The Arizona State Narrative

The Arizona Co-Occurring State Incentive Grant (AZ COSIG): *Creating Co-Occurring and Culturally Competent Services within Criminal Justice Programs,* continues to focus on individuals re-entering the community from the criminal justice system who have been identified with co-morbid substance use and mental illness.

Year 5 of the AZ COSIG will address the following objectives:

Strengthening Support for Services Integration and Systems Transformation

1. Initiating a paradigm shift in the Arizona criminal justice system that facilitates the identification and delivery of integrated services for inmates with CODs by continuing to promote and support collaboration between and within the criminal justice state agencies.

2. Adapting and applying systems transformation efforts to the Arizona Department of Juvenile Corrections (ADJC) by assessing organizational readiness for change (TCU-CJ-SOF). This represents the first such effort conducted in the juvenile justice system.

3. Adopting a Needs Assessment Tool in the Administrative Office of the Court-Juvenile Justice Services that will identify youth with co-occurring disorders, facilitate interagency coordination and enhance data sharing with system partners.

Services Pilot Project Expansion

1. Institutionalizing co-occurring treatment curriculum to all (approximately 27,750) COD adult inmates served by the Arizona Department of Corrections (ADC).

2. Serving over 20 ex-offenders in the Community Re-Entry component of *Knowledge for a Better Tomorrow* pilot project providing a Comprehensive Continuous Integrated System of Care (CCISC) model including up to six (6) months of subsidized housing for inmates completing residential treatment.

3. Strategizing and planning development of COSIG projects with ADJC, including adapting and applying the CCISC model to a community re-entry pilot project for youth.

Training and Curriculum Development

1. The development of a COD curriculum using the COCE products adapted to Arizona with eventual infusion into the Corrections Officer Training Academy (COTA) that Arizona utilizes to prepare incoming corrections officers.

2. Inclusion of COD training in the annual in-service curriculum mandated for Corrections Officers throughout the ADC system.

3. ADJC conducted a customized COD training curriculum for Youth Corrections Officers (YCOs) in the academy (January 2007) and plans for additional training components (intermediate and advanced levels) with material targeting direct service and clinical staff.

The Arkansas State Narrative

Through the Arkansas Co-Occurring State Incentive Grant, behavioral health professionals in Arkansas are working to develop sustaining systems for integrating treatment to individuals with a co-occurring mental illness and substance use disorder consistent with the "No Wrong Door" principle.

The specific aims of the project are to 1) develop and implement screening and assessment protocols that identify persons with co-occurring disorders, and that are acceptable to the mental health and substance abuse communities, and 2) train both communities in using these protocols, and on the needs of, and services for, those with co-occurring disorders. The following are key components in implementing proposal aims.

Key Component: Screening and Assessment

Modified versions of the Mental Health Screening Form III (MHSF III) and the Texas Christian University Drug Screen (TCU), both in the public domain, were selected for use. In Arkansas, the State contracts with independent non-profit organizations for services. Contract language between the State and these organizations was changed to ensure the sustainability of efforts to screen each new admission into the behavioral health system regardless of their point of entry into the treatment system.

Key Component: Workforce Development

Online training developed by the University of South Florida (http://cmhwbt.fmhi.usf.edu/co-occurring/intro_oo_title.cfm) on Co-Occurring Disorders, and available at no fee, was recommended to State providers as a baseline level of training for current staff. By making continuing education credit available and the use of a small amount of COSIG incentive money, most programs were able to train more than 80 percent of their treatment staff in the nine intensive modules offered.

Additionally, Arkansas patterned a model of continuous training on what has been available to COSIG States through the Co-Occurring Center for Excellence (COCE). Monthly conference calls with continuing education credit available, often using the Power Point version of the TIP 42, are led by COSIG staff and volunteers from the local medical school. This popular forum is recognized as inexpensive to behavioral health organizations by employers.

Key Component: Financial Incentives

A change in the language of the Arkansas Medicaid manual has removed a disincentive to the identification of a co-occurring disorder for mental health providers removing their fear of losing Medicaid benefits.

The State has made expanding substance abuse services a priority. Project 95 has been embraced by the Department of Human Services with its goal being the securing of Medicaid coverage for Substance Abuse services through increasing state revenues committed to the Medicaid match. Implementation of Evidence-Based Practices is likely to be tied to this increased Medicaid coverage.

Key Component: Licensure and Credentialing

Extensive review of licensure standards at the practitioner and program levels resulted in the COSIG team's recommendation that the State create a COD certificate. The Arkansas Substance Abuse Certification Board will implement a co-occurring credential through the IC&RC, creating certification at the Diplomate, Bachelor, and Associate level in mid-2008.

Key Component: Data Collection

In response to SAMHSA's COSIG data requirements, Arkansas has put increasing emphasis on developing its ability to gather statewide data on key performance measures in both its systems of care. Building on the past year's accomplishment of establishing a unique client identifier, the State is now moving toward creating an integrated, shared/linked data system. Arkansas sought assistance from COCE on approaches to meeting SAMHSA's data requirements. In the July – September 2007 quarter, 41,447 individuals were screened for the presence of a co-occurring disorder. Another 48,380 were screened between October and December.

Co-occurring Policy Academy Involvement

Arkansas became a Policy Academy State in September 2005, 2 years after it received its COSIG award. The Policy Academy has been helpful in engaging high-level policymakers. Participation in the Policy Academy allowed the State to add additional COD goals, including cultural competence and quality improvement. The plan is serving as a blueprint for ongoing efforts to integrate services for people with COD post COSIG. Policy Academy areas of focus include: 1) the creation of a welcoming environment for service recipients 2) workforce development 3) stigma and the credibility of treatment 4) financial efficiency, and 5) accountability and quality improvement for treatment services.

Plans for Services Integration & the Future of Co-occurring Services in Arkansas

Improvement in the clinical integration of services is a new goal for Arkansas's COSIG project in its fifth year. With SAMHSA's approval of carry-over funds in year five, Arkansas will have telemedicine capability in each of the 35 publicly funded programs, allowing for client participation in conferences and access to consultation services for the most rural parts of the state. The project expects to use existing substance abuse training dollars to sustain the telemedicine function after COSIG funding ends.

The Connecticut State Narrative

The three goals of the Connecticut (CT) Co-Occurring State Incentive Grant (COSIG) are to:

1. *Establish statewide standardized screening and integrated assessment to identify individuals with co-occurring disorders (CODs) and their treatment needs, regardless of where the individual initially presents for care;*
2. *Promote coordination and integration across treatment modalities; and*
3. *Promote dissemination of information and data-based decision-making.*

Current activities include:

Screening and Assessment
Effective July 1, 2007, all Connecticut (CT) Department of Mental Health and Addiction Services (DMHAS) facilities and DMHAS-funded providers are required to administer a standardized mental health screening measure and a standardized substance use screening measure to all clients upon program admission. Contract language requiring these screenings was implemented for all DMHAS funded providers. Providers can choose between four measures: Mental Health Screening Form-III, Modified MINI, Simple Screening Instrument for Alcohol and Other Drugs, and CAGE-Adapted to Include Drugs. Providers are submitting client-level screening results to DMHAS.

Workforce Development/Licensure and Credentialing

- *Developing and implementing a COD core curriculum.* The DMHAS Education and Training Division continues to deliver workshops through the CT COD Academy. The development of the CT COD on-line training product was recently initiated.
- *COD credentialing process.* The CT Certification Board (CCB) provides a COD credential and more than 300 individuals in CT have now received this credential.
- *Partnership with Higher Education.* DMHAS developed a strong partnership with Southern CT State University's School of Social Work over the past year, along with consultation

from Case Western Reserve University's School of Social Work. This has resulted in a new MSW Intensive Weekend Cohort Program that will include a focus on co-occurring disorders. The first cohort of 10 students will begin the program in the fall 2008.

Services Integration

The following activities have been recently implemented to support statewide services integration:

- *Co-Occurring Practice Improvement Collaborative.* Eight agencies (4 mental health and 4 addiction treatment agencies) were selected to be part of the first CT Co-Occurring Practice Improvement Collaborative that began in January 2007. The four selected LMHAs received training, consultation and implementation support from Forrest Foster of Dartmouth's Evidence Based Practices Center on the Integrated Dual Disorders Treatment (IDDT) model. The four addiction treatment agencies received training, consultation and implementation support from Dr. Mark McGovern of Dartmouth on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index and toolkit. These agencies met every other month as a group with the consultants and the COSIG project manager. The Collaborative is designed to help the participating agencies integrate services, produce integrated treatment "tools," and to provide lessons learned for other agencies statewide. In January 2008, 5 more agencies were selected via Request for Qualifications (RFQ) process to join the Collaborative. The two COSIG pilot sites and the eight DMHAS operated facilities have developed their co-occurring enhanced services in the same way as this Collaborative process.
- *CT Co-Occurring Enhanced Program Guidelines.* A diverse group of 15 stakeholders volunteered to be part of the Co-Occurring Guidelines Workgroup and over the course of six months produced the CT Co-Occurring Enhanced Program Guidelines and Competencies.

Financing

- *Co-Occurring Enhanced Intensive Outpatient Programs (IOPs).* The CT COSIG and Access to Recovery (ATR) II initiatives partnered to offer enhanced rates to IOPs that meet the CT Co-Occurring Enhanced Program Guidelines. IOPs that meet these criteria receive a 25% rate increase for individuals with COD in our state's fee-for-service General Assistance program.
- *Co-Occurring Enhanced Residential Programs.* DMHAS is in the process of implementing two new 20-bed co-occurring enhanced residential programs that were recently selected through a Request for Proposals (RFP) process. These programs are being developed to meet the CT Co-Occurring Enhanced Program Guidelines and will serve individuals with substance dependence and moderate mental health disorders (i.e., Quadrant III).

Management Information and Data Systems

- *Identification of Individuals with COD.* The CT Operational Definition for Identifying Individuals with COD was completed over this past year and preliminary analyses using our statewide data were examined. This definition and analyses identify individuals with co-occurring disorders, their distribution across the four quadrants, their demographics and the prevalence of certain diagnostic combinations. Further analyses are planned to identify outcomes of individuals with co-occurring disorders. The goal of these data infrastructure developments is to inform program development for this population at the statewide, regional, agency and program levels.

- *IDDT and DDCAT Fidelity Data.* Over 70 IDDT fidelity scale assessments and over 70 DDCAT assessments have been examined at statewide, regional, agency, and program levels to inform continuing workforce development and program development efforts.

Program Pilot Studies

The Morris Foundation has successfully enhanced their addiction treatment services to provide effective integrated care for persons with CODs. They have been using the DDCAT Index and Toolkit to guide their process. The Hispanic Clinic at the CT Mental Health Center has successfully enhanced their mental health services to provide effective integrated care for Latinos/as with CODs. They have implemented a culturally modified version of IDDT with training, consultation, and implementation support from Forrest Foster, Research Associate from Dartmouth's Evidence Based Practices Center. Consumers/individuals from both pilot sites who are in recovery and meet the eligibility criteria are being asked to participate in the local evaluation being conducted by evaluators at Yale University.

Policy

The Commissioner's Policy Statement on Serving People with Co-Occurring Mental Health and Substance Use Disorders was released on January 12, 2007, after almost a year of concerted development efforts.

Other Significant Project Activities

The Co-Occurring Steering Committee, which is chaired by the Commissioner and is the primary statewide governance structure to coordinate and oversee the planning, development, and implementation of all phases of CT's co-occurring activities and initiatives, continues to meet on a monthly basis. The Committee ensures consistency, accountability, and sustainability for CT's COD strategy, and provides strategic and operational advice to the various COD workgroups.

The District of Columbia Narrative

WHAT IS DC COSIG?

The District of Columbia Department of Mental Health (DMH) and the Department of Health-Addictions Prevention and Recovery Administration (DOH-APRA) have used COSIG to form an effective collaboration to improve services for individuals with co-occurring disorders within the District's public behavioral healthcare system. Funded by a COSIG grant from SAMHSA for the period 09/01/05 to 08/31/10, the District assembled a professional COSIG team to provide technical expertise and evaluation for this systems change project:

DC COSIG Team	
Steven Steury, MD	Project Director
William Reidy, MSW	Deputy Director-DC COSIG
Michelle Broadnax, MD	Project Medical Director
M. Lynn Smith, MA	Director of Training
Cathia Moise, MPH	Medical Data Analyst
Nike Hamilton, MA	Practice Enhancement Specialist
Valentine Onwuche, MA	Clinical Specialist
Willa Day Morris, MSW	Homeless COD Trainer
Vicki Whitfield	Program Specialist
Robin Berlin, MD	Practice Enhancement Specialist
Ann Doucette, PhD	Evaluator, George Washington Univ.
Toby Martin, PhD	Evaluator, George Washington Univ.

GOALS

The DC COSIG system level goal is to create an integrated approach to service delivery with "no wrong door" to appropriate treatment for individuals with co-occurring mental illness and substance use disorders in the public mental health and addictions treatment system.

ACTIONS

DC COSIG identified four objectives that target key drivers of the desired system change. Portfolios of COSIG projects are clustered under each objective, with an integral evaluation component provided by George Washington University.

The four DC COSIG objectives are:

1. System Supports for Integrated Service Delivery: focuses on aligning system level rules, policies, procedures, structures, and processes to support the goal of delivering integrated services for persons with co-occurring mental illness and substance use disorders across the DMH and APRA systems;

2. Universal Screening For Co-Occurring Disorder: establishes system capability for routinely identifying individuals with Co-Occurring Disorders and planning appropriately for their care by establishing COD screening, integrated assessment, and treatment plans which appropriately address each disorder as standard practice in partner agencies;

3. Expand Workforce Competencies in Co-Occurring Disorders: establishes comprehensive educational and training programs for Clinicians and Managers to provide at least 150 Behavioral Health Professionals who have completed the COSIG 100 hour Certificate Training in Co-Occurring Disorder Clinical Competency, as well as providing a broad range of targeted trainings, technical assistance, and coaching on COD to mental health and addictions programs across the City to facilitate implementation of effective co-occurring disorder practices.

4. System Incentives & Infrastructure Support for Continued Improvement of COD Consumer Outcomes: establish a sustainable infrastructure to support provider performance monitoring and improvement through the application of continuous quality improvement, "Clinically Informed Outcomes Management", and implementation of effective treatments for COD.

ACCOMPLISHMENTS

DMH & APRA have made significant progress towards their goals. The COSIG Project execution plan focuses on connecting all levels of mental health and substance use treatment staff, frontline to senior management, to a sustainable cross-agency improvement strategy centered on meeting the needs of our consumers through the application of effective practices and continuous quality improvement (CQI).

OBJECTIVE 1:
Establish System Supports for Integrated Service Delivery for individuals with Co-Occurring mental illness and substance use disorders.

OBJECTIVE 1 PROJECTS	ACCOMPLISHMENTS
DC COSIG Interagency Leadership Group	DMH & APRA Senior Leadership meets monthly to guide project work, align system rules, policies, procedures, processes and structures, monitor progress, act to remove barriers and embed co-occurring competent practices into standard operations to assure sustainability beyond the life of the COSIG grant.

Provider Agency Co-Occurring Competency Designation for DMH & APRA	-COSIG developed co-occurring disorder (COD) criteria for certified DMH & APRA agencies COD Competency Designation. -DMH & APRA approved voluntary agency designation of competency process - Implementation workgroup recruiting participation providers for Provider Agency COD Competency Designation.
Agency incentives for achieving Provider Agency COD Competency Designation	- Identified Payment Codes to be made available only to COD Competent Agencies -Submitted these specified payment codes for approval of enhanced reimbursement under Medicaid MHRS -Worked with APRA to identify payment coded for Designated Agencies only and submitted codes Medicaid to be approved for enhanced reimbursement
Agency "COD Practice Leader" Test Sites for COD Competency Designation Process	-DC COSIG Provider Agency readiness assessments - COSIG developed "Co-Occurring (COD) Scorecard" & chart audits tool to inform "Agency COD Competency Achievement Plan" for volunteer APRA & DMH Provider Agencies. -COSIG Technical Assistance and targeted training as assisting volunteer Agencies achieve full COD Competency. -One Agency approved, and six in process.
Collaboration with other DMH, APRA, & DC Key Initiatives	--APRA's "Access to Recovery" grant collaboration to bring recovery supports and wrap around services to co-occurring clients -APRA's State Substance Use Adolescent Care Coordination grant collaboration incorporate basic co-occurring competency as an aspect of their work, and to enable them to build on the COSIG work to advance their own initiatives. -COSIG Provides TA and training on co-occurring disorders to support Criminal Justice and Homeless projects.
Youth SUD & COD Integrated Network Development for Medicaid funded Services	- Formed **c**ollaboration with Medicaid, APRA, State Adolescent Substance Care Coordination Project, MCOs, DMH to close the gap in youth substance use treatment services in DC. -developed interagency work plan to establish a Medicaid reimbursable network of youth providers in the District of Columbia to provide substance use treatment services and integrated services for co-occurring disorders. DC COSIC work includes: -Expanded provider network from 2 agencies to 8 agencies, of which 4 are dually certified by DMH & APRA -Providing technical assistance to DMH Certified Providers around provision of COD services for youth and achievement of Agency Competency Designation in COD -Working with DMH & APRA to align and streamline Provider Agency Certification Process to facilitate Agency dual certifications.

Data Sharing	COSIG has established a relationship with the DC Office of the Chief Technology Officer (OCTO), and is working directly with that agency to promote DMH and APRA's use of their "Safe Passages Information System" for cross-agency data sharing has been promising.

OBJECTIVE 2:
Establish universal screening, assessment, & treatment planning for co-occurring disorders in all APRA & DMH provider sites.

OBJECTIVE 2 PROJECTS	ACCOMPLISHMENTS
Establish Routine Universal COD Process	DMH & APRA adopted COSIG recommendations in 2006 and require COD Screening, Assessment & appropriate treatment planning
Performance Monitoring	DC COSIG regular COD performance clinical chart audits, using SAMHSA sampling specification, finds: -a screening rates of 88.6- 100 percent in agencies -assessment rate of 51 – 98.4 percent of consumers seeking services from DMH & APRA, who screen positive on COD -few agencies are providing both substance and mental health services within the same agency (18.7 – 40 percent). -when two agencies involved, audits reveal the contact and coordination among service providers for treatment of consumers with co-occurring disorders is Minimal
Performance Improvement- Feedback & TA	-Performance data given to agencies with TA and targeted training as needed to improve performance

OBJECTIVE 3:
Expand workforce competency in co-occurring disorders.

OBJECTIVE 3 PROJECTS	ACCOMPLISHMENTS
DC COSIG Co-Occurring Clinical Competency Training Manual	-developed manual as basis for a 100 hour training program which awards graduates a "Certificate of Co-Occurring Clinical Competency". - Product will be available to DMH, APRA and other community provider agencies by Aug. 2008 for future use in staff training programs.
100 hours Certificate of Co-Occurring Disorder Clinical Competency Training Program	- will have graduated a total of 150 +/- DC mental health and substance use professions by August 2008. COSIG Certificate is aligned with national consensus standards and should prepare graduates to easily qualify for national certification when that option becomes available through Professional Certification Organizations.
COSIG Educational and Training Programs	Over 50 provider agencies and more than 350 mental health and substance use clinicians have participated in various COSIG

	Educational and.
COSIG "Brown Bag and Targeted Trainings	Specific Co-Occurring Disorder topic trainings have been conducted in 12 different agencies with over 250 mental health and substance use staff have participated.
COD Clinical Leadership Training	COSIG sponsored 30 clinical supervisors and program managers to compete a 6 month cross- discipline mentoring program to build co-occurring disorder program leadership skills. Each of the participants does COD project in own agency.
DC COSIG Train-the-Trainer Programs	6 graduates of COSIG's Certificate Training Program graduates are being trained to teach the Clinical Competency Training, and by August 2008 a total of 25 agency trainers will have competed the TIP 42 Train-the Trainer Program.
Psychiatric Bedside Teaching for Co-Occurring Disorders	-Psychiatrist Practice Enhancement Specialist conducts regular onsite bedside teaching sessions with staff at APRA's Detoxification and Stabilization Center, Women's Program, and Access and Referral Center (ARC).
COSIG Homeless Training Project	-COD Training customized to the needs of the city's Homeless provided onsite for 15 service agencies. The goal is to train 30 to 50 Homeless staff in co-occurring disorders by August 2008.
COD Stage-wise Group Treatment Training and Supervision",	-Initiated in March 2007 and continues every two weeks with hospital staff at St. Elizabeth Hospital. COSIG provides training and clinical supervision to 12 hospital therapist who conducts weekly co-occurring disorder treatment groups for hospitalized patients.
Consumer Empowerment	-The COSIG works with consumers to develop a self-sustaining network of "Double Trouble Recovery" self-help 12-step programs in DC. DC COSIG continues to provide technical assistance, DTR materials, and practical supports to the groups and ongoing support for the peer leaders. 3 DTR groups are now running and 4 more are expected by the end of August 2008.

OBJECTIVE 4:
Establish Continuous Quality Improvement Supports for Cross-Agency Improvement of Consumer Outcomes for Individuals with Co-Occurring Disorders.

OBJECTIVE 4 PROJECTS	ACCOMPISHMENTS
COSIG Clinical Chart Audits	-1019 onsite chart audits completed at APRA & DMH completed using the SAMHSA COD Outcomes indicators. -- 6 Agency COD Competency audits are being conducted to guide implementation of APRA & DMH COD Competency Designation
COD Cross-Agency CQI Team at Comprehensive Psychiatric Emergency Program (CPEP)/ Detoxification and Stabilization Center Collaboration	-interagency CQI Team improved collaboration and consumer access to substance use and mental heath services in these settings. Work includes: -ongoing clinical cross-training of staff; -Social Workers assigned to ARC and Detoxification Programs completing 100hr COD Competency Training in Feb '08; -COSIG "psychiatric bed-side COD teaching" at Detoxification and Stabilization Center weekly; -development of MOU between APRA & DMH to formalize

	improved collaborative processes to improve access for consumers.
COD Cross-Agency CQI with APRRA'S Assessment Referral Center (ARC)/ DMH Access Helpline	COSIG brought staff from these services together to develop easy-access pathways to coordinated MH & SA treatment for individuals with COD to improve consumer access.
COD Cross-Agency CQI-Youth Continuity of Care Improvement Project	-facilitated a cross-agency CQI effort in FY07& FY08 to improve continuity of care for high risk youth between psychiatric hospitalization & community-based services. The CQI Team included staff from 3 community hospital psychiatric units, DMH Youth Providers, APRA Youth Services, MAA, MCOs, DYRS, and CFSA. Communication and notification processes between providers where significantly improved to support the requirements of DMH Continuity of Care Guidelines. Systematic tracking of transition planning at 3 hospitals was developed, and a "Youth Acute Care Directory" was assembled to exchange key contacts information. DMH Youth Services is continuing the CQI project in FY08 focused on improving provider performance on access standards with the creation of Provider Improvement Work Groups. -Follow-up work led to addition cross-agency collaboration listed under objective #1 to close the youth SU & COD treatment gap.
St. Elizabeth Hospital COD CQI Project	-Developed state hospital initiative in FY07 & FY08 with the aim of improving treatment for individuals with co-occurring mental illness and substance use disorders hospitalized at St. E's through standardized screening, expanded assessments, stage-wise treatment, and transition planning for community based treatment. -Screening & assessment processes have been designed & implemented. - Three hour COD training has been provided to all 149 staff, including training for all physicians. Policies have been revised to encompass COD competent care. -The COSIG100 hour Clinical Competency Training Program is conducted onsite for approximately 40 St. Elizabeth staff. -Ten (10) hospital staff is being trained as COD trainers to integrate COSIG COD training into the standard offerings of the hospital training department, and required training for new staff. -COSIG Practice Enhancement Specialist provides training and supervision in COD Stage-Wise Group Therapy to 12 staff that are now running COD groups at the hospital. -The hospital has created a COD Coordinator. Performance monitoring on COD indicators in being integrated into routine hospital performance improvement activities.

Regional Performance Improvement Collaborations with the Metropolitan Washington Council of Governments (MWCOG)	-The COSIG Deputy Director currently is working with MWCOG as the chair of the Substance Abuse & Mental Health Committee to create a Regional Collaborative to Improve Healthcare for Individuals with Mental Health & Substance Use Disorders. The aim is to create a collaborative structure to promote the achievement of integrated services across the region for individuals with co-occurring mental health, substance use, and medical disorders, in a way that supports mutual learning, the quick spread of best practices and innovation to improve consumer outcomes.
Clinically Informed Outcomes Management	Working closely with George Washington University to improve consumer outcomes through the establishment of practice-based evidence of treatment effectiveness within the public behavioral healthcare treatment system. Consumer self-reported outcomes are now routinely collected at the point of service and tracked over time at COSIG test sites. Real time feedback is given to the treatment team, alerting them to issues that may call for a revision of the treatment plan to achieve desired outcome. DMH & APRA have decided to support broader implementation of CIOM across their Provider Agencies. COSIG is developing a spread plan. (See evaluation section for more detail on CIOM)

HOW IS DC COSIG BEING EVALUATED?

Ann Doucette. Ph.D. and Toby Martin, Ph.D. of The George Washington University Department of Health Policy serve as the COSIG Evaluators. They participate in all COSIG meetings, allowing them to systematically gather information on the decision-making processes and the action plan, as well as anticipate the challenges and barriers that the COSIG initiative might face. The evaluation plan addresses the following elements:

- *Integrated treatment:* Tracking the increase in COD screening and treatment. DMH and APRA agencies are participating in ongoing random review of clinical records. Data from the chart audits are analyzed by the COSIG team and serve as a status barometer on where agencies are in terms of screening and treatment plans for individuals with COD.

- *Integrated data:* DMH, APRA, and MAA (DC Medicaid) use incompatible data platforms making it impossible to participate in HIPAA compliant data sharing across agencies. These issues have been raised with the DC Office of Chief Technology Officer (OCTO), an agency whose mission is to integrate data across human services agencies in the district. While there is recognition of the benefits of data sharing, integrated data across DMH and APRA remains a challenge.

- *Processes and Outcomes of Care*: In order to capture the effects of the COSIG initiative for consumers, Dr. Ann Doucette developed a *Clinically*

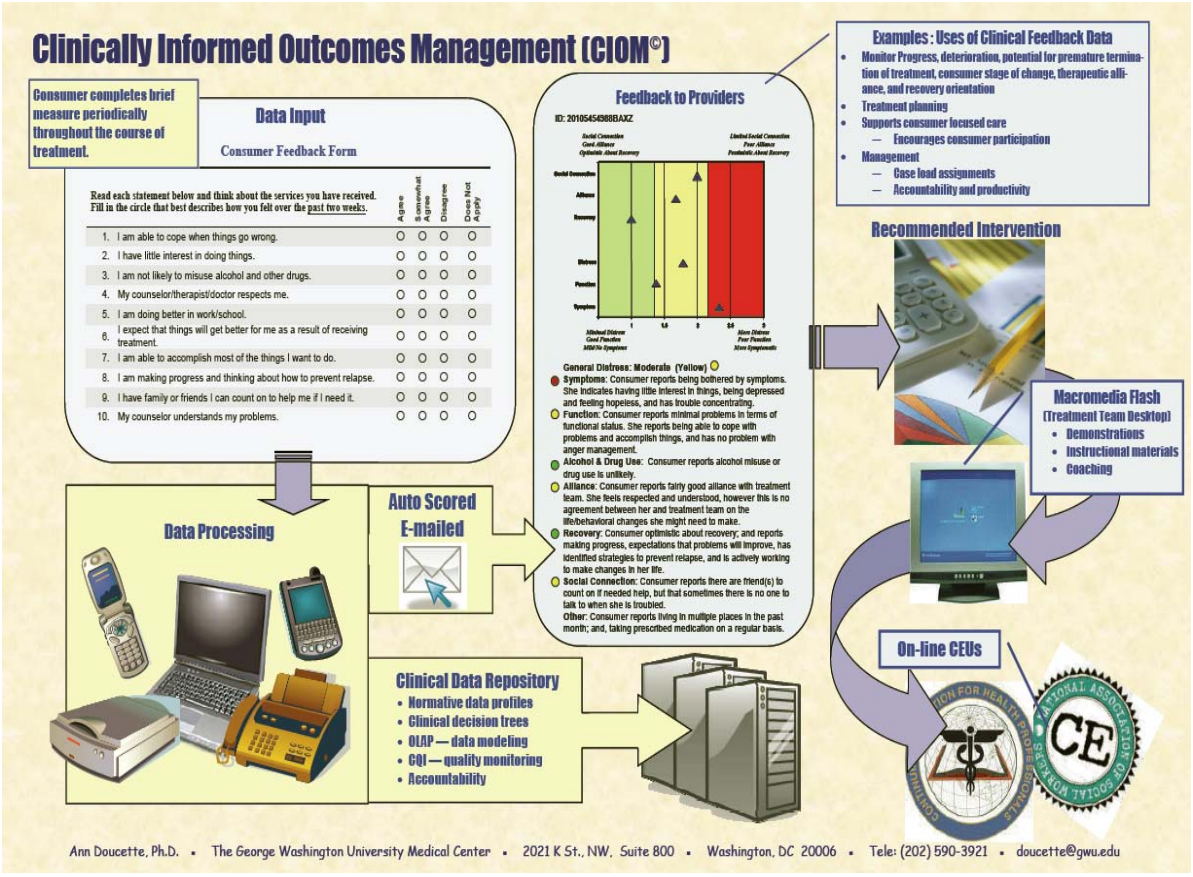
Informed Outcomes Management (CIOM) system. The CIOM builds on previous academic work. The CIOM provides (a) a ***voice*** for consumers in assessing their own therapeutic progress and improvement, (b) enhances treatment/service outcomes though consumer reported progress and provides supports for Treatment Teams, (c) establishes a practice based evidence approach that identifies effective treatments and interventions provided by Treatment Teams, and lastly (d) provides alerts to counselors, therapists, case managers when consumers report unexpected deterioration or unidentified problems.

- A brief survey (29 items) was developed for use in the District of Columbia assessing symptoms, functional status, social connectedness, therapeutic alliance, stage of change, orientation to recovery, use of alcohol/other drugs, general health status, housing stability, and engagement in education and/or employment. The survey development was informed by consumer groups. As a result several items were added by consumer request (e.g., adherence to medication protocols, ability to manage anger, etc.). Consumers complete the survey monthly or more frequently depending on the agency. The surveys are sent to the University of Pittsburgh for automated processing. The survey is scored and the results are color coded for easy interpretation by treatment team members. Results are sent along with a graphic illustration, narrative explanation of scores, and recommendations for optimizing treatment to the respective agency. Scoring, narrative results and recommendation algorithms were developed by Dr. Doucette. In addition, graphs are also sent to providers depicting the longitudinal progress of the consumer over time.

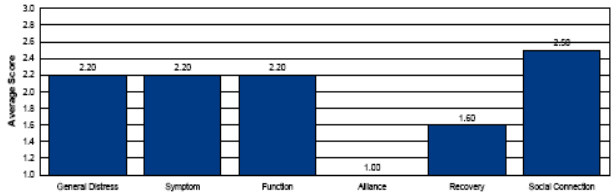
To date three mental health agencies and three substance abuse agencies are participating in the CIOM. More than 3500 surveys have been processed in the past eight months. There have however, been significant challenges in implementing the CIOM. While providers acknowledge the benefits of having outcome data concurrent with treatment, they also recognize their inability to readily incorporate the information into treatment planning and day-to-day agency operations. Support and coaching have proven to be valuable components to the successful implementation of the CIOM. We are planning to establish stronger ties to the COSIG training efforts and are building linkages between the CIOM recommendations and the components of the COSIG COD training.

The District has begun discussion planning with DC COSIG to sustain the CIOM as part of an ongoing continuous quality improvement (CQI) effort. To that end, the CIOM has been piloted in Los Angeles and El Dorado counties in California. California modified the DC consumer survey, by adding several recovery support items that characterize their treatment systems.

The figures below illustrate the framework of the CIOM and the types of reports provided to the participating agencies through the DC COSIG.



Individual Report



General Distress Moderate -- Orange — *Consider a more thorough evaluation/assessment. Screen for possible co-occurring conditions, especially alcohol and/or other drug use. Ask consumer about their perceived progress and what suggestions they may have in explaining reported distress. If the consumer is taking medication as part of their treatment ask about their adherence to the medication. Consider physical health problems and inquire about any needed medical referrals. Reviewer treatment plan and consider modifications that may be needed. Inquire about housing stability, etc.*

Consumer reports moderate levels of distress -- some functional impairment, and is experiencing some symptomatic difficulty.

Suicidality Severe -- Red

Serious concern -- active intervention and monitoring

Symptom

Consumer indicates feeling somewhat depressed and sad.
Consumer reports being somewhat bothered by their symptoms.
Consumer reports feeling a loss of control over life.

Function

Consumer reports some improvement in work/school activities, but also indicates continuing difficulties.
Consumer indicates that they are unable to accomplish the things they want to do.
Consumer indicates having physical health problems.
Consumer worries about taking his/her anger out on others.
Consumer reports not always getting the care they need for their health problems.
Controlling their temper is sometimes a problem.

Alcohol/Drug Use

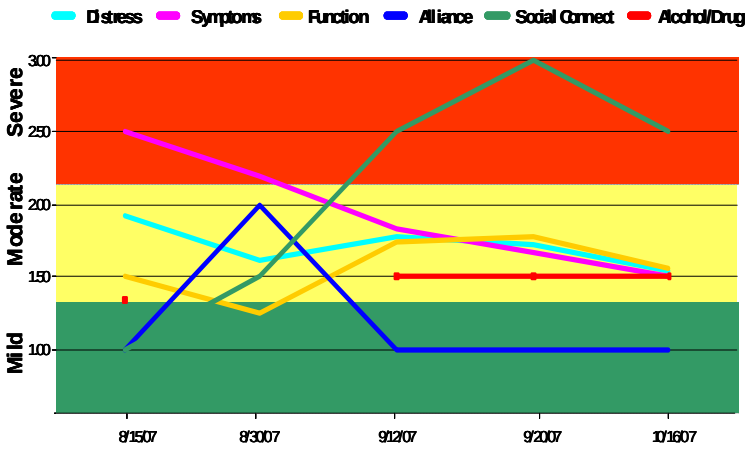
Consumer reports some concern about misuse of alcohol and/or drugs.
Consumer reports sometimes being told their drinking and/or drug use is a problem.
Consumer indicates that using alcohol and/or drugs is sometimes helpful in managing when they feel badly.

Alliance

Consumer reports feeling respected by treatment provider(s).
Consumer reports that the treatment team always understands the problems they are experiencing.
Consumer reports that there is agreement on changes that would be beneficial for them to make in their life.

Social Connection — *Consider linkages to peer-to-peer supports and other community support. Ensure that consumer knows about the 800 access help line and other appropriate community supports.*

Longitudinal Consumer Report



CIOM is currently being tested in DMH & APRA provider sites: 2 DC CSA Clinical Teams (ACT & CST), Green Door, APRA's Women's Services and Good Hope Road. With the planned addition of several additional test sites, COSIG will have clinical outcomes tracking data for approximately 2200 consumers.

Helping APRA & DMH Clinical Teams use the CIOM feedback to improve care is the focus of COSIG's educational support and technical assistance to CIOM test site providers. This activity applies tools and educational resources from COSIG on evidence and consensus based clinical practices to the specific needs of individual consumers. Additional, technical assistance is focused on using aggregate data to guide CQI of programs to better fit the needs of the consumers.

CIOM is a powerful tool for measuring & improving our public behavioral healthcare system's effectiveness in obtaining desired consumer outcomes. Because of this, CIOM Sustainability Planning is underway. COSIG has recommended broad implementation of CIOM across the DMH & APRA provider system beginning in FY09. Preliminary discussions with OCTO have begun & an implementation proposal is under development by COSIG for the Directors

Clinically informed Outcomes Management (CIOM): In addition to an investigation of agency infrastructure, identification of need for co-occurring treatment, and integrated treatment approaches, we continue to examine the impact of providing clinical feedback to counselors and clinicians in terms of client/consumers reported progress.

The DC COSIG CIOM Data- warehouse developed in collaboration with George Washington University began collecting client self-reported outcome data in OCT & Nov 2006 from the COSIG's APRA and DMH test sites. Individual client progress is now being tracked and feedback given to clinicians. As this outcome database expands, data will be aggregated to practice, program, agency and system level and will be a rich souse of data for evaluation.

Pilot test of the CIOM are will underway selected DMH and APRA sites, we will plan with DMH and APRA from a broader implementation and adoption of the CIOM model with their respective providers.

DC COSIG CONTACT INFORMATION

For more information about the DC COSIG contact:

Steve Steury, MD
Chief Clinical Officer
DC Dept of Mental Health
64 New York Ave. NE
Washington, DC 20002
Steve.steury@dc.gov

William Reidy, MSW
Deputy Director DC-COSIG
DC Dept. of Mental Health
64 New York Ave., NE
Washington, DC 20002
william.reidy@dc.gov
202-673-7758

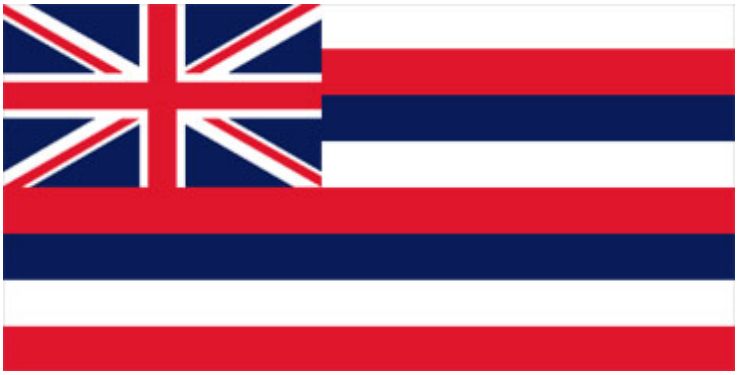
M. Lynn Smith, MA
DC COSIG Director of Training
DC Dept of Mental Health
64 New York Ave. NE
Washington, DC 20002
Lynn.smith@dc.gov

The Delaware State Narrative

Over the past several years, the Division of Substance Abuse and Mental Health (DSAMH) has spent considerable time developing and implementing comprehensive plans to expand and enhance co-occurring disorders services in both DSAMH agencies and other systems that provide substance abuse and mental health treatment.

In September of 2007, DSAMH was awarded a Co-occurring State Incentive Grant (COSIG). This five year grant provides funding to improve and enhance treatment for clients with co-occurring substance use and mental health disorders throughout the statewide treatment system. These resources will also allow DSAMH to continue to develop skills and competencies in the workforce, and to improve the ability of providers to make data-driven decisions for quality improvement of co-occurring treatment services.

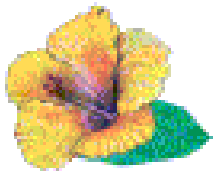
The entire substance abuse and mental health treatment system will receive training and on-site assistance to implement practice change from an internationally known expert, David Mee-Lee, M.D. A board-certified psychiatrist, Dr. Lee is also certified by examination of the American Society of Addiction Medicine (ASAM). He is a Senior Fellow for the Co-Occurring Center for Excellence (COCE) for Substance Abuse and Mental Health Services Administration (SAMHSA). Dr. Mee-Lee has more than 25 years experience in treatment and program development for people with co-occurring mental and substance use disorders.



The Hawai'i State Narrative

HAWAIʻI COSIG PROJECT SYMBOL: The Yellow Hibiscus, Hawaiʻi's State Flower

Designed by the late Edward Naong, a Waipahu Hawaiʻi Clubhouse Member



The Hawaiʻi COSIG Project Proposal's Three Primary Proposal Goals:

1. Establish a system-spanning task force that will be responsible for the continuing development and implementation of action plans and protocols to: a) assess the status of the State's co-occurring disorder (COD) services system, b) identify unmet needs, gaps, and other problems within this system, c) develop and enact strategies to resolve these obstacles to care, and d) build capacity and infrastructure to sustain a high-quality, integrated, and seamless system of care.
2. Conduct a services pilot project to test a locally developed set of capacity and infrastructure enhancement strategies; promote the plans and protocols of the system spanning taskforce that relate directly to the improvement of services to people with COD.
3. Develop a continuous quality improvement framework for co-occurring services using an array of evaluation methodologies.

Accomplishments

The following outlines targeted achievements and benchmarks toward these three goals.

Goal #1

- A Project Taskforce (PTF) was formed on September 24, 2004. A total of fifteen (15) meetings have been held since its' inception.

- Four work committees were formed to develop the statewide strategic plan: Workforce Development and Training, Treatment Systems, Screening and Assessment, and Infrastructure. Meetings were held monthly until committee plans were completed and passed PTF approval.
- Technical assistance and training from the Co-Occurring Center for Excellence was requested and approval was granted to assist Hawai‘i in the formation and work plan for the PTF work committees.
- Presentations to the PTF have included: evaluation updates and final reports, Mobile Team updates and progress, Strategic Plan updates, Community Partnership project, Division updates, Web site page updates, and technical assistance.
- A final evaluation report evaluating the work of the PTF and using a survey method has been completed.
- A Statewide Needs Assessment on co-occurring services containing three phases: focus groups, community partner interviews, and survey was conducted, and a final integrated report on all three phases has been completed and used to develop strategies, goals, and action areas to improve services for co-occurring disorders.
- Developed a Statewide Strategic Plan for Integrated Treatment of Substance Use and Mental Disorders, completed development of an implementation plan, identified action priority areas for FY’08, and identified interdivision implementation committees. Implementation underway.

Goal #2

- A Pilot Project was launched in fiscal year two and ended November 2006. The project included a mobile team of four interdisciplinary staff members; a social worker, an advanced practice nurse, a certified peer specialist, and a psychiatrist.
- Work Plans were completed for three community provider sites: Windward Community Mental Health Center (WCMHC), Hina Mauka, and Po‘ailani.
- Three evaluation and work initiatives provided by the Mobile Team were approved by PTF; Technology Transfer, Community Development, and Consumer Involvement. In addition, case consultations were provided to WCMHC and Hina Mauka.
- Two community collaborations were formed to support co-occurring services within their respective communities; Ho‘oulu in the Windward (WW) O‘ahu area and one in the Moloka‘i community.
- Service area was expanded out of the original geographic area on the island of Oahu in order to increase involvement with additional substance abuse providers, particularly in rural areas, as supported by the COSIG Statewide Needs Assessment on Co-Occurring Disorder services.
- Mobile Team provided a total of over 50 training events to a total of 1,054 participants and approximately 100 consultation sessions with involved community partners.
- A final evaluation report has been completed on the project positively supporting the use of an interdisciplinary team able to provide training, consultation, and community development to various communities statewide supporting the building of infrastructure to improve co-occurring services in the community.

Goal #3

- Continual project evaluation has occurred on all elements of the project. A final project evaluation report is underway and expected to be completed within the last project year.

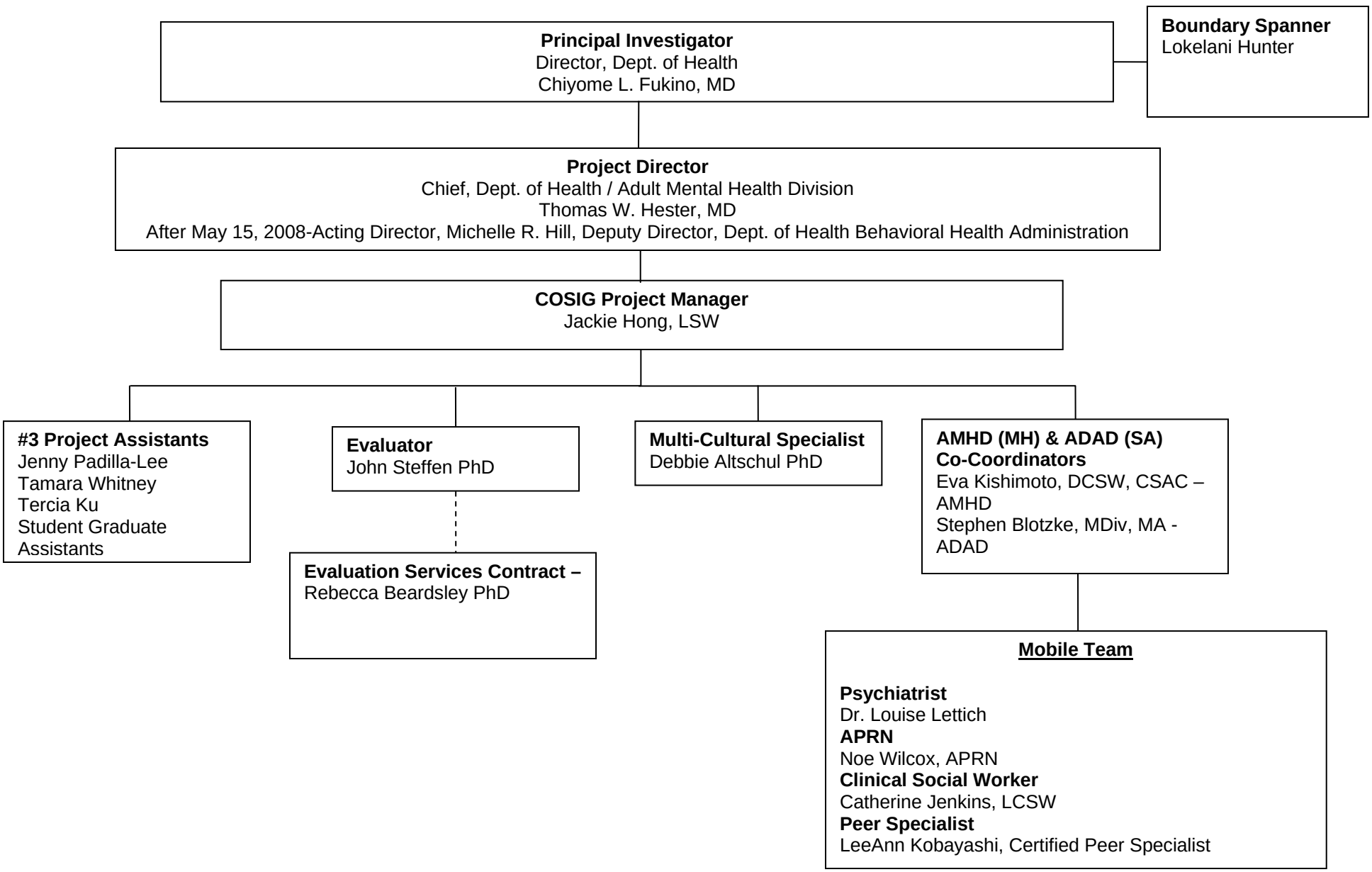
Additional Grant Activities

- Web Site Corner: A Web Site Co-Occurring Corner has been developed and posted in the State of Hawai‘i, Dept. of Health, Adult Mental Health Division site. The website address is http://www.amhd.org/Cooccurring.
- Native Hawaiian Community Collaboration - ‘Imi Ke Ola Mau: COSIG has provided leadership to the development of a partnership between Native Hawaiian community groups and community and government providers who provide and/or support culturally appropriate substance abuse and mental health services to Native Hawaiians, their families, and their communities. The group has developed a strategic plan, a mission and vision statement, conducted two statewide forums, provided support to research efforts, and developed a long-term administrative structure and supporting research and evaluation towards improving treatment outcomes for Native Hawaiians who are over represented in our SA system, public safety, corrections, and child abuse systems in the State of Hawai‘i. The group also selected and participated in the SAMHSA 4th Policy Academy on Co-Occurring Disorders for Native Group in Sept. 2007 in Arizona.
- Conducted Statewide Clubhouse Training Forum on August 31, 2006.
- Provided over six community educational workshops on co-occurring substance abuse and mental health disorders, including upcoming partnership training with the Co-Occurring Center for Excellence on the TIP 42 with a cultural panel provided to all SA and MH providers in government and private systems.
- Completed Memorandum of Understanding to Collaborate for the Improvement of Care for Individuals with Co-Occurring Substance Use and Mental Disorders, between all three government behavioral health division serving adults and adolescents.

Barriers to Date

- Contract and procurement delays
- Personnel issues
- Hiring and recruitment delays
- Lack of evaluation staff resources
- Retention of consumer representatives

HAWAIʻI COSIG PROJECT ORGANIZATION CHART



The Louisiana State Narrative

Funded by the Louisiana Co-occurring State Incentive Grant, the Louisiana Integrated Treatment Services (LITS) Initiative seeks to develop a statewide treatment delivery system in which all publicly-funded Mental Health and Substance Abuse programs are Co-occurring Diagnosis Capable (CODC). The current concentration of LITS activities exist both at the State and local program levels.

At the State Level
At the State level, the Office for Addictive Disorders and the Office of Mental Health are working together to enhance statewide CODC in multiple areas, including: Workforce Development, Funding, Clinical Protocols, Information Management and Evaluation.

At the Local Level
The primary activities related to service integration occur at the local level within Louisiana's ten geographic areas. Each area has a Local Steering Committee, comprised of Mental Health and Addictive Disorders professionals, who spearhead LITS implementation at the community level. Working through the Local Steering Committees, the LITS Initiative is intended to help build infrastructure by supporting programs as they work to become co-occurring capable. Currently, the Local Steering Committees, through utilization of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and DDCAT- Mental Health version Fidelity Instruments, have identified certain 'critical program elements' that are targets for resource application such that most mental health and addictive disorder clinics could demonstrate improved performance with reasonable efforts and in a reasonable period of time. These initial critical elements have formed the first stage of a strategically developed implementation process for ongoing co-occurring enhancements.

The Future
Following implementation of this first phase, subsequent phases of change will include areas involving more resource intensity and/or the need for system level changes. For more information about LITS, visit our Web site at www.litsla.org.
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Co-Occurring State Integration Initiative
MAINE
COSII

The Maine State Narrative

General Goals

The goal of the Maine COSIG grant is to build state infrastructure that will enable provider agencies to effectively provide integrated treatment to those with co-occurring disorders. Our goals involve five targeted areas of focus: screening, assessment, treatment, training and evaluation.

The project functions at two levels: we develop and enhance state infrastructure through the work of the Project Team, Project Steering Committee, and targeted work committees, all overseen by a State Advisory Group; we implement capacity building structural changes in culturally varied pilot sites throughout the State. We offer training, consultation, and technical assistance in best practices to pilot sites as well as to 50 others who have signed an MOU with the State to implement integrated treatment. Finally, we conduct formal evaluation of outcomes based on predetermined indicators.

Performance Objectives for implementation of grant goals include the following:

1. **Screen** at least 3000 individuals per year for the presence of co-occurring disorders;
2. **Assess** the level of severity of co-occurring disorders in at least 2000 people per year;
3. **Treat** both disorders in a comprehensive and coordinated manner in at least 1000 people per year
4. **Train** providers in 50 agencies per year to screen, assess, and develop treatment plans for people with co-occurring disorders of all cultures; and
5. **Evaluate** the impact of treatment services on individuals who have co-occurring disorders and their families.

Significant Accomplishments for Grant Year 3

Infrastructure:

- ➢ Achieved significantly better buy-in and attention to the grant from DHHS leadership
- ➢ Established better collaboration between the Offices of Adult/Child Mental Health and Substance Abuse
- ➢ Worked closely with the new ASO (managed care) provider to integrated COD into the clinical criteria
- ➢ Participated in the development and incorporation of COD language in the Substance Abuse licensing regulations that were adopted in February, 2008
- ➢ Developed an Integrated Services Policy formally issued in May, 2007
- ➢ Conducted consultation and training with DHHS Leadership, including the Commissioners Office
- ➢ Began the work of including COD language in Maine Care Policy
- ➢ Developed developmental contract language for provider contracts
- ➢ Provided recommendations to the DHHS Management Team for implementation of integrated care across offices
- ➢ Have coordinated efforts with the managers of several other Department Grants including Systems Transformation, Access to Recovery, STAR-SI.

Workforce Development:

- ➢ Developed Core Competencies and Scope of Practice Statements
- ➢ Developed a collaborative relationship with academic institutions to begin discussions about workforce training and education; partnering with the substance abuse provider advocacy organization on workforce issues
- ➢ Developed and distributed a survey of academic institutions and their available courses on COD
- ➢ Developed a Workforce Policy statement

Data and Evaluation:

- ➢ Developed preliminary Cost Study
- ➢ Began the work of creating Integrated Data Reports
- ➢ Began submission of all required COMS data
- ➢ Have compiled demographic, follow up, and outcome data on over 600 clients enrolled in integrated treatment

- ➢ Conducted a major mid-course evaluation of our grant progress and effectiveness to date
- ➢ Conducted pre and post COD fidelity studies with all new project provider sites

Clinical:

- ➢ Developed a formal definition of COD-capable services
- ➢ Completed a screening pilot in all pilot/enhancement sites that has informed leadership decision making on directions for future screening policy
- ➢ Began the development of clinical protocols and standards, including identifying a standard screening tool and assessment protocols.

Pilots, Peers, Technical Assistance:

- ➢ Engaged more consumers in active participation on the grant by instituting a Consumer Input Group that is actively working on marketing and training manuals for consumer outreach to agencies and other consumers in the community
- ➢ Added 20 new pilot enhancement sites to the project
- ➢ Provided ongoing training and technical assistance to 20 new pilot sites
- ➢ Revised budget projections to potentially provide continuation of enhancement sites until the end of Year 5
- ➢ Provided an innovative Teleconference Series on Multi-Cultural Responsiveness in Maine
- ➢ Public Relations activities include work with the Partnership for a Healthy Maine project on Smoke Free Housing/Behavioral Health Committee, the Council on Compulsive Gambling, high risk drinking for youth, and integrated behavioral and primary health care.

COMMENTS

State Infrastructure:

This year has seen some significant progress on State infrastructure goals. We have been successful, with the help of our consultants, in engaging the Commissioner of the Department to issue an Integrated Services Policy Statement. We have met several times with the Departmental Management Team to increase buy- in and to work at broadening ownership of the initiative to all offices within the Department. The Commissioner has been supportive of our efforts at encouraging regulatory change as well as our focus on Maine Care policy. In February, 2008, Maine adopted licensing regulations that incorporate co-occurring language in the Regulations for Licensing and Certifying of Substance Abuse Treatment Programs. The Office of Substance Abuse and Division of Licensing and Regulatory Services have jointly designed a provider training module on

the new co-occurring licensing rules, and the OSA/DLRS training team began offering it to all OSA providers, including COSIG pilot agencies, in March 2008. We have held at least two consultation meetings with the Commissioner's Office and the Management Team outlining next steps for Co-occurring implementation. We are proceeding with work on Data Integration Reports, Cost Study, and explorations of rate setting.

Training and Evaluation

Of significance this year was a Mid-Course grant evaluation conducted by our evaluators, Hornby Zeller Associates (HZA). As part of the evaluation process, HZA contacted multiple Department members to assess their level of engagement with the grant as well as their feedback for the Project Team about our effectiveness. The process of conducting the evaluation in this way helped to increase buy-in from managers and served as a basis for much of the discussion that was held in a consultation/training meeting with the DHHS management team conducted by our consultants in October, 2007. Data collection by our evaluation team is beginning to provide very interesting and relevant outcome data on the work of the pilot and enhancement sites. In addition, we have set up a system for monitoring our sites' accountability and compliance with their contract requirements. We also conduct pre- and post-fidelity studies with each site using the Maine version of the DDCAT.

Training continues to occur in multiple formats that include Regional Meetings for Pilots and Providers, teleconferences, day-long conferences with both national and state expert presenters, ITV broadcasts of interactive training on our Co-occurring Curriculum, on-line access to our Co-occurring Curriculum, and consultation with Drs. Minkoff and Cline in various formats for both the Project Team and the Pilot Sites. We also train our Pilot Sites in the NIATx Rapid Cycle Change process to provide them with a change technology process that will enhance their capacity for implementing new COD practices and hold bimonthly meeting with all the current pilot sites. Support and monitoring is done also through individual sites visits by project staff.

One of the highlights of this year's training was a nine-session Teleconference Series on Multi-Cultural Responsiveness that provided presentations from each of the major cultural groups in Maine including our many refugee populations. In general, teleconference presentations have become an effective way of providing training that is cost effective, convenient, and very much sought after by providers. We have engaged many national presenters on various topics for these presentations, many of whom were identified through COCE.

A total of 603 different agencies have participated in these training opportunities. In Grant Year 4, it is anticipated that another 1,000 people will have received 150 hours of training or consultation and 10 more expansion sites will have fully implemented the CCISC model for co-occurring change.

The principal consultation and technical assistance for the grant is provided by Doctors Minkoff and Cline, who provide direct assistance to project staff on a monthly basis. The technical assistance supports the project's strategic planning and on the State level, the development of the integrated procedure, policies, indicators, regulations and other structural supports for co-occurring work. In addition, consultation has been provided to the State leadership, regional performance partnerships, and to the pilot and expansion sites. Doctors Minkoff and Cline met with 47 agencies (80 persons) at the beginning of the grant and met individually with each of the first expansion sites, with the second expansion sites as a group, and will meet with the next and final round of expansion sites. They led a State leadership summit in 2007 and have an ongoing role in assisting the State to implement CCISC within their own departments.

Mentoring activities by the three regional pilot sites have been provided through participating on the regional consultation teams, offering training, and by hosting monthly clinical consultation study groups in each of the three regions. One pilot agency has held focus groups with the interpreters of the various cultural groups who are represented here in Maine. Case consultation is being implemented in the expansion site meetings and will be facilitated by sites that are farther along in their implementation processes.

Learning communities and partnerships have been formed in each three regions in the State and across the expansion sites in order to engage and support agencies in their efforts to enhance their services. The Regional Performance Partnership meetings initially began with quarterly meetings but have moved to bimonthly meetings with approximately 20-30 agencies participating. Examples of training topics that have been provided to these groups include technology transfer, lessons learned from pilot agencies, cultural competence, local development of self-help meetings, and, more recently, training on polices developed through the committees.

Various training activities with different formats have been developed and implemented in order to best reach and engage agencies and clinicians from across the State. These formats include teleconferencing, interactive video teleconferencing, regional trainings, presentations by pilot sites to other pilot sites, on-site agency training, and workshops.

In addition, there have been numerous presentations by the mentor agencies, consumers, and project staff on a variety of clinical topics, including consumer recovery stories, basic co-occurring integration, and the COSII initiative itself, both in-state and out of state. Audiences have included primary care providers, criminal justice providers, professional organizations, schools, and behavioral health providers. A series of Motivational Interviewing workshops were held in each of the three regions in Years 1 and 2. In Year 3, treatment planning workshops will be held across the State to share and implement the work that is occurring within the State committees. It is anticipated that during the remainder of Year 3 and into Year 4, training on system changes will continue with expected implementation of integrated regulations and enhanced contract expectations. During Grant Year 3, a three-part series is being offered to ACT teams across the Maine on the IDDT model. Marc Bono is engaged to provide such training. Five teams currently

have taken advantage of the training. Other workshops and conferences on co-occurring topics have been made available through CCSME and through technical assistance requests from COCE. Examples of such requests include: a workshop on data and quality.

During Year 4, the focus will be on compiling and making available through the website and other listings (such as OSA's Information and Resource Center) the lessons learned and materials developed, so that these resources can continue to support and sustain future work on co-occurring disorders. In addition, the Co-Occurring Institute is anticipated to be an ongoing annual event to showcase the ongoing advancements and work occurring across the Northeast in years to come.

Pilot and Enhancement Site Work

Our three original Pilot Sites, one from each region of the State, continue to contract with us through July of this year. They provide ongoing data and mentoring/training of the enhancement sites, and input on strategies for integrated care and implementation. The first round of enhancement sites began their work with the project in January,2007, a second cohort began this January (2008), and the third cohort will begin in January, 2009. Each is contracted for 18 months. We expect to be able to continue working with these sites through the end of Year 5 of the grant, assuming our expected funding is available. The three primary pilot sites will continue with their mentoring activities. At this point, we recognize the need for more careful engagement with the enhancement and pilot sites to track what specifically they are doing that is different from business as usual to account for the outcomes we see in the data. Often, while they tell us they are making specific changes, reviews of charts do not seem to support, or at least not to document, this activity. Our goal for the coming year is to be much more specific in our evaluation and questioning of clinical practice. We will implement a case review process at pilot site meetings and the Project Team will meet regularly for pilot and enhancement site review.

A Screening Pilot was completed at the end of the summer. The co-directors of the project made a decision to require standardized screening from all providers. We have identified a screening tool, the AC-OK, developed by Andrew Cherry of the Oklahoma COSIG team, that will be adapted for use. It will be piloted for 90 days at our new sites, and then implemented state-wide. Implementation will require significant work and planning.

The Minnesota State Narrative

Minnesota is in its second year of participation with the Co-Occurring State Incentive Grant (COSIG) to expand infrastructure development activities for co-occurring disorders treatment. Systems transformation under this grant will include the implementation of the Evidence-Based Practice known as Integrated Dual Disorder Treatment (IDDT) in the mental health treatment system, and Integrated Services for persons with co-occurring disorders in the addictions treatment system. Grant activities are focused on meeting five capacity building goals:

- *Standardized screening and assessment for co-occurring disorders in both mental health and chemical dependency settings*
- *Complementary licensure and credentialing requirements for mental health and chemical health clinicians*
- *Service coordination and network building between mental health and chemical health treatment providers and their local healthcare clinics*
- *Financial planning for co-occurring disorders services*
- *Information sharing: Technical assistance to provider agencies, State publications and reports on co-occurring disorders, and electronic news updates and information on co-occurring disorders treatment in Minnesota.*

Systems transformation activities highlights over the past year have included:

<u>Service Capacity Development</u>

- The selection of 20 demonstration sites to implement co-occurring disorders services

- Conducted 21 IDDT and 9 DDCAT fidelity scale rating scales at demonstration sites and upon request by other treatment providers interested in implementing co-occurring disorders services;
- The development of technical assistance tools, including a state website on co-occurring disorders treatment activities, publication of a monthly newsletter highlighting specific areas of policies and procedures supportive of systems change, such as writing mission statements, developing waiting room materials, and writing policies and procedures on screening and assessment, developed a state listserv to encourage sharing of information between demonstration sites, a monthly "Implementation Leader Network" teleconference to underscore and support the unique role of the implementation leader, the development of a state-level advisory workgroup to discuss clinical competencies, program guidelines, and financing models for co-occurring disorders services
- Developed a course of 36 hours of training for demonstration sites
- Provided motivational interviewing training to over 1000 counselors
- Developed coaching circles as part of ongoing skill development of motivational interviewing

State Policy Work

- The development of a state-level policy and technical assistance center
- Developed a state-level policy team as a vehicle for cross-divisional policy making
- Developed a state policy statement on the implementation of evidence-based practices
- Developed a state policy evidence-based practice internal workgroup to address statewide implementation, technical assistance and policy to give direction on how transformation can and should occur across multiple evidence-based practices

The Missouri State Narrative

Project Period:
September, 2003 – September, 2008
Key Personnel:
Project Director: Andrew L. Homer, Missouri Institute of Mental Health
Project Co-Director: Joe Parks, M.D., Missouri Department of Mental Health
Evaluation Directors: Ron Claus & Heather Gotham, Missouri Institute of Mental Health
Training Director: Pat Stilen, Mid-America Addiction Technology Transfer Center

PHASE I GOALS

Treatment

- Implement pilot co-occurring treatment at 14 sites across Missouri.

Half the sites were alcohol and drug treatment centers, which used TIP 42 as the model for services development. Half the sites were mental health treatment centers, which used the IDDT toolkit as the model for services development. There were seven rural and seven urban sites. Half of the sites had contracts with the State for both alcohol and drug and mental health services. The other half were free-standing mental health or alcohol and drug treatment centers.

Screening and Assessment

- Implement standardized screening and assessment instruments at the pilot sites.
- Evaluate the screening and assessment protocols.

Training

- Conduct intensive cross-training on attitudes, awareness and values related to co-occurring substance-related and other mental illnesses.
- Provide intensive training on Motivational Interviewing.
- Conduct leadership training.

Evaluation

- Collect client data at admission and 6-months post admission.

- Conduct fidelity assessments at pilot sites.
- Assess awareness of, attitudes towards and utilization of self-help among clinicians at the pilot sites.
- Conduct statewide surveys of provider utilization of evidence-based practices for treating individuals with co-occurring substance-related and other mental illnesses.

PHASE I ACCOMPLISHMENTS

Treatment

- Identified rules and regulations that hindered services for clients with COD, which led to clarification and several rule changes
- Fidelity measures showed that most agencies increased capability to appropriately treat clients with COD (e.g., SA sites contracted for medication services and hired MH staff; MH sites contracted with SA staff and provided SA treatment groups).

Screening and Assessment

- Implemented standardized screening and assessment tools at 14 pilot provider sites:
    - CAGE-AID and MHSF-III
    - ASI and CDIS
- Completed a feasibility study of the tools:
    - Staff from all sites provided feedback & comments
    - Found little support for CDIS, changed to use the MINI
    - Identified training needs & approaches to make MINI implementation run more smoothly

Training

- Provided intensive cross training throughout Years 1 and 2:
    - 14 sites divided into three regions
    - 189 hours of training
    - Provided intensive training on Motivational Interviewing at all 14 sites
- Increased level of awareness regarding COD and need for more appropriate treatment services across the State.
- Increased communication between mental health and substance abuse staff and agencies.
- Conducted training for future leaders focused on COD services.

Evaluation

- Client data collection project just completed.
- Completed and reported results of two fidelity assessments.
- Completed and reported results of self-help utilization.
- Completed and reported two statewide surveys of utilization of COD practices.

PHASE II GOALS October, 2006 – September, 2008

Implement Sustainable Changes in Infrastructure

- Program Certification Standards for COD programs in mental health and alcohol and drug abuse
- Counselor credentialing
- Medicaid reimbursement for COD services

Statewide Implementation of Standardized Screening and Assessment Protocols

- MHSF-III for Mental Health Screening
- CAGE-AID for Alcohol and Drug Screening
- ASI for ADA Assessment
- M.I.N.I. for Mental Health Assessment

Treatment

- Work intensively with a select group of treatment agencies interested in developing evidenced-based programming.
- Alcohol and drug treatment programs will use TIP 42 as the model for services development.
- Mental health treatment programs will use the IDDT toolkit as the model for services development.

Evaluation

- Conduct fidelity visits to Phase II sites every six months starting in October, 2006:
    - DDCAT/IDDT tools, organizational readiness to change, leadership, staff attitudes toward evidence-based practices, attitudes about COD and 12 step services
    - Develop client-level assessment of fidelity to accompany the DDCAT

The New Mexico State Narrative

The work of COSIG New Mexico is based on 13 goals, developed by the grant writers and refined through the input of multiple stakeholders, including the COD Policy Academy. The project goals can be divided into three major areas:

1. *Statewide System Change* in service definitions, COD-related policies, and clinical education;
2. *Implementation of Evidence-Based Clinical Practices* (EBPs) through training and technical assistance at demonstration sites and other programs; and
3. *Consensus-building* at all levels, with a particular emphasis on consumer input.

Highlights of NM COSIG efforts during the past year include:

- Implementation of evidence-based practices for adult co-occurring services at three COSIG Demonstration Sites: two community mental health centers and one substance abuse residential treatment center. Implementation priorities are identified in an Implementation Work Plan, which reflects assessment results (IDDT, GOI and/or DDCAT) and program preferences.
- Development of an evidence-based model for Community Treatment of Youth with COD (Youth Model).
- Use of Youth Model to draft Youth Assessment Tools modeled on the IDDT fidelity scale and the General Organization Index (GOI): Youth Fidelity Scale for integrated community COD services and Youth Organizational Index.
- Implementation of evidence-based co-occurring services for youth at a COSIG Demonstration Site: a community-based youth program in Albuquerque. Implementation

priorities are identified in an Implementation Work Plan, which reflects assessment results and program preferences.

- Significant improvement in fidelity assessment scores at all Demonstration Sites over a 12-month implementation period.
- Continued representation on the State's Service Definitions Committee to ensure adherence to EBPs and inclusion of services for co-occurring disorders.
- Participation in formation of Native American COD Policy Academy based at New Mexico's Santa Clara Pueblo.
- Partnership with the New Mexico Native American Co-Occurring Disorders Workgroup to offer a series of clinical trainings on effective integrated COD services to Native American providers.
- Meeting with the New Mexico Administrative Office of the Courts to discuss value and viability of COD tracts in youth and adults courts.
- Development of a low-tech, inexpensive web-based (Skype) approach to interactive training and supervision. This is being used in Community Reinforcement Approach trainings at a COSIG demonstration site.
- Use of Corrections Behavioral Health consultant, Judy Cox, to work with multiple state agencies to develop recommendations for improved services to recently released prisoners with co-occurring disorders (Re-entry Project).
- Presentation at a Juvenile Justice conference on implementation of evidence-based services for youth with co-occurring disorders, based on work at youth COSIG Demonstration Site.

The Oklahoma State Narrative

Background

Oklahoma chose to integrate treatment through model rather than pilot programs. Labeling seven chosen programs as 'pilots' conveyed the connotation that they would "go away" when the grant ended. The message the Oklahoma COSIG project wanted to convey was one of sustainability, so the term *model program* was chosen. To further the concept of permanence, the COSIG project was named the Integrated Services Initiative (ISI), and it was made clear that the ISI would continue following the grant.

Almost immediately, the number of model programs was expanded to 15 at the urging of our Zialogic consultants and requests by the provider community. This recommendation followed a statewide tour promoting integration of treatment for persons with co-occurring psychiatric and substance use disorders. The positive reception Drs. Ken Minkoff and Chris Cline encountered on the tour allowed the State to expand the number of models. The programs were chosen as a strategic mix of mental health and substance abuse providers in areas of heavy service and in a rural area.

Model programs sign a Consensus Document and agree to:

- Assume leadership in the development of a single comprehensive system of care in their respective areas.
- Achieve co-occurring capability for their organizations.
- Conduct self-assessments using the COMPASS and CODECAT self audit instruments at regular intervals.
- Implement universal screening; provide training in their local areas as well as other areas of the State.

These programs received a small financial incentive for accomplishing certain tasks, including training staff, doing an agency-wide self audit, and active participation in ISI committees. Agencies other than the models were invited to be involved in the process on a voluntary basis. These *participating agencies* did not receive financial incentives but neither were they held to the deadlines required of the model programs. They participated at their own pace.

Today
Now, in the fourth year of the grant, the interest level and the number of provider agencies wanting to participate on their own prompted the COSIG team to walk the ISI out to each and every agency offering mental health and substance abuse services in Oklahoma. To accomplish this, an additional 13 model programs were chosen in key geographic locations, allowing all providers to partner with a continuum of care that includes a mentoring program.

Much of the interest has been prompted by changes in Oklahoma Department of Mental Health and Substance Abuse Services regulations expecting co-occurring capability of each and every provider of services in Oklahoma. However, the overwhelming attitude among providers of both mental health and substance abuse providers has been that integrating treatment is needed and overdue. This opinion appears to be the primary explanation for the voluntary involvement of agencies.

Formed under The Integrated Services Initiative Advisory Group (ISIAG), with subcommittee groups to work on Outcomes and Evaluation, Welcoming/Screening and Assessment, Training/Workforce Development, Finance, Systems Integration and Performance Improvement, the ISI has made excellent progress toward integration of treatment for co-occurring disorders (COD). The ISIAG structure brings together consumers, advocates, providers, State office staff and representatives from other State agencies. Serving on these subcommittees provides a way for stakeholders to actively have a say in the way integrated treatment is implemented in Oklahoma. All activities and products developed are routed through the ISIAG. Regional Change Agent Planning groups have been established which meet monthly. Executive Planning Groups comprised of the chief executives of each of the model programs also meet monthly and work closely with the Change Agent Groups.

Accomplishments
Accomplishments of the Oklahoma COSIG/ISI process include:

Welcoming, Screening, Assessment & Recovery Planning: Development of a comprehensive process that establishes welcoming, engagement, integrated screening, assessment and recovery planning in every ODMHSAS-operated and contracted facility offering treatment for mental health and substance use issue. The process seeks to involve the person seeking services in planning their treatment and serves as a guideline for agencies to use when writing their policies. No tools or instruments are mandated; instead, the developed process emphasizes the expectation of COD in each person seeking treatment and establishes assessment as an ongoing process throughout treatment.

Improvements in Screening for COD: The recovery planning process establishes screening as a formal process for the first time in our system. Previously, screening was part of the assessment process. At the beginning of Oklahoma's first year of COSIG involvement, we were identifying only 8 percent of those seeking treatment as having co-occurring psychiatric and substance use disorders, much lower than the 50 to 70 percent that national data suggested we should be seeing. Today, nearly 35 percent of those who seek services from the ODMHSAS system of care are recognized as needing care for COD. While still low, we continue to improve. A common screening instrument for use by mental health and substance abuse providers was created, piloted, and has been evaluated for reliability and validity. The instrument is sound and is being made available to any provider who wants to use it (though its use is not mandated). It is believed that the widespread pilot of this instrument helped increase our identification of persons needing COD services.

Consumer Involvement: Oklahoma decided from the outset of its COSIG participation to involve consumers at every stage of the process, from planning to implementation. Included has been an emphasis on peer-to-peer service that includes the hiring of persons in recovery to serve as Recovery Support Specialists, independent of grant funding. Grant funds were utilized to help establish Double Trouble in Recovery (DTR) groups in model programs. These groups emphasized safety and welcoming to persons who often did not feel comfortable and welcome attending other self-help groups. Today, several DTR groups have moved into communities and are thriving independently.

Changes in Rules and Regulations Requiring COD Services: A fundamental part of Oklahoma's effort to integrate services has been the stepped inclusion of language calling for co-occurring services in ODMHSAS operated and contracted facilities. This began with insertion of clauses requiring that treatment providers expect each person to have co-occurring disorders and screen for these conditions then link the person receiving services with providers supplying the appropriate services. Ultimately, the rules and regulations will require each provider in the system to be co-occurring capable. Many of these requirements have been placed in contracts initially to pilot them before being added formally to rules.

Changes in Contracts Promote Integration: Oklahoma has utilized separate contracts for mental health and substance abuse treatment services. As part of the effort to further integrate treatment, ODMHSAS leadership initiated a discussion on moving to a single contract which would allow any agency to provide the services for which they are capable. This would allow a continuum of services at several levels within each agency. Through COCE-arranged technical assistance, single contracts used in other states were examined and a single contract is now being used for all community mental health centers. It is hoped that next year such a contract will be utilized for all service providers. A review of Medicaid rules defining billable services for substance abuse treatment, group counseling, and case management has been conducted. The Centers for Medicare and Medicaid Services has agreed to include substance abuse services in the State plan.

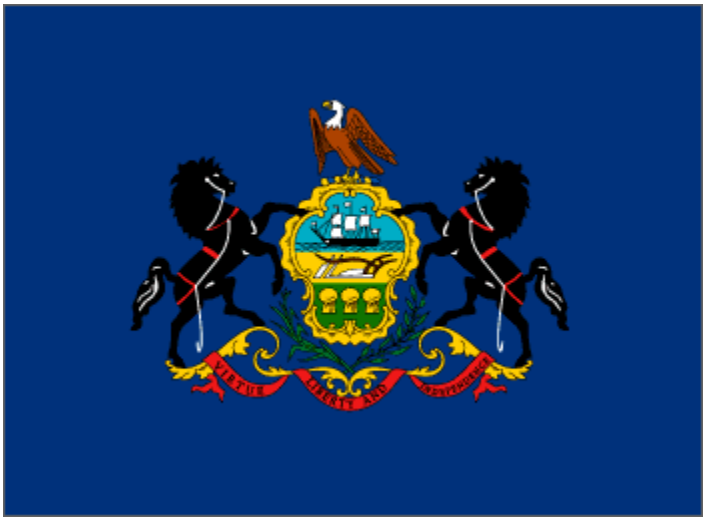
Expansion of Number of Mentoring Programs: The widespread acceptance of the principles of integrated treatment and the willingness of existing providers to implement integrated services has prompted the expansion to a total of 28. Oklahoma originally proposed using seven mentoring programs, expanded that to 15 and now has added another 13 programs, quadrupling the original proposal. These are programs which received incentives to implement integrated treatment on a prescribed timeline. Many other programs have chosen to participate voluntarily without financial incentives, prompting the COSIG team to begin a statewide walkout of integrated treatment principles to all providers in the system.

Training Curriculum: Part of the requirements for being a model program is that each program trains its staff in the principles of integrated treatment. Through a Training and Workforce Development Subcommittee, participants in the ISI developed a core training curriculum with a manual. Trainers have been developed in all model programs that carry this training to their individual agencies allowing staff to receive the core curriculum within their workplace. An intermediate and advanced training curriculum is in development and will be completed this year.

Licensure and Credentialing: Oklahoma has begun the process to directly affect change in the licensure laws governing counselors who offer treatment services. An ongoing committee has been established with members of all licensing boards to review possible changes in licensure related to COD services; it will continue to work on these issues until consensus related to the sanctioning of COD services among licensed professionals in Oklahoma is achieved.

Collaborations with Other State Agencies: Through other collaboratives, ODMHSAS is working with a large group of other State agencies to form working relationships with them, including the Oklahoma Health Care Authority (Medicaid), Department of Human Services, Department of Health, Office of Juvenile Affairs, Department of Corrections and others involved in delivering behavioral health services. This collaborative work will continue and the COSIG/ISI efforts will continue to link with this group.

Transformation: Oklahoma was fortunate to also be a recipient of a Transformation Grant, and the work of the COSIG/ISI group is being dovetailed into the work of the Transformation Grant. An ODMHSAS-wide meeting was held recently to discuss the roles of each workgroup within the Department an how each can contribute to the work of transformation. The entire COSIG/ISI team participated and will continue to be part of that effort.



The Pennsylvania State Narrative

Background:

Pennsylvania applied for a Co-Occurring State Incentive Grant (COSIG) in 2003 and was among the first cohorts to receive this award from the Substance Abuse and Mental Health Services Administration (SAMHSA). The primary goal of this infrastructure development process is to create a coordinated, effective system of behavioral health care for the provision of consensus and evidence-based co-occurring services by a trained competent workforce across the State.

COSIG Goals:

- To affect statewide infrastructure change, building on existing resources, and to support co-occurring services;
- To create and test an approval process for licensed facilities to deliver co-occurring services;
- To ensure core and advanced training curriculums and professional credentials are available to support ongoing workforce competency in treating co-occurring disorders;
- To identify a process for universal screening and assessment for co-occurring disorders across the behavioral health system;
- To develop a dedicated reimbursement mechanism for co-occurring service provision; and,
- To develop a process for data sharing across behavioral health systems

State Outcomes:

- Issuance of the Co-Occurring Disorder Competency Bulletin
- Establishment of State Policy for Co-occurring Services
- Universal screening and assessment process for co-occurring disorders
- Draft set of outpatient integrated treatment regulations allowing the provision of MH/SA treatment under a single licensure framework
- DOH/DPW Memorandum of Understanding for oversight of co-occurring services
- Co-Occurring Adult and Adolescent Training Curriculum
- Competency-based Co-Occurring Disorder Professional Certification (CCDP)
- 50 Certified co-occurring trainers across the State to provide local access to required co-occurring training topics
- Dedicated co-occurring resource and training website
- Development of a co-occurring training module for certified peer specialists
- Inclusion of co-occurring screening and assessment performance indicators in all HealthChoices contracts, Pennsylvania's statewide mandatory Medicaid behavioral health managed care program
- Development of a special payment indicator for co-occurring services reimbursement rates.

The South Carolina State Narrative

Overall Project Goal

The SC DOORS TO RECOVERY project represents a bold initiative between South Carolina's Department of Mental Health (SCDMH), Department of Alcohol & Other Drug Abuse Services (DAODAS), and State Agency of Vocational Rehabilitation (SCVRD). The project is designed to:

> *Improve recognition, diagnosis, and treatment of co-occurring mental health and substance use disorders through a uniform screening and assessment protocol, intensive training and cross-training of staff in best practices, and better collaboration and information sharing.*

Important changes in the service systems of each of the three collaborating agencies are being developed during the first two years of the grant, with pilot projects serving as test sites for implementation in two regions of the State. Once perfected, these changes will be disseminated statewide during the later years of the grant.

Through consultation with COCE in the development of the project Action Plan, the original project objectives were revised to reflect the need for policy development in key objectives. As revised, the objectives now read:

1. To develop and implement a standard protocol for screening and assessment of co-occurring disorders (COD)
2. To develop a competent workforce for co-occurring disorders
3. To improve and expand service coordination
4. To review and implement COD treatment
5. To review and expand stakeholder involvement and leadership coordination
6. To develop financial options
7. To develop MIS systems to identify COD clients and the client management system to allow service providers to share relevant client information
8. To develop a mechanism for gathering SAMHSA required data
9. To develop and implement a strategy for expanding COD services statewide

SC DOORS TO RECOVERY

Leadership and Structure

Project leadership and governance was structured to provide maximum opportunities for collaborative decisionmaking by key stakeholders at multiple levels.

Leadership Council
Agency heads and executive staff from all three partnering agencies and the Governor's Office meet every other month to provide guidance and oversight.

Sub-Group Leaders
Agency department heads meet regularly to review and provide leadership on a variety of COSIG issues.

Workgroups

- Screening & Assessment / Treatment Services
- Workforce Development
- Policy Development/Systems Integration
- Financing
- Management Information & Data Systems

Accomplishments

Standardized Screening, Assessment, & Treatment

- Working on identifying and comparing services provided across agencies, commonalities, billing rates and parity between DMH and DAODAS; exploring other States' Medicaid billing practices and possible options for SC.
- Identified new or current training modules utilized by each State agency into which COD screening and assessment training will best be integrated. Training department of DMH is developing a four-hour course on COD, including screening and assessment, to be delivered to all agency clinical staff in 2008. DAODAS will explore incorporating this into the curriculum of their Assessment, Intervention and Treatment Planning Course. VR is developing a new training module.

Workforce Development

- Developed a comprehensive statewide training plan based on the assessment of COD competencies and training completed through key informant interviews, literature review, and previous needs assessment
- TIP 42 and Privacy training are being offered in numerous locations statewide.

Service Coordination, Systems Integration, and Network Building

- Developed a set of "Guiding Principles" in areas corresponding to COSIG Workgroups: Finance; Screening/Assessment/Treatment; Data; and Workforce. Guiding Principles will serve as

attachment to a Policy Statement from each agency relating COD programming to mission of the agency and welcoming environment.

Financial Planning

- Finalizing Medicaid proposal to request approval to allow parity in billing frequency for a specific range of covered services between mental health and alcohol and drug providers. Proposal to be submitted to SCDMH and SCDAODAS executive staff for approval prior to Medicaid agency.

Management Information & Data Systems

- Co-occurring Measures (screening, assessment, treatment type)
- Developed, piloted and refined an online system for collecting co-occurring measures. This system is currently being used by the pilot sites; use will be expanded as additional sites are added.
- Client Management System (CMS) data
- Developed a web-based HIPAA compliant client information/management system designed to provide access to aggregate and client specific data for performance of clinical and/or administrative duties. This system provides access to Medicaid claims data (diagnosis, services received, dates and amounts paid) and Medicaid eligibility application (category of assistance, geographic data) for the purpose of care management activities. It is a tool for insuring appropriate care, follow-up and management, by referral to and coordination with other agencies and Medicaid providers.

The South Dakota State Narrative

GOALS

1) Improve the recognition of co-occurring mental health and substance abuse issues;
2) Increase the provision of co-occurring treatment services across the State;
3) Form system enhancements that will result in more welcoming, accessible, integrated, continuous, and comprehensive services for individuals with co-occurring disorders;
4) Create a quality improvement partnership between the Division of Alcohol and Drug Abuse and the Division of Mental Health so that all agencies and programs engaged in the process become co-occurring capable; and
5) Develop and/or increase core competences of all clinical staff to improve treatment for individuals with co-occurring disorders.

CURRENT ACTIVITIES

State Level Infrastructure

The South Dakota COSIG project received funding for FY 2008, but started this project two years ago. At that time, the core group, the Steering Committee, identified the needs of the State and reviewed ways in which services could be integrated. The Steering Committee was re-established as the Executive Team of South Dakota. This group is comprised of the Director of the Division Alcohol and Drug Abuse, the Director of the Division of Mental Health Dakota, the Administrator of Human Service Center (the only State hospital in South Dakota), the Executive Director of the South Dakota Council of Mental Health Centers/South Dakota Substance Abuse Directors, the Program Management Consultant, and the Program Manager. South Dakota contracted with Black Hills Special Services in December of 2007 to become the program management consultant to the State for this project. This team then hired a program manager though Black Hills Special Services for this project. She began her duties on March 31, 2008. South Dakota also contracts with WICHE for Outcome data collection and with Zialogic, Inc. for technical assistance and ongoing training needs.

The Executive Team meets monthly to work on project goals and objectives. Some of the immediate tasks will be to review the administrative rules and regulations to reflect the type of services expected by service providers within the State. The Executive Team has already had the consultants from Zialogic, Inc. review these and recommend changes. They will also be looking at billing structures to address financing co-occurring disorder services.

In December, the Executive Team released a draft of the "Recovery-Oriented System Transformation" for adults, children, and families with mental health, substance abuse, and developmental disorders and disabilities charter for South Dakota. This was distributed to all change agents in December (see below). The curriculum was developed with the assistance of Zialogic, Inc. Both the Division of Alcohol and Drug Abuse and the Division of Mental Health have also revised agency contracts for the upcoming fiscal year to outline the use of co-occurring services within accredited agencies.

The Executive Team has also created the COD Advisory Group, comprised of the Executive Team members, staff from the Division of Mental Health and the Division of Alcohol and Drug Abuse, the consultants from Zialogic, Inc., and WICHE. Division staff will be completing the CO-FIT in the upcoming months to continually refine goals and objectives for the next fiscal year. Division staff will also be implementing changes in accreditation reviews to offer additional support to agencies in integrating their services and reviewing progress. Barriers to progress will be reviewed and brought back to the Executive Team to advise further systems integration.

Program Level Activities

South Dakota has identified 31 participating agencies in this project. Most have been involved for almost two years and have already made progress in becoming co-occurring capable agencies. While some agencies have just started evaluating their services, all have voluntarily expressed their interest. These agencies are comprised of community mental health centers, drug and alcohol treatment agencies (inpatient and outpatient), State operated correctional mental health and alcohol and drug abuse treatment programs, inpatient psychiatric residential treatment facilities, and the State-directed psychiatric hospital and chemical dependency program. The Executive Team also arranges for selected agencies to receive quarterly technical assistance in implementing the CCISC implementation model. At the present time, a few agencies have already received two visits from the consultants from Zialogic, Inc.

Welcoming

All of our agencies are working on welcoming practices and policies within their own agencies. One agency has developed a Welcoming Team to promote further changes.

Screening and Assessment

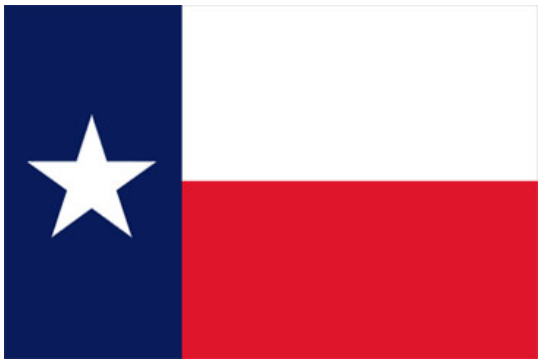
Provider agencies are also looking at how to sufficiently screen and assess for co-occurring disorders. While this is in the early stages, a few agencies have already started this process by reviewing screening tools and implementing the use of these tools at intake.

Workforce Development

The first change agent meeting took place in December 2007. Approximately 80 individuals representing the provider agencies from across the State of South Dakota attended this meeting. Change agents also attended the March 2008 meeting and another is scheduled for May 20, 2008. These meetings involved direct training from the consultants from Zialogic, Inc. All change agents have received the training curriculum. Expectations of change agents have been outlined and include: providing training and supervision in accordance with the principles of the CCISC model in order to establish and enhance dual diagnosis competency in the program staff; and provide program consultation to facilitate development and implementation of quality improvement action planning to establish and enhance dual diagnosis capability in the program as a whole. They are also encouraged to provide feedback to the Executive Team regarding policy support. They are asked to share their expertise and offer support to fellow colleagues across the state. This feedback is encouraged through the use of the web-based site for South Dakota at http://co-occurringdisorders.wikispaces.com/

Other Significant Activities

The Executive Team is working with WICHE to develop data collection tools for the project. Additionally, the management information system used by both divisions will be updated to include more co-occurring data.



The Texas State Narrative

Goals and Objectives

The Texas COSIG project supports the State's capacity building goals to

1. *Train* clinical staff on specific competencies in order to screen and assess for co-occurring psychiatric and substance use disorders (COPSD);
2. *Treat* both disorders in a comprehensive and coordinated manner that is seamless to the client and involves the client's family;
3. *Evaluate* the State's current practice for serving clients with co-occurring disorders; that promotes a "No Wrong Door" approach to placing clients into integrated services; and
4. *Utilize a voucher system* to access alternative resources that supports clients in treatment. The vouchers fund community supports that are not included in mainstream treatment. Allowable community supports are childcare, housing supports, transportation, temporary food assistance, and support for education, vocational assistance, clothing, medical care, prescriptions and peer mentoring.

The Texas COSIG project also supports the State's coordination and collaborative commitment with multiple State and local agencies in Texas to strengthen the systems of care for persons with co-occurring disorders through policy and curriculum development. The target population for this project consists of youth and adults with COPSD who are receiving substance and mental health treatment from the Texas Department of State Health Services who could benefit from adjunct community supports.

Achievements

- $941,560 of the carryover funds is enabling our COSIG voucher contractors to increase co-occurring capacity by voucher arrangements for allowable community supports. The carryover funds will provide services for an additional 549 consumers with co-occurring disorders in Texas by August 31, 2007.
- The award has enabled COSIG to dedicate $424,488 to the Client Management Behavioral Health System (CMBHS) project. The project is being spearheaded by the Department of State Health Services, Mental Health and Substance Abuse, and is designed to build an infrastructure that will allow for the delivery of the most effective services possible to behavioral health consumers in Texas. The focus for the CMBHS project is to integrate the substance abuse and mental health information system including data, business and clinical processes. To accomplish this goal, an

- The Gulf Coast Addiction Technology Transfer Center (GCATTC) at the University of Texas provides training and clinical technical assistance on the use of assessment instruments, including the Mini International Neuropsychiatric Interview (MINI), the Brief Symptom Index (BSI), the Brief Derogatis Psychiatric Rating Scale (BDPRS), the Client Evaluation of Self in Treatment (CEST), and the Substance Abuse Treatment Scale (SATS). All ten current programs have received initial and booster training on the use of these instruments as needed.
- The GCATTC is conducting the overall project evaluation and provides ongoing data collection and management of project-specific data. GCATTC is also currently conducting site visits to complete the Dual Diagnosis Capability in Addictions Treatment (DDCAT) assessment to provide a process evaluation measure for the evaluation.
- The GCATTC will develop a program self-rating COPSD fidelity instrument for the COSIG project to be available statewide for both substance abuse and mental health treatment providers. This project is currently underway and scheduled for completion in 2008.
- $24,300 of the carryover funds will be used to implement GPRA reporting and co-occurring measures that SAMHSA requires of COSIG.

The Vermont State Narrative

Major Goals

The primary goals of Vermont's Co-Occurring State Infrastructure Grant are to:

1. Re-design our respective information and business systems to support integrated treatment services;
2. Train and provide ongoing technical assistance and quality improvement to local clinical and administrative leaders on the principles and practices of integrated treatment using evidence-based approaches; and
3. Create and support community based programs for people with co-occurring disorders (COD).

Accomplishments (First 18 months)

- Working with 26 agencies including primary care, treatment courts, and homeless service providers on a quality improvement process based on the Dual Diagnosis Capability in Addiction Treatment tool fidelity tools.
- Established a statewide initiative to develop peer led co-occurring groups, consumer information, trainings, and education programs to be established in every county of the State.
- Established the Vermont Integrated Services Forum comprised of medical, substance use, and mental health providers, consumers, and State personnel that will guide the activities of the grant and share information and promote best practice for health integration.
- Developed a Co-occurring Policy Statement on co-occurring conditions for the Agency of Human Services and developed an e-learning site for online co-occurring 101 training.
- Implemented a mental health and substance use screening tool as well as a Homeless Management Information System that connects the statewide PATH homeless service providers.
- Developed an Integrated Services Web Site :**https://healthvermont.gov/mh/visi/**

The Virginia State Narrative

Goals

- Develop infrastructure to support service integration at all levels of the public mental health and substance abuse services system;
- Develop capacity to screen and assess consumers for co-occurring disorders; and
- Develop capabilities to provide treatment and other services to persons with dual diagnoses and promote the adoption of best practices, including Evidence-Based Practices.

Activities

Infrastructure development in the past year included the completion of the Co-Morbidity Program Audit and Self- Survey/COMPASS instrument by 23 Community Services Boards (CSBs) and four State hospitals. Based on the COMPASS results, quality improvement plans have been developed and implemented by 16 CSBs and two State hospitals. Ongoing technical assistance has been provided by project consultants Dr. Kenneth Minkoff and Dr. Chris Cline.

A State Steering Committee has been constituted which is comprised of consumers and advocates, staff of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, and staff of CSBs and State hospitals.

Funding for COD services has been expanded by working with the Department of Medical Assistance Services (Virginia's State Medicaid agency), to allow reimbursement for substance abuse treatment in the context of co-occurring disorders. This set the stage for Virginia's first-ever Medicaid Substance Abuse reimbursement policy, which became effective in July 2007.

Over $310,000 in grant funds were provided to CSBs in FY 2007 to support training in various clinical best practices. Project staff estimates that more than 3,000 clinicians from around the State have been trained with Virginia's COSIG grant funds. An online VASIP Workforce Survey was implemented in FY 2008 to obtain information about clinicians' knowledge, skill, and ability at treating MH/SA co-occurring disorders. More than 2,300 responses from all 40 CSBs

were received. Later in 2008, this same instrument will be used to survey staff in State hospitals.

Virginia's COSIG Project also sponsored a State Transformation Conference in September 2007 entitled "The Nitty-Gritty of System Transformation: How to Make It Happen." More than 325 clinicians and administrators from our public system attended the conference, which provided information to participants on the processes and challenges of system change. Nationally known experts Dean L. Fixen, Ph.D, David Mee-Lee, M.D., Kenneth Minkoff, M.D., Christie Cline, M.D., and Stanley Sacks, Ph.D., provided workshops on various aspects of implementing new practices and providing services for co-occurring disorders. The conference provided knowledge exposure training on a number of evidence-based and clinical best practices, including Integrated Dual Disorders Treatment, Double Trouble in Recovery, and Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT-5) for adolescents and others. In addition, sessions of interest to consumers were provided, such as Wellness Recovery Action Planning (WRAP) and Consumer Empowerment Leadership Training (CELT).

A comprehensive workforce development plan has been developed by the Workforce Development subcommittee of the Advisory Committee in collaboration with a number of partners, including the Mid-Atlantic ATTC, Virginia's SAC (State Adolescent Substance Abuse Treatment Coordination) grant known as Project TREAT (Training and Resources for Effective Adolescent Treatment), CSBs, and facilities. Plans are in place to incorporate this design into the Department's ongoing workforce development initiatives.

In March and April of 2008, scholarships were offered to enable mental health staff from CSBs and State hospitals and consumers to attend the Virginia Summer Institute of Addiction Studies which will take place in Williamsburg, VA the week of June 16, 2008. COSIG sponsored mental health staff and COD consumer attendance at the summer institute in July 2007 and attendees found it to be a helpful learning experience.

Planning has begun to offer, in collaboration with Project TREAT, a statewide screening and assessment conference to educate providers for adolescents and adults with co-occurring disorders. The conference is planned for Fall, 2008. It will target clinical staff and community partners such as staff from forensic services, social services, education, adult and juvenile justice, and CSA teams.