Statewide Suicide Prevention guidelines should include protocols and trainings for SBIRT interventions targeting individuals at risk for suicide.

- Recommendation 5.4: DMH and ADP should develop joint certification of COD-competent residential treatment programs.

Goal 6: Peer-based Wellness and Recovery Services

Peers from diverse communities will be broadly involved across the continuum of care as experts, ambassadors, cultural brokers, trainers and providers of peer-based wellness and recovery services.

- Recommendation 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, [64] including peer-provided and peer-run services which are culturally and linguistically appropriate.

- Recommendation 6.1.1: The MHSOAC should 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.

- Recommendation 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.

- Recommendation 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.[65] Training should support the provision of services in the least restrictive environment.

- Recommendation 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

[64] President's New Freedom Commission on Mental Health, op. cit.
[65] ibid

limited to, ambassadors, cultural brokers, trainers and providers of peer-based wellness and recovery services.

Goal 7: Support Families

Families will play a significant role in supporting and sustaining recovery for individuals with COD.

- Recommendation 7.1: The MHSOAC should support community partnerships with client, peer and family organizations.
- Recommendation 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.
- Recommendation 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.
- Recommendation 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.

Goal 8: Trauma Awareness

Recognizing that many Individuals with co-occurring disorders have experienced at least one significant trauma, COD clients will receive trauma-informed services; awareness of and competency to recognize and treat trauma will be valued and promoted as a core competence in MHSA programs.

- Recommendation 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 substance-use disorders.
- Recommendation 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.[66]

- Recommendation 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.
- Recommendation 8.4: Prevention and Early Intervention funds should be used to educate the public and mental health practitioners about the increased risks of physical violence and emotional trauma incurred as a result of alcohol and drug abuse. Such efforts are essential because alcohol and substance abuse are among the most significant precipitants of domestic violence and other forms of physical violence.

Goal 9: Measurements & Outcomes

Progress will be measured utilizing appropriate evidence and outcomes.

- Recommendation 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.
- Recommendation 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.
- Recommendation 9.3: The MHSOAC should develop appropriate "process" indicators to measure progress towards systemic transformation, cultural competency and co-occurring disorders competency.
- Recommendation 9.4: The MHSOAC should promote the use of MHSA Workforce Education and Training to train 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.
- Recommendation 9.5: DMH and ADP should inventory by county the availability of integrated adolescent mental health and/or substance abuse treatment services.

[66] Jennings, A., op. cit.

- Recommendation 9.6: DMH should support statewide implementation of HUD's Homeless Management Information System, including identifying chronic homeless and housing-related outcome measures.

Goal 10: Incentivize Progress

Performance-based Incentives should build upon systemic strengths and encourage transformation of the mental health system towards co-occurring disorders competency.

- Recommendation 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. [67]
- Recommendation 10.2: The MHSOAC should publicly acknowledge and celebrate innovative best practices developed by counties and partners that advance the ability to provide culturally competent and comprehensively integrated care for COD.

The Future of Co-Occurring Disorders

Co-occurring disorders are pervasive and disabling, yet individuals with co-occurring disorders are underserved. As a result, they suffer significant negative consequences, including hospitalization, arrests, school failure and homelessness—these consequences are unnecessary and costly.

Multiple policy commissions, including the Institute of Medicine, SAMHSA, the President's New Freedom Commission on Mental Health and California's Little Hoover Commission, affirm the ability to transform our mental health system to meet the needs of individuals with severe mental illness and/or substance abuse.

Nationally sanctioned innovations improve outcomes for co-occurring disorders while reducing unnecessary expense. Each of these innovations–such as screening for substance abuse in emergency rooms and primary care, diversion of

[67] President's New Freedom Commission on Mental Health, op. cit.

mentally ill or substance abuse offenders to treatment, supportive housing, peer-assisted management of psychiatric crisis and school-based prevention–enhance our ability to “work smarter, not harder.” These innovations also expand treatment capacity by leveraging the strengths and resources arising from new partnerships. Each innovation results in a small revolution in the delivery of mental health care.

The COD Workgroup calls upon the MHSOAC and state and county leaders to support this transformation in mental health care by immediately investing in the integrated treatment of co-occurring disorders—to take action both politically and financially—to turn sound policy into a statewide reality. The long-term dividends from investment in COD will reap major financial savings and improve overall mental health and social welfare far beyond meeting the challenge of co-occurring mental illness and substance abuse.

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MHSOAC COD Workgroup Co-Chairs,

David Pating and Beth Gould