NYS Health
Center for Excellence in Integrated Care

FINAL REPORT

OF PROJECT ACTIVITIES

November 1, 2008   to   October 31, 2013

FINAL REPORT

OF PROJECT ACTIVITIES

November 1, 2008   to   October 31, 2013

Award 1 — 2008-2496857   *start* **November 1, 2008**

60 months *ending*   **October 31, 2013**

56 months of data collection began **November 20, 2008**; ended **June 27, 2013**

People First*: Center of Excellence for the Integration of Care (CEIC) for Individuals with Co-occurring Mental Health & Substance Use Disorders*

$ 3,201,644

Award 2— 2009-3426912   *start*   **January 1, 2010**

44 months *ending*   **August 31, 2013**

37 months of data collection began **May 10, 2010**; ended **June 27, 2013**

Expanding Technical Assistance Support and Reach of NYSHealth Center for Excellence in Integrated Care

$ 442,570

Award 3— 11-02788   *start*   **April 1, 2011**

31 months *ending* **October 31, 2013**

23 months of data collection began **June 21, 2011**; ended **April 10, 2013**

NYSHealth's CEIC:
Tracking Progress in NYS Addiction & Mental Health Providers' Provision of Outpatient Integrated Care

$ 282,524

FINAL REPORT OF PROJECT ACTIVITIES

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X. EXECUTIVE SUMMARY

x1.   ABSTRACT

Over the past two decades, "integrated treatment" has become a prominent strategy to meet the needs of clients with co-occurring mental health and substance use disorders. Early in 2008, the New York State *Office of Mental Health* (**OMH**) and *Office of Alcoholism & Substance Abuse Services* (**OASAS**) initiated system level policy changes to foster the integration of mental health and substance abuse services. Recognizing the importance of co-occurring disorders as a major health problem. *New York State Health Foundation* (**NYSHealth**) funded *National Development and Research Institutes, Inc.* (**NDRI**) to conduct this project, known as the ***Center for Excellence in Integrated Care*** (**CEIC**).

A large number of addiction and mental health outpatient clinics (**n=603**) participated in this far-reaching and ambitious initiative to assess and improve integrated services for New York State residents with co-occurring substance abuse and mental health disorders. The **603 programs** that had completed an initial (baseline) assessment of its capability to deliver integrated services to its clients with co-occurring disorders (the combination of mental health and substance use conditions) received an average overall score of 2.71, using standard instruments. This score, while below 3.0 (the "*Capable*" level on a 5-point scale indicative of a commendable level of service integration), was much closer to "*Capable*" than to "*Basic*" (a score of 1.0, indicative of the delivery of services for only one of the disorders).

To improve program performance, CEIC employed a multifaceted approach to technical assistance and implementation support that featured direct, "hands-on" methods that advanced realistic program changes, resulting in better client care and outcomes. At follow-up, an average of two years after the baseline assessment, and after having received CEIC's services, a sub-sample (n=150) had realized significant gains, scoring 3.04 (i.e., above "*Capable*"), and the proportion of programs achieving a "*Capable*" score had more than doubled, from 22% at baseline to 52% at follow-up. Addiction and mental health programs received similar average overall scores at baseline, and both showed significant improvement at follow-up; thus, the entire system of outpatient behavioral healthcare has improved, and is becoming "*Capable*."

A complementary analysis, using data from the **New York State** (**NYS**) *Office of Alcoholism and Substance Abuse Services* (**OASAS**) *Local Service Plan Evidence Based & Best Practices Intervention Survey* (usually abbreviated to "***Local Service Plan Survey***" or "LSP survey"), revealed significantly greater increases in "*Service Integration*" for programs that received CEIC services than those that did not. Furthermore, clients with co-occurring disorders who received outpatient treatment from programs with higher scores remained in treatment longer; prior research has consistently found that retention [more time] in treatment has produced better client outcomes. It seems reasonable to conclude that CEIC's *services contributed to the improvements evident in integrated care* and that *other statewide activities* (e.g., *policy changes, directives, and trainings*) *had an important and synergistic role*. CEIC disseminated findings from the project in many presentations throughout New York State as well as at national conferences, and has produced three manuscripts (peer-reviewed journals have published two of these articles, while the third is in review). CEIC's work to foster integrated care continues with funding to NDRI from the *Substance Abuse and Mental Health Services Administration* (**SAMHSA**) under the auspices of the *Northeast & Caribbean Addiction Technology Transfer Center* (**NeC-ATTC**) and from *The Nicholson Foundation* of New Jersey under a pilot project in *Federally Qualified Health Centers* (**FQHC**s).

x2. INTRODUCTION

Over the past two decades, "integrated treatment" has become a prominent strategy to meet the needs of clients with co-occurring mental health and substance use disorders (**co-occurring disorders**, or "**COD**"). Integrated treatment is generally considered to be any mechanism that combines treatment interventions for COD within a treatment or service setting (*Center for Substance Abuse Treatment*, 2005). A range of integrated approaches suitable for persons with COD have been documented in several comprehensive resources (e.g., *Center for Substance Abuse Treatment*, 2005; Drake, Mueser, Brunette, & McHugo, 2004; Drake, O'Neal, & Wallach, 2008; Nunes, Selzer, Levounis, & Davies, 2010), and a growing research base has been established for such approaches (see reviews by Drake et al., 2004, 2008). As a result, integrated treatment is widely perceived as the best choice for persons with COD.

Early in 2008, the New York State *Office of Mental Health* (**OMH**) and *Office of Alcoholism & Substance Abuse Services* (**OASAS**) initiated system level policy changes to foster the integration of mental health and substance abuse services, in accordance with the recommendations of their joint *Task Force on Co-occurring Disorders* (NYS OMH & OASAS, December 2007). The **New York State Health Foundation** (**NYSHealth**) regarded COD as a major health problem and recognized the importance of these State efforts. Thus, the Foundation included integrated care as a funding priority, formulating a contract solicitation with the objective of transforming the system of care for 1.4 million New Yorkers suffering from both mental health and substance use disorders. On March 25, 2008, NYSHealth issued invitations to bid and, in November of that same year, a contract was awarded to an arm of National Development & Research Institutes (NDRI), **NDRI-USA** (formerly NDRI State, Inc., which was reconfigured in 2013, becoming NDRI-USA) to establish the ***Center for Excellence in Integrated Care*** (**CEIC**).[1] A large-scale project, CEIC's purpose (as reported here) was to assess and increase the capacity of New York State mental health and addiction outpatient clinics to provide integrated mental health and substance abuse services in the areas of screening, assessment and evidence-based treatment for persons with COD.

In the summer of 2008, **OMH** and **OASAS** distributed guidance documents and recommendations in the areas of screening, assessment, and evidence-based treatments to the Directors of every licensed mental health and substance abuse program in the State (NYS OMH & OASAS, 2008a,b). That fall (November 2008), the NYSHealth **CEIC** initiative began its efforts to effect system-wide improvements in the degree to which services for substance use and mental health conditions ("co-occurring disorders" or "dual diagnosis") were integrated in the areas of screening, assessment and evidence-based treatment practices (EBPs) in licensed mental health and substance abuse outpatient programs. In January 2009, the OMH and OASAS Commissioners attended a NYSHealth press event in Albany to introduce CEIC to the State (NYSHealth, 2008c). Immediately following the press event, CEIC senior staff convened a kick-off meeting with their network of collaborators and advisors to solidify commitments and Statewide support for the initiative.

In April of 2011, NYSHealth expanded the scope of the project, funding CEIC to complete an evaluation of progress in integrating the NYS behavioral health care system[2] (NYSHealth, 2011). Almost five years later (October 31, 2013), the initiative had provided direct technical assistance and implementation support to 603 OMH- and OASAS-licensed outpatient programs. This ***Final Report of Project Activities*** outlines project activities and the status of the integration of care across the State system of outpatient care for mental health

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[1] Grant #**2008-2496857**, "*People First: Center of Excellence for the Integration of Care* (CEIC) *for Individuals with Co-occurring Mental Health & Substance Use Disorders*"; NYSHealth, 2008a,b,c). In January 2010, additional funding was awarded (Grant #**2009-3426312**; *Expanding Technical Assistance Support and Reach of NYSHealth Center for Excellence in Integrated Care*"; NYSHealth, 2010), which added 1 FTE to the technical assistance staff, thereby increasing the reach and penetration of the project. Dr. Shelley Scheffler was hired and devoted her time to the project from March 1, 2010 to August 28, 2013.

[2] The third award was approved with a start-date of April 1, 2011 and a planned term of 19 months (i.e., Grant #**11-02788**, "*NYSHealth's* CEIC: *Tracking Progress in NYS Addiction & Mental Health Providers' Provision of Outpatient Integrated Care*"; NYSHealth, 2011). Ms. Ashley Arner, Clinical Assessor, joined the project on May 16, 2011; her employment ended on November 21, 2012. The first follow-up assessment was completed on June 21, 2011; Dr. Scheffler completed the final follow-up assessment (n=150) on April 4, 2013.

and substance use; this ***Executive Summary*** condenses and encapsulates salient methods, results, and findings to provide an abbreviated version of the full report that follows.

x3. METHODS

Measures

McGovern and colleagues developed two *Dual Diagnosis Capability* (DDC) indices: one for use in *Addiction Treatment* (AT) settings — the DDCAT index (McGovern, Becker, & Lambert-Harris, 2007a; McGovern, Matzkin, & Giard, 2007b; SAMHSA, 2011a); and the other for use in *Mental Health Treatment* (MHT) settings — the DDCMHT index (Gotham, Brown, Comaty, McGovern, & Claus, 2013; SAMHSA, 2011b)— to measure the capability of programs to deliver integrated services. From their development in 2003[3] to 2010, these two indices have been used in over 30 state regulatory authorities, several large county governments, private treatment programs, and several nations (Gotham, Claus, Selig, & Homer, 2010; SAMHSA, 2012a,b). Published data from the DDCA[MH]T indices show that the vast majority (70-80%) of programs do not meet the "Capable" standard (a score of 3.0 on a 5-point scale; Gotham et al., 2010; Lee & Cameron, 2009; Matthews, Kelly, & Deane, 2011; McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2012a; McGovern, Lambert-Harris, McHugo, Giard, & Mangrum, 2010; Sacks, Chaple, et al., 2013).

The DDCAT and DDCMHT indices employed in this study included 35 items organized into 7 dimensions, enumerated in **Table x3[a]** below.

Table x3[a] — *DDC[MH]T dimensions and number of items in each dimension*

Item #	Dimension	# of Items	Item #	Dimension	# of Items
[1]	**Program Structure**	4 items	[5]	**Continuity of Care**	5 items
[2]	**Program Milieu**	2 items	[6]	**Staffing**	5 items
[3]	**Clinical Process –** *Assessment*	7 items	[7]	**Training**	2 items
[4]	**Clinical Process –** *Treatment*	10 items			

Each item was scored on a 5-point scale of *Dual Diagnosis Capability* with three anchor points: **1**="***Basic***," AOS (*Addiction Only Services*) or MHOS (*Mental Health Only Services*); **3**="***Capable***," DDC (*Dual Diagnosis Capable*); and **5**="***Enhanced***," DDE (*Dual Diagnosis Enhanced*). The score for each dimension is the average of item scores within that dimension, and the overall score is the average of the scores for the 7 dimensions themselves. Both the DDCAT (McGovern et al., 2007a,b; SAMHSA, 2011a) and DDCMHT indices have demonstrated good psychometric properties, including internal consistency reliability and inter-rater reliability (Gotham et al., 2013; SAMHSA, 2011b).

Site Visit Procedures

During the on-site visit, which lasted from 3 to 4 hours, an assigned CEIC assessor used either the DDCAT (for addiction programs) or the DDCMHT (for mental health programs) to obtain independent scores for the program. Assessors were senior clinical and research staff who had received training from the developer of the DDCA[MH]T indices, Dr. Mark McGovern. The primary data source was an in-depth semi-structured interview organized along the 7 dimensions of the DDCA[MH]T and administered collectively to a group drawn from key program staff (typically representatives of executive leadership, program directors, clinical supervisors, medical staff, and counselors); consumers were also interviewed whenever possible. The assessor obtained additional information from: observing program activities (such as client groups and staff

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[3] Development of the DDCAT began in 2003; development of the DDCMHT began in 2004.

meetings); talking with other program staff; reviewing program documents (policy and procedure manuals, clinical forms and charts); and touring the program facility.

Technical Assistance | Implementation Support

The approach to technical assistance and implementation support consisted of a series of four activities, collectively intended to build a program's capacity to provide COD clients with effective, high quality care.

- **Site Visit Feedback**. At the end of the site visit, the assessor provided preliminary feedback to program staff, summarizing key strengths to build on, and identifying immediate opportunities to improve COD capability. Thus, the baseline assessment provided not only a standard measure of COD capability, but also a framework and benchmarks for technical assistance.

- **Assessment Report**. Within a week of the site visit, the provider received a formal report that included:

[a] a narrative review of the assessor's observations and recommendations for improving the program's COD capability in each dimension;

[b] a program score sheet denoting the score received on each of the 35 items, summary scores for each dimension and overall; and

[c] a line graph of dimension scores, depicting the program's profile such that the provider could readily identify strengths and opportunities for enhancement.

The report's recommendations contained links to relevant training/technical assistance resources, including (but not limited to) webinars, curricula, workshops, and in-service training manuals (e.g., CSAT's *Treatment Improvement Protocols* [TIPs] and *Technical Assistance Publications* [TAPs]), NYS-level trainings (especially the web-based *Focus on Integrated Treatment* [FIT; Center for Practice Improvement [CPI], N.D.[a]) along with other relevant resources (e.g., journal articles, reports, fact sheets).

- **Implementation Support**. CEIC developed resource documents to support building capability (e.g., A template for drafting a clinic-specific *Implementation Plan*, "*Quick Guides*" that summarized the most common recommendations), along with detailed program guidelines (also available as a video) that provided a roadmap to achieving "Capable" or "Enhanced" levels of care. The primary emphasis was on "*Getting-to-Capable*"; i.e., changes that were easy to implement, required few resources, and circumvented barriers, yet could have a potent effect (e.g., welcoming clients; posting educational material; screening; starting a dual recovery group).

- **Forums & Workshops.** Follow-up workshops were offered to programs that had completed an on-site assessment. The "*Building Capability Forum*" was designed to reinforce feedback (from the on-site assessment and subsequent report), and to provide guidance for implementing recommendations. Specifically, providers were encouraged to develop an implementation plan with 5 to 7 goals (along with specific objectives) that could be achieved quickly. For providers who had not yet developed recovery approaches, and who reported significant barriers to implementing changes, a supplementary *Peer Recovery Workshop* was offered to assist in translating more traditional service delivery models into a recovery orientation.

Embedded in these four components were several other implementation principles and approaches, including:

[a] involving leadership and program staff from all levels;

[b] fostering rapid cycle change;

[c] facilitating peer-to-peer learning; and

[d] encouraging staff training.

The central idea was to use direct, "hands-on" methods to promote realistic program change that would improve client care and outcomes.

x4.   RESULTS

Results at Baseline

The **603** programs assessed at baseline received an average score of **2.71** (for the 7 dimensions combined; see **Figure x4[a]**), demonstrating that New York State licensed outpatient mental health and substance abuse programs were operating much closer to "co-occurring capable" (a score of 3.0) — a commendable level of service — than to "basic" (i.e., *Addiction or Mental Health Services Only* [AOS or MHOS]). Programs received the highest scores in the domains of **Assessment** and **Staffing**, which means that programs generally do a good job of identifying the presence of a co-occurring mental health or substance use disorder, and employ staff members who are qualified (or whose competencies can be upgraded through training) to accommodate the co-occurring conditions during the course of treatment. These results indicated that New York State programs had a solid foundation from which other changes could be implemented to increase the program's overall capability. The potential for advancement was greatest in the domains of *Program Structure*, *Program Milieu*, *Treatment*, *Continuity of Care*, and *Training*, areas in which certain improvements would be fairly easy to achieve given the current status of staffing and resources. The project demonstrated that COD capability can be assessed system-wide using direct observation.

Figure x4[a]—   *Average baseline* DDCA[MH]T *scores* (**n=603**) *by dimension and overall obtained from on-site assessments*
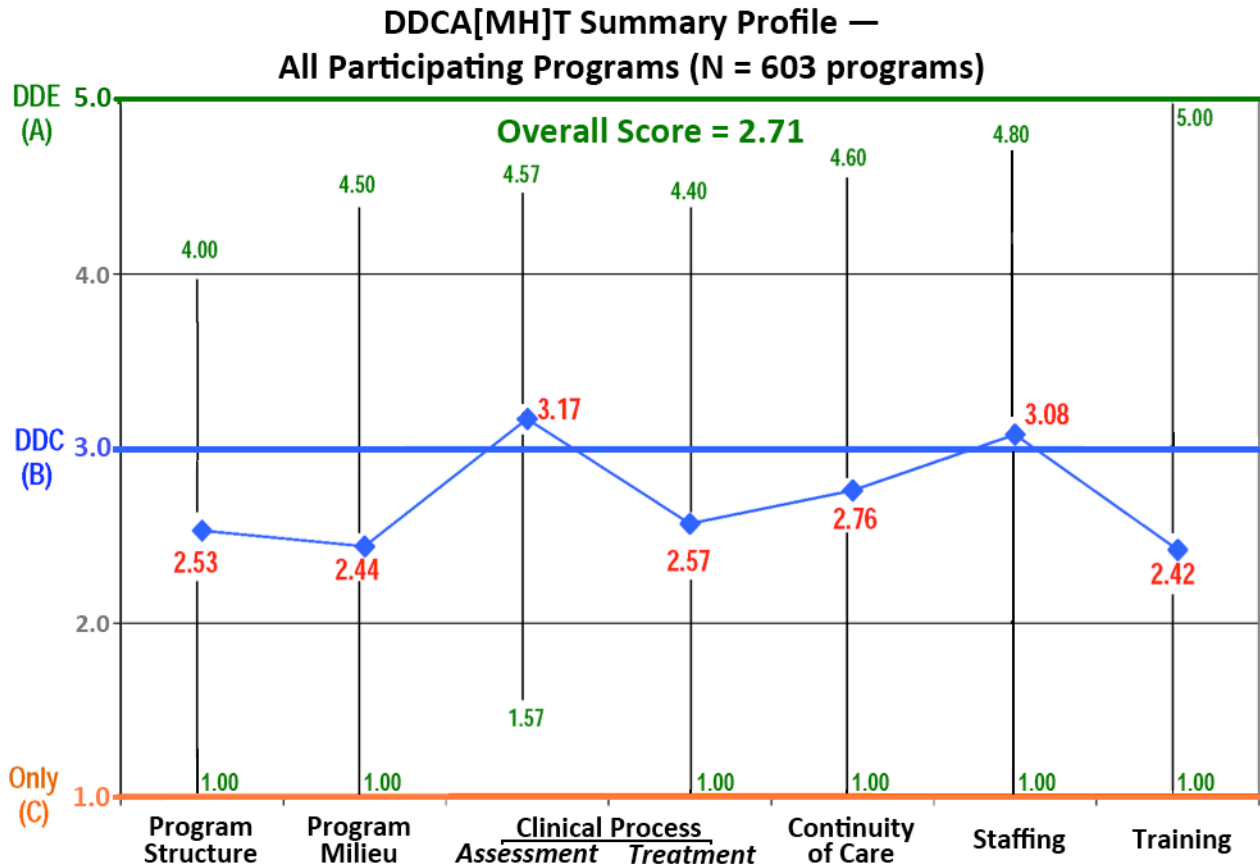
Results at Follow-up

CEIC conducted follow-up assessments of **150** randomly selected programs at least one year after their baseline assessment. The Assessor who conducted the follow-up assessment was different from the Assessor who conducted the baseline assessment; the follow-up Assessor did not know the results of the baseline assessment. The baseline DDCA[MH]T scores for the 150 programs (depicted in **Figure x4[b]**) had an average overall score of 2.68,[4] which demonstrated that these programs were closer to "*Capable*" (**3.0**=**DDC**) than to "*Basic*" (**1.0**= **AOS** or **MHOS**). The *Assessment* and *Staffing* dimensions had the highest baseline scores (above "*Capable*"), while *Program Structure*, *Program Milieu*, *Treatment*, *Continuity of Care*, and *Training* were all below "*Capable*." At follow-up:

- the average overall score had increased significantly to 3.04, shown in **Figure x4[b]**;
- significant gains were achieved overall and in each of the dimensions, ranging from a low of 0.16 for *Assessment* to a high of 0.68 for *Training,* shown in **Figure x4[b]**; and
- 78 of the 150 programs (52%) were rated "Capable" or above, more than double the 33 programs (22%) that were rated "Capable" or above at baseline, shown in **Figure x4[c]** (next page).

Figure x4[b]— *Average baseline and follow-up scores* (**n=150**) *by dimension and overall obtained from on-site assessments using the* DDCA[MH]T *indices**
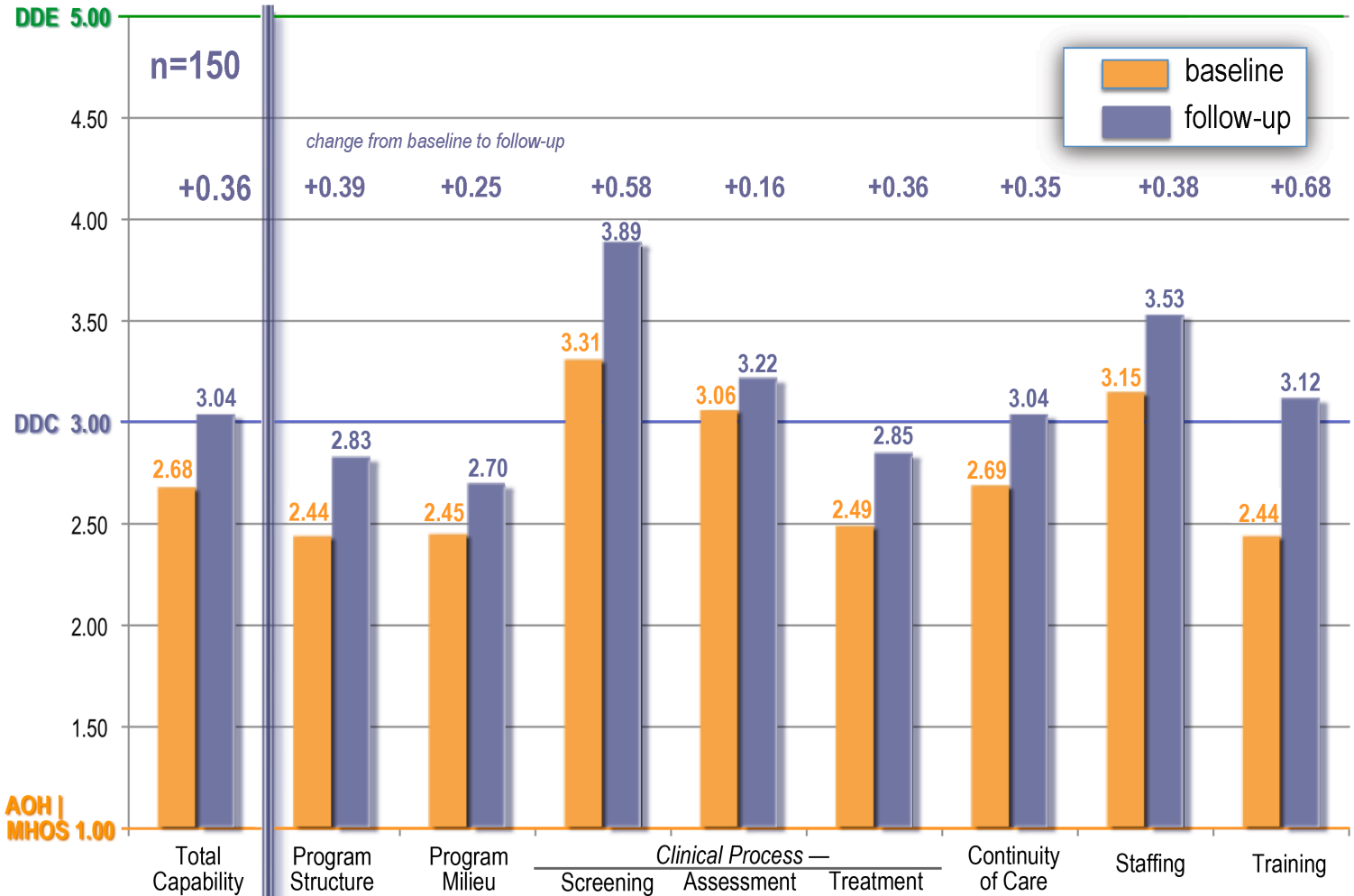
The **Screening item has been separated from the **Assessment** dimension and is presented separately.*

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[4] The full baseline sample (n=603) had a total score of 2.71; SD=standard deviation

x5. DISCUSSION

Summary of Findings

A large number of addiction and mental health outpatient clinics (N=603) participated in this far-reaching effort to improve integrated services for persons with co-occurring substance abuse and mental health conditions in New York State. At baseline, these 603 programs had an average overall score of 2.71, measured with the DDCA[MH]T indices, which is below "Capable," but closer to "Capable" than to "Basic" (AOS | MHOS). Baseline results for a sub-sample (n=**150**, used in an evaluation study) likewise scored somewhat below the "*Capable*" level (**2.68**). At follow-up, an average of two years after the baseline assessment, and after having received technical assistance and implementation support from CEIC specialists, the sub-sample had realized significant gains, scoring above the "*Capable*" level (**3.04**) and the percent of programs at the "Capable" level had more than doubled from 22% to 52% (**Figure x4[c]**). Significant improvement was evident for all 7 dimensions, and for the majority of items (26 of 35); in other words, the system has improved and is becoming *Capable.*

Figure x4[c]— *Proportion of clinics with ratings of DDC ("**Capable**") or higher before (at baseline) and after (at follow-up) receiving technical assistance & implementation supports*

Addiction and mental health programs had similar overall Capability scores at baseline and both showed significant improvement at follow up. Further, an analysis using data from the OASAS *Local Service Plan Survey* (LSP) revealed greater increases in "*Service Integration*" for programs that received CEIC services than for programs that did not make use of CEIC technical assistance. Also, clients with co-occurring disorders who received outpatient treatment from programs with higher DDCA[MH]T scores were found to stay in treatment longer; retention in treatment has long been an important predictor of positive outcomes, in that more time in treatment has consistently resulted in better outcomes (e.g., Fuller, 2009; Greenfield, et al., 2006; Joe, Simpson, & Broome, 1998; Ouimette, 2003; Simpson, Joe, & Brown, 1997). CEIC has disseminated findings from the project in many presentations throughout New York State as well as at State and national conferences, and has three manuscripts (two have been published in peer-reviewed journals and the third is in review) (Chaple & Sacks, 2013; Chaple et al., 2013; Sacks et al., 2013).

The Impact of Technical Assistance | Implementation Support

Over the life of the project, NYS enacted a number of state-level systemic changes with the potential to facilitate services integration. Foremost, OMH and OASAS jointly issued directives and guidance documents to promote the use of evidence-based screening, assessment, and treatment services; changes in licensing and financing that affected billing and reimbursement for services followed. Other curricula-driven training and technical assistance activities occurred simultaneously (e.g., *Trauma-informed Care;*[5] *Wellness Self*

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[5] e.g., SAMHSA's National Registry of Evidence-based Programs & Practices [NREPP], 2006; Najavits, 2006, 2007, 2009; Najavits et al., 2009

Management;[6] and *Recovery*). One major State initiative was the *Focus on Integrated Treatment* (FIT), a web-based training system to advance COD competencies (Center for Practice Improvement [CPI], N.D.[a]).

The influence of such factors could not be measured or tested, but an examination of average scores for baseline assessments in each of four years revealed that COD capability was essentially constant (Year 1=2.62, n=86; Year 2=2.75, n=166; Year 3=2.68, n=196; Year 4=2.72, n=125). The fact that baseline scores did not increase over time, along with other findings from the evaluation, lend credence to the inference that the project's technical assistance and implementation support had a positive effect, although other factors — NYS policy directives, other initiatives in staff training and technical assistance — were operative at the same time. Further, an analysis of data from the OASAS *Local Service Plan Survey* (LSP) revealed greater increases (that reached significance) in "*Service Integration*" for programs

Figure x5[a] — *OASAS Local Plan Survey (LSP) measures of* **Service Integration** *from 2010 to 2012 for programs that did* (**n=126**) *and did not* (**n=249**) *receive CEIC technical assistance.*
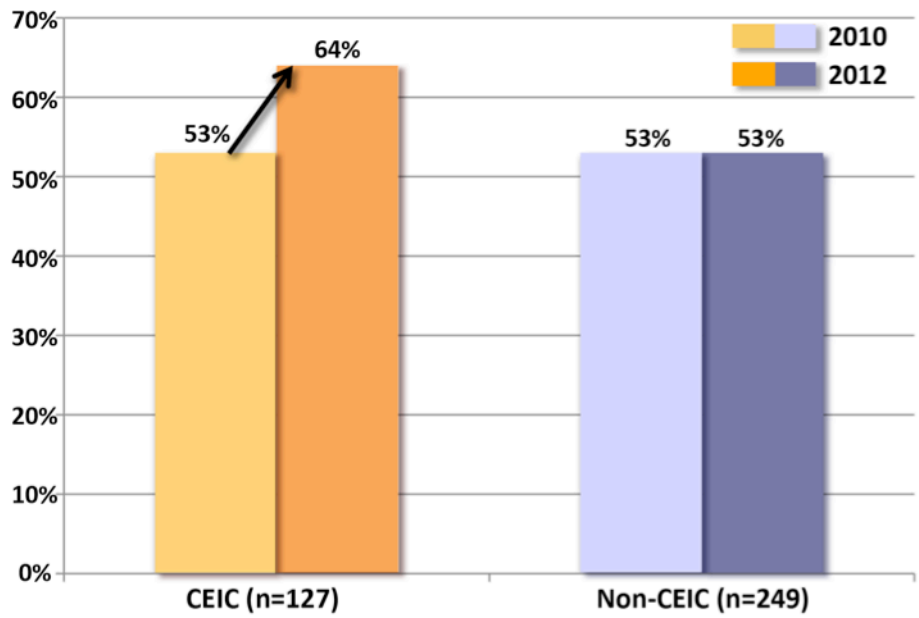
that received CEIC services than for programs that did not make use of CEIC technical assistance (see **Figure x5[a]**).

Limitations

While study results demonstrated substantial and significant improvements in COD capability among participating programs, several limitations should be noted.

The baseline sample was not randomly selected from the universe of outpatient providers; rather, it was comprised of programs that, once approached, volunteered to participate (i.e., a "convenience" sample). These programs could have been early adopters, or those that, for whatever reason, were especially amenable to technical assistance. Ultimately, the large baseline sample size (n=603) served to ensure that the full spectrum (scores ranging from 1.52 to 4.06) of capability was represented.

Interviewer bias could have artificially inflated follow-up scores. Although follow-up and baseline assessors differed, and unaware of the baseline score, assessors were still members of the same project staff and were certainly aware of the project's goals. As a partial check on interviewer bias, an inter-rater reliability (ICC) of 0.961 for the overall score was established for a subset of 10 follow-up clinics.

Although considerable efforts have gone into developing the DDCA[MH]T indices and establishing their psychometric properties, further study is required to determine: the factor structure of the measures; the importance and proper weighting of each dimension; and the validity of the measure in relation to client outcomes. With regard to the latter, a recent study found a significant positive relationship between DDCAT scores and length of stay (a known predictor of longer term outcomes), which indicated that clients with

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[6] Center for Practice Improvement [CPI], N.D.[b,c]

COD stayed longer in treatment programs that had higher scores (Chaple, Sacks, Melnick, McKendrick, & Brandau, 2013).

Implications for Behavioral Health

The evaluation study presented in this report represents the most extensive effort to measure and improve COD capability in a State outpatient system of behavioral health care, and the largest scale evaluation of the impact of technical assistance on COD capability conducted to date. Results from this study demonstrate that significant gains can be made in the delivery of integrated behavioral health services and, ultimately, that achievement of a "Capable" rating is a feasible goal. In so doing, this initiative offers specific guidance to behavioral health providers on how to improve COD capability, which in turn, will improve the quality of behavioral health care provided to individuals with COD.

This study has implications for the integration of behavioral health with primary care, promulgated under the *Affordable Care Act* (H.R. 3590, 2010). That is, the activities, approaches and successes in integrating substance abuse and mental health services provide a foundation for the additional integration with medical services. A new measure exists — the ***Dual Disorder Capability in Healthcare Settings*** (**DDCHCS**) index — that holds promise for measuring such integration (McGovern, Urada, Lambert-Harris, Sullivan, & Mazade, 2012b; SAMHSA, 2011c), as a basis for determining the improvements that are needed in healthcare settings, such as *Federally Qualified Health Centers* (FQHCs) and *Health Homes*. A pilot study that the CEIC team has been conducting in FQHCs has revealed that, while overall integration was lower (total score=2.0), comparable increases (up to 2.3) in integrated services could be achieved, using a process of assessment, technical assistance, and implementation support similar to the one reported here. NDRI continues CEIC's work to foster integrated care through the SAMHSA-funded ***Northeast & Caribbean Addiction Technology Transfer Center*** (**NeC-ATTC**), and a pilot project funded by ***The Nicholson Foundation*** of New Jersey.

x6. CONCLUSIONS

First, the results provide evidence that significant program gains can be achieved in the delivery of integrated services for persons with co-occurring conditions; even system change can be realized, with sufficient funding. **Second**, the achievement of a "*Capable*" rating (i.e., 3.0="*Dual Diagnosis Capable*") is a realistic and feasible goal because, for the most part, any barriers are easily circumvented, implementation is feasible, extensive new resources are not required, yet services will be improved, and continued gains can be fostered. **Third**, some corroboration of the efficacy of a multifaceted, direct, "hands on" approach to technical assistance and implementation support can be construed. **Fourth,** the fact that baseline capability scores remained stable for cohorts assessed in each of the five years, along with the main findings from the evaluation study, tends to confirm that the CEIC's technical assistance and implementation support contributed to the observed improvements in integrated care. **Finally**, it seems reasonable to infer that other statewide activities (e.g., NYS mandates and policy changes); NYS-level trainings, especially the web-based *Focus on Integrated Treatment* (Center for Practice Improvement [CPI], N.D.[a]) also played an important role in the positive effects achieved.

A. Background

A1. STATEMENT OF THE PROBLEM — NATIONAL

Co-occurring disorders (COD)— a diagnosis of one or more mental disorders as well as a substance use (dependence or abuse) disorder — represent a persistent social problem that results in significant costs, not only in fiscal resources, but also in human costs to communities, families and individuals. Along with needing treatment for their behavioral conditions, to attain and sustain recovery, persons with COD must have other needs met relating to their medical/physical health, family, legal, housing, and employment. Studies have documented poorer outcomes for clients with COD, expressed as higher rates of HIV infection, drug relapse, re-hospitalization, depression, and risk of suicide (Drake et al., 1998; U.S. Department of Health & Human Services, 1999).

In the general U.S. population, rates of co-occurring disorders are high. The *2009 National Survey on Drug Use & Health* (NSDUH; Substance Abuse & Mental Health Services Administration [SAMHSA], 2010) compiled information on 227.2 million American adults (18 or older) concerning their mental health and substance

Figure A1[a]— *Substance Use & Mental Health Disorders among Adults 18 & over in the past year — Findings from the* 2009 National Survey on Drug Use & Health [NSDUH]
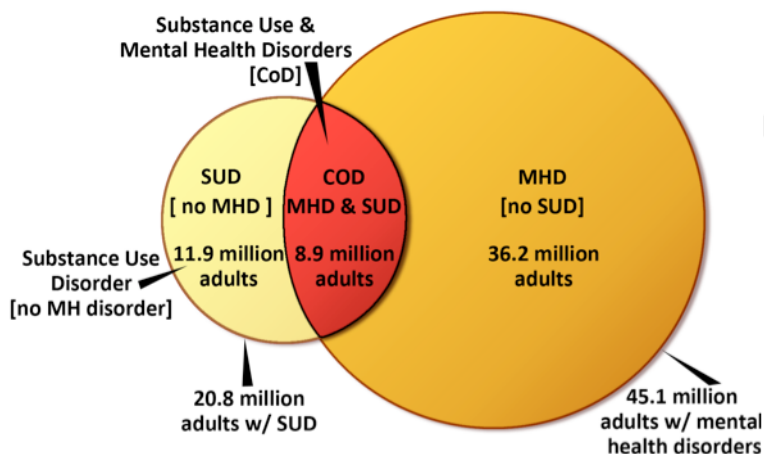
Figure A1[b]— *Substance Use & Serious Mental Health Disorders among Adults 18 & over in the past year —Findings from the* 2009 NSDUH
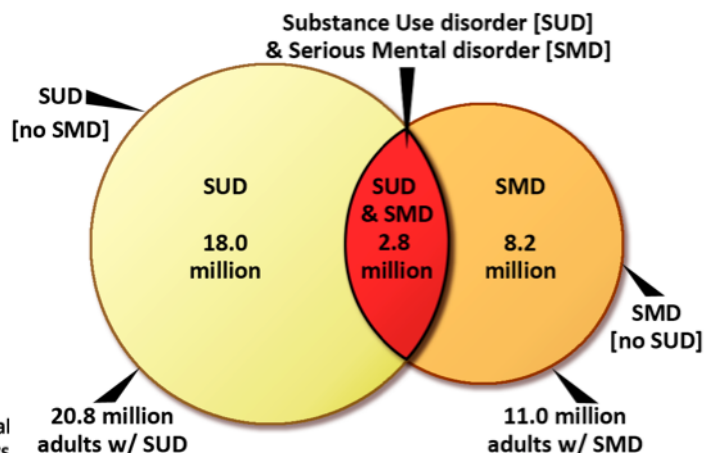
use status in the past 12 months. The survey found 20.8 million (9.2%) had a substance use disorder (SUD; dependence or abuse), and 45.1 million (19.9%) had a mental health disorder (MHD); 8.9 million (3.9%) had both disorders and 21.2% (48.1 million) had a single disorder (MHD or SUD). As illustrated in **Figure A1[a]**, 42.8% of the adults in the SUD sub-group had a co-occurring MHD, while 19.7% of the adults in the MHD sub-group had a co-occurring SUD. In comparison, of adults *without* an MHD, only 6.5% (11.9 million) met criteria for substance abuse or dependence, and only 17.6% (36.2 million) of adults *without* an SUD had a mental disorder. Statistics for American adults with serious mental disorders (SMDs) are shown in **Figure A1[b]**. Of the 20.8 million adults with SUDs, 13.5% (2.8 million) had a co-occurring SMD, while 25.5% of the 11.0 million adults with SMDs had a co-occurring SUD; 18.0 million (86.5%) had only an SUD, and 8.2 million (74.6%) had only an SMD.

Despite the high prevalence of co-occurring disorders and the destructive nature of the condition, few individuals receive the treatment required to manage either disorder. As shown in **Figure 1A[c]**, among the 8.9 million adults who had co-occurring mental and substance use disorders during the past year, a mere 7.4% received treatment for *both* disorders, while 55.8% received no treatment at all; 36.7% received services for a single disorder (32.9% received mental health services, and 3.8% received substance abuse services). Similarly, as illustrated in **Figure 1A[d]**, of the 2.8 million adults who had substance use disorders co-occurring with serious mental disorders in the past year, only 13.5% received treatment for both disorders, while 37.6% received no treatment at all; 48.9% received treatment for a single disorder (47.3% received mental health services, and just 1.6% received substance abuse services). The large proportion of untreated individuals represent a significant drain on community, family, and individual resources, contributing to a wide variety of social ills.

Figure A1[c]—*Substance Use & Mental Health Disorders among Adults 18 & over — Treatment services received in the past year*

Figure A1[d]—*Substance Use & **Serious** Mental Health Disorders among Adults 18 & over — Treatment services received in the past year*

8.9 million adults with co-occurring substance use & mental disorders [COD]

2.8 million adults with co-occurring substance use & serious mental disorders [SUD & SMD]
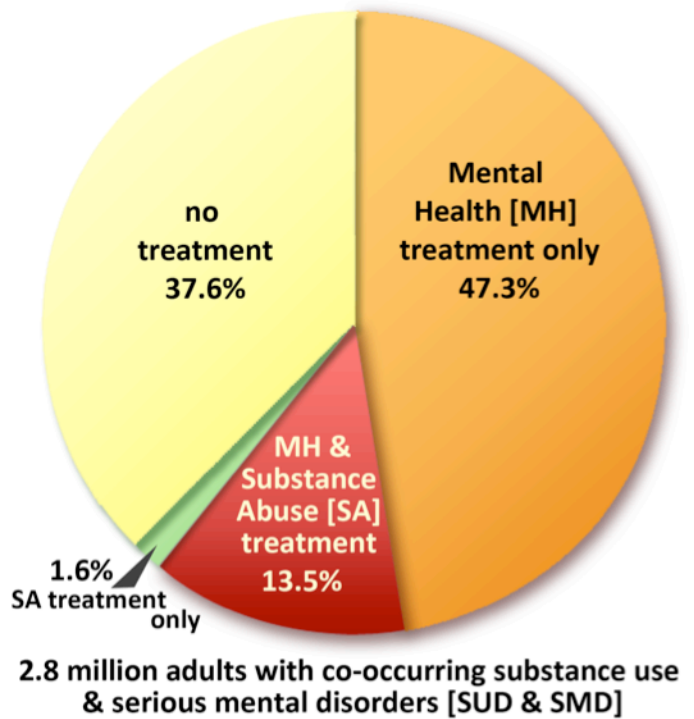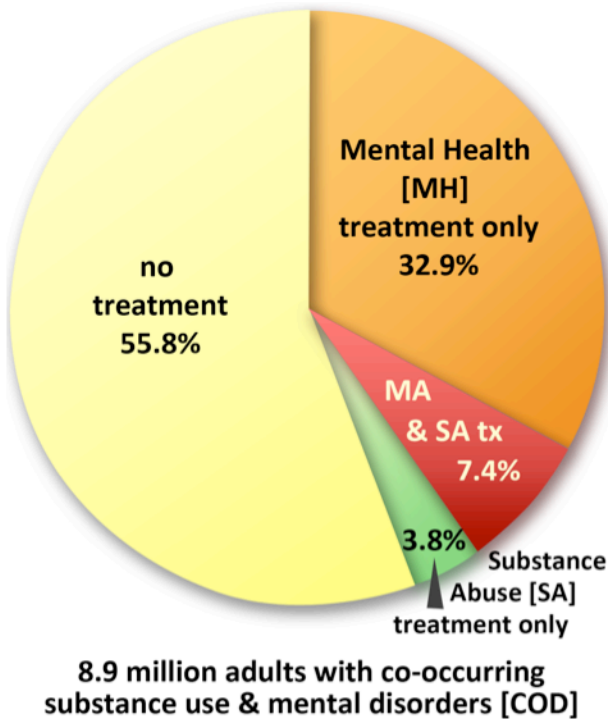
Co-occurring disorders presents a serious challenge for treatment systems, primarily because individuals with COD have multiple and distinctive needs that require specific approaches to deliver effective programming (Minkoff & Cline, 2004; Sacks et al., 2003; SAMHSA, 2002). The combined symptoms of persons with co-occurring disorders, compared to those with a single disorder, elevate the risks of psychiatric admission (Hunt, Bergin, & Bashir, 2002), relapse to drug use (McGovern, Wrisley, & Drake, 2005), unemployment (Cook et al., 2007), housing instability or homelessness (McNeil, Binder, & Robinson, 2005), incarceration (James & Glaze, 2006), physical health problems (Larson et al., 2007), HIV (Dausey & Desai, 2003), and suicide (SAMHSA, 2010). Furthermore, many people coping with COD have difficulty identifying, accessing and coordinating the mental health and substance abuse services they require (Minkoff & Cline, 2004; SAMHSA, 2002).

Beginning at the end of the 20th century and continuing through the first 10 years of this century, significant national attention was focused on the challenges associated with the treatment of COD. Major initiatives, such as the Surgeon General's *Report on Mental Health* (U.S. Department of Health & Human Services [DHHS], 1999); SAMHSA's *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders* (SAMHSA, 2002); the President's New Freedom Commission final report on *Achieving the Promise*: *Transforming Mental Health care in America* (New Freedom Commission, 2003), Treatment Improvement Protocol (TIP) #42 on *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005), and SAMHSA's annual *National Survey on Drug Use and Health* (NSDUH), all note the high prevalence of COD, the lack of integrated substance use and mental health services, and the poor outcomes experienced for individuals with COD, especially in the absence of integrated care.

These concerns stimulated recommendations for treatment programming from national organizations responsible for lending direction to substance abuse and mental health treatment. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) jointly promoted a "four quadrant" theoretical framework that differentiates COD patients according to the severity of the mental health and substance use disorders (NASMHPD & NASADAD, 1999). The American Society of Addiction Medicine (ASAM) developed its own framework to categorize treatment programs according to the degree to which services have been integrated (i.e., "addiction only," "dual diagnosis capable," and "dual diagnosis enhanced"); this framework guides the measurement and assessment of a program's capacity to treat individuals with COD (ASAM, 2007). In 2002, SAMHSA began awarding Co-Occurring State Incentive Grants (COSIG) to help states to develop and enhance their infrastructures and the capacity of their service systems to provide accessible, comprehensive, integrated/coordinated, and evidence-based treatment services to persons with co-occurring disorders. Finally, in the next year, SAMHSA funded its *Co-Occurring Center for Excellence in Co-occurring Disorders* (COCE) to help states and programs achieve integrated substance abuse and mental health services (SAMHSA, 2003; Urban, Sacks, & the CDM Group, 2003). Each of these initiatives illustrates that the integration of mental health and addiction treatment services is essential to meet the needs of individuals with COD, and would be complimented with parallel initiatives undertaken in New York State (NYS; see section A2 below).

A2. STATEMENT OF THE PROBLEM — NEW YORK STATE

Consistent with national statistics, **New York State** (**NYS**) has reported a high rate of co-occurring disorders; OASAS cited a steady increase, from 24% in 2000 to 40% in 2008, in clients with a co-occurring mental health problem being admitted to substance abuse treatment facilities (NYS OASAS, 2011, 2012). NYS activated its statewide effort to integrate behavioral health care in 2001 (NYS OMH & OASAS, 2001a,b), forming a joint **OMH/OASAS** *Task Force on Co-occurring Disorders* a few years later; the Task Force published its initial recommendations in 2007 (NYS OMH & OASAS, 2007). A year later (2008), OMH and OASAS began disseminating instructions to outpatient program directors (NYS OMH & OASAS, 2008a,b), and the *New York State Health Foundation* (**NYSHealth**) funded CEIC to assist substance abuse and mental health outpatient programs statewide in improving care for COD, and in complying with State mandates associated with integrated care (NYSHealth, 2008a, 2010, 2011). According to NYSHealth (2008c), when the CEIC project was initiated, more than 1.4 million New Yorkers had co-occurring mental health and addictive disorders.

Information from OMH-licensed programs indicated that 18% of their clients had a co-occurring substance abuse diagnosis, with the caveat that these data understated the actual prevalence of co-occurring substance use disorders. The reason for the low estimate related to the fact that OMH programs are required to report only one diagnosis for each individual admitted (i.e., the primary mental health diagnosis), and any other diagnoses would most likely be omitted (OMH & OASAS, 2007, report of the OMH/OASAS *Task Force on Co-Occurring Disorders*); indeed, more than 50% of NYS Medicaid claims for schizophrenia included a substance use diagnosis (NYS OMH & OASAS Commissioners' Letter, June 20th, 2008a). These figures are in keeping with historical reports in the literature in which 50% to 75% of clients in substance abuse treatment programs had a co-occurring mental disorder, while studies conducted in mental health settings similarly found that between 20% and 50% of these clients had a co-occurring substance use disorder (e.g., Compton et al., 2000; Sacks et al. 1997b). Again, it is important to keep in mind that, of the 1.4 million New Yorkers with COD, more than 50% receive no treatment, while fewer than 10% receive evidence-based treatment for both conditions (NYSHealth, 2008c), despite the fact that effective interventions are available. When integrated treatment is provided, persons with co-occurring disorders have high rates of recovery. Integrated treatment combines evidence-based interventions for mental health and substance use in a clinical interaction such that the same clinicians (or teams of clinicians) or programs coordinate and deliver appropriate interventions, modifying traditional interventions as needed (NYS-OMH, 2004).

The substance use and/or mental health needs and deficits of those New York residents who did receive treatment were substantial. For example, data from the *Patient Characteristics Survey* (NYS OMH, 2007, 2008) revealed that 83% of all persons admitted to mental health programs (81% of those in outpatient programs)[7] in 2007 were diagnosed with severe disorders, either Severe Mental Illness (SMI) or Severe Emotional Disturbance (SED) (NYS OMH, 2008, 2012, 2013). According to OASAS (NYS OASAS, 2008), clients with co-occurring disorders who received treatment services have a multitude of problems: 37% had less than a high school education, 63% were unemployed, 38% had criminal justice involvement, 13% were homeless at admission, 28% had some form of physical impairment, and 66% were dependent on Medicaid or public assistance. Likewise, data for a subset of patients (n=295) obtained from the OASAS *Treatment Outcome Study* (OASAS, 2006) revealed extensive drug use; for example, 87% of respondents reported regular alcohol use to intoxication over an average of 9.4 years, coupled with regular lifetime drug use, also for long periods of time (e.g., averages of 9.4 years for marijuana use and 6.7 years for cocaine use). Overall, 78% of respondents drank alcohol to intoxication and used illegal drugs regularly in their lifetimes, although not necessarily at the same time.

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[7] More recent statistics show little variation, as 84% of all persons admitted to mental health programs (82% of those in outpatient programs) in 2011 were diagnosed with severe disorders (either SMI or SED). Summary reports compiled from data obtained using the NYS OMH *Patient Characteristics Survey* (PCS) are available online for 1999, 2000, 2001, 2003, 2005, 2007, 2009 and 2011; these reports, along with planning reports, the forms used, documentation, and other related information can be accessed at the PCS website (NYS OMH, 2013), http://bi.omh.ny.gov/pcs/index (data obtained in subsequent years will be added as available).

A2a. OASAS – OMH INTERAGENCY COLLABORATION

Since 1998, OASAS and OMH have collaborated (e.g., NYS-OMH, 2004:p66) on a series of policy and programming initiatives to improve care for persons with COD focused on two broad goals:

[1] to improve care to persons with the most severe mental health and addictive disorders through integration and inter-system coordination of care; and

[2] to improve the proficiency of both systems of care to identify and engage clients with co-occurring disorders.

Both agencies have endorsed the *New York Model* (NYS-OASAS, 2001; NYS-OMH, 2004, 2012; SAMHSA, 1999, 2006), a conceptual framework for describing symptom severity, locus of care, and level of service integration needed among mental health, substance abuse, and primary health care systems, as well as a *Statement of Principles and Values*. The two agencies then convened a Quadrant IV Task Force, whose report in 2001, *Treating Co-Occurring Mental Health and Addictive Disorders in New York State: A Comprehensive View*, continues to edify the agencies' collaborative ventures (the *New York Model* and the *Statement of Principals and Values* are included in the 2001 *Quadrant IV Task Force Repor*t, NYS-OASAS).

Next, OMH and OASAS established an Interagency *Workgroup on Co-occurring Disorders* to improve the coordination and integration of care (IWCD; NYS-OASAS, 2005; NYS-OMH, 2004:p66), meeting monthly until 2009 to discuss the agencies' collaborative efforts. Then, OMH and OASAS jointly supported the *Dual Recovery Coordinator* (DRC) *Demonstration Project*, which created positions for **Dual Recovery Coordinators** in 14 counties plus New York City; most of these positions continue to be supported (Alexander & Hoagland, 2004). The DRCs work with local providers in their respective counties to integrate mental health and substance use services, develop infrastructure and networks across substance use and mental health agencies, provide staff training, and mediate conflicts resulting from service integration.

Other contemporaneous efforts included a joint (OMH and OASAS) initiative to improve the efficiency of both systems in identifying and engaging COD clients that trained experienced clinicians, drawn from six regions across New York State (600 clinicians participated statewide). Program models for treating clients with COD were selected and recommended — OMH adopted the *Integrated Dual Disorders Treatment* (IDDT) model, while OASAS adapted the American Society of Addiction Medicine (ASAM) *Patient Placement Criteria – Second Edition* (PPC 2R) program guidelines for "**Dual Disorder Capable**" (**DDC**) and "**Dual Disorder Enhanced**" (**DDE**)[8] programming (ASAM, 2007).

At the same time, each endorsed a validated screening tool — OASAS recommended the *Modified Mini Screen* [MMS] to identify mental health disorders in substance abuse service settings, while OMH endorsed the *Dartmouth Assessment of Lifestyle Instrument* [DALI] to screen for substance use disorders in mental health service settings. This work was advanced in 2005, when a New York City Department of Health and Mental Hygiene *Quality Improvement Project* (QIP) included the implementation of the MMS and collaborated with OASAS to ensure consistency across participating providers (NYS-OASAS, 2005). OASAS then strongly encouraged its licensed providers in New York City to adopt the MMS as regular clinical practice; those that did received training in administering the MMS and were required to complete an implementation plan, which included the development of follow-up procedures for those who received a positive score. In 2001, when OASAS introduced the first initiatives to encourage services improvements for co-occurring disorders, fewer than 10% of providers were using a formal screening procedure; by 2010, 71% of providers were at the implementation stage or beyond, and 45% of OASAS-licensed programs were considered to have achieved "sustainable" use of a formal screening process using an endorsed instrument.

In May 2007, OMH and OASAS again collaborated in convening a statewide *Task Force on Co-occurring Disorders* to identify means of improving services for co-occurring disorders in both the mental health and

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[8] The terms "DDC" and "DDE" are interchangeable with "co-occurring capable" or "COD capable" and "co-occurring enhanced" or "COD enhanced," respectively. In general "dual diagnosis" and "co-occurring disorders" or "COD" are equivalent terms.

substance abuse service systems. The recommendations of the Task Force were formalized in a report issued at the end of 2007 (NYS-OMH & OASAS, December 2007). The Commissioners of OASAS and OMH translated the Task Force recommendations into two guidance packages that were sent to Directors of all OMH- and OASAS-licensed outpatient programs statewide in the summer of 2008 (NYS OMH & OASAS, 2007a,b; the first package was sent on June 20; the second was sent on July 31). In November 2008,[9] with funds from the *New York State Health Foundation* (**NYSHealth**) and directions to foster integrated care, **CEIC** began to effect system-wide improvements in the degree to which services for substance use and mental health conditions ("co-occurring disorders" or "dual diagnosis") were integrated in licensed mental health and substance abuse outpatient programs. CEIC coordinated and collaborated with OMH and OASAS throughout the duration of the project (details are contained in the "***CEIC Methods***" section of ***Appendix 2***).

A3. MEASURING CO-OCCURRING CAPABILITY

To promote the goal of service integration for individuals with COD, fidelity scales were developed to measure a program's capacity to deliver integrated services for individuals with COD. The *Integrated Dual Disorders Treatment* (IDDT) fidelity scales (Mueser, Noordsy, Drake, Fox & Barlow, 2003) were intended to measure fidelity in programs that implemented IDDT, a multi-disciplinary approach used in mental health settings to treat individuals with severe mental illness. The developers did not recommend administering the IDDT fidelity scales in addiction treatment settings (where mental problems tend to be less severe), which meant that other instruments were needed to measure co-occurring capability in substance use populations. Responding to this need, Dr. Mark McGovern and colleagues developed the *Dual Diagnosis Capability* indices, beginning with the *Dual Diagnosis Capability in Addiction Treatment* (DDCAT).

The DDCAT index was intended to assess co-occurring capability in addiction treatment programs (McGovern, Matzkin, & Giard, 2007). A parallel version — the *Dual Diagnosis Capability in Mental Health Treatment* (DDCMHT) index — was subsequently constructed to assess COD capability in mental health programs (Brown, Comaty & McGovern, n.d., ca 2007; Gotham et al., 2013). Both versions of the index use the ASAM taxonomy to define programs operationally according to their level of capability: "***Addiction Only Service***" (**AOS**) or "***Mental Health Only Service***" (**MHOS**), "***Dual Diagnosis***[10] ***Capable***" (**DDC**), and "***Dual Diagnosis Enhanced***" (**DDE**). The use of these instruments spread to many states through SAMHSA's COCE. Given that the occurrence of a co-occurring disorder is common in both addiction and mental health settings, it has been suggested that all programs should achieve a minimal rating of "*Dual Disorder Capable*" (**DDC**) (Minkoff, Zweben, Rosenthal, & Ries, 2003). From their development in 2003[11] to 2010, the two indices have been used in over 30 state regulatory authorities, several large county governments, private treatment programs, and several nations (Gotham, Claus, Selig, & Homer, 2010; SAMHSA, 2012a,b). Although limited, published data that systematically describe program capacity to deliver integrated services for COD suggest that the vast majority (70% to 80%) of programs do not meet DDC criteria (Gotham et al., 2010; Lee & Cameron, 2009; Matthews, Kelly, & Deane, 2010; McGovern, Lambert-Harris, McHugo, Giard, & Mangrum, 2010), despite considerable evidence that services are more effective when integrated (Dixon et al., 2010; NYS-OMH, 2004).

Ultimately, prior studies measuring co-occurring capability have been limited, primarily because the unit of analysis for measurement is the program, which complicates sample accumulation and makes data collection costly. Nonetheless, research using the DDCA[MH]T indices has consistently demonstrated that the use of an

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[9] The CEIC initiative began on November 1, 2008, with an end date of October 31, 2012; the funder, NYSHealth, held a press event, followed by a kick-off meeting of CEIC's advisory group, which marked the start of technical assistance and implementation supports. The project was subsequently extended for a fifth year, to October 31, 2013; data collection ended June 27, 2013, while dissemination activities (including compiling this final report) continued to October 31, 2013.

[10] "Dual Disorder" and "co-occurring disorders" or "COD" (sometimes abbreviated to "co-occurring") are equivalent terms, and tend to be used interchangeably.

[11] Development of the DDCAT began in 2003; development of the DDCMHT began in 2004.

independent objective assessor (compared to program self-assessment) yields more realistic ratings and avoids potential overestimation of capability (Lee & Cameron, 2009; McGovern et al., 2007). Thus, using an independent rater to administer DDCA[MH]T assessments remains the most accurate, and therefore preferable, method of data collection, despite the significant cost factor.

Although prior research has contributed to an initial understanding of co-occurring capability among mental health and substance abuse treatment providers, new studies can advance the current knowledge base in several ways. First, even the largest of the prior studies was constrained by a limited sample size, which presents problems of statistical power and of the generalizability of the findings. Second, another limitation on the generalizability of prior work is that, while prior studies have recruited programs from multiple states, the accumulated data has come primarily from convenience samples, rather than representative samples that could contribute to significant findings at either the state or national level. Third, none of the previous studies have focused exclusively on one level of care (e.g. outpatient). This is a critical point, since the capacity to provide integrated COD services, as well as the methods by which this would be accomplished, could vary according to modality. The current project, which concentrates on outpatient programs in New York State, has the potential to identify clear policy implications for NYS regarding the impact of the DDCA[MH]T assessment process across the entire outpatient service system (mental health and addiction) as a means of measuring the current level of capability along with subsequent improvements in capability.

This ***Final Report of Project Activities*** describes CEIC's activities from its inception on November 1, 2008 through the end of data collection on June 27, 2013,[12] while other project activities (mainly related to dissemination of project information) continued through August 31; during September and October, this report was compiled and other dissemination activities were completed.

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[12] The official term of **the CEIC initiative** was from **November 1**, **2008** to **October 31**, **2013**; **data collection** began **November 20**, **2008** and ended **June 27**, **2013**.

B. CEIC Initiative

B1. INTRODUCTION

B1a. CENTER FOR EXCELLENCE IN INTEGRATED CARE [CEIC] & EXPANDING TECHNICAL ASSISTANCE SUPPORT AND REACH OF CEIC

In November 2008, the New York State Health Foundation (NYSHealth) established the ***Center for Excellence in Integrated Care*** (**CEIC**, **Director Stanley Sacks**, **PHD**; Grant #**2008-2496857**, "*People First: Center of Excellence for the Integration of Care* (CEIC) *for Individuals with Co-occurring Mental Health & Substance Use Disorders*," November 1, 2008 to October 31, 2013;[13] NYSHealth, 2008a, 2010).[14] A subsequent award funded a full-time technical assistance specialist, which allowed CEIC to expand its reach and penetration (Grant #**2009-3426912**, "*Expanding Technical Assistance Support and Reach of NYSHealth Center for Excellence in Integrated Care*," January 1, 2010 to October 31, 2013; NYSHealth, 2010) in affecting the system of care for 1.4 million New Yorkers suffering from both mental health and substance use disorders ("co-occurring disorders" or "COD"). Specifically, NYSHealth funded CEIC to help substance abuse and mental health outpatient programs across New York State to improve their capability to provide "integrated care" (services for both addiction and mental health problems), a process known as "***building co-occurring capability***" or, simply, "***building capability***." For the life of the initiative (5 years), CEIC technical assistance specialists worked with providers, free of charge, to assist each program in achieving a higher level of integrated care, ensuring that services were recovery-oriented, person-centered, and culturally competent. Concurrently, the New York State OMH and the OASAS were initiating system level changes to support the integration of mental health and substance abuse services, largely as a consequence of the recommendations of the OASAS/OMH *Task Force on Co-Occurring Disorders* (NYS-OMH & OASAS, 2007).

Building on the objectives of NYSHealth and the recommendations of the New York State (NYS) *Task Force on Co-occurring Disorders*, CEIC's primary goal was to build the capacity of New York State OMH- and OASAS-licensed outpatient clinics to provide integrated clinical care for people with co-occurring disorders,

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[13] Data collection began on November 20, 2008, and concluded on June 27. 2013.

[14] The original grant (#2008-2496857), which funded CEIC, was augmented at the beginning of 2010 with supplementary funds (Grant #2009-3426912, January 1, 2010) to support a full-time technical assistance specialist for the duration of the project (NYSHealth, 2010). Shelley Scheffler, PHD, was hired on March 1, 2010 to assist with baseline data collection and other technical assistance activities; her training began immediately. She began assisting with baseline data collection on May 10, 2010, and continued until the final baseline assessment was conducted on June 27, 2013. She contributed to the reliability component of evaluation study (the third award #11-02788) and conducted the final half-dozen assessment site-visits. Her position ended on August 29, 2013.

ensuring that the services delivered were recovery-oriented, person-centered, and culturally competent. Four clinical care goals were keyed to the recommendations of the Task Force; namely, to implement:

[1]   a ***uniform and standardized*** approach to screening;

[2]   a ***domain or component*** approach to assessment;

[3]   the use of selected ***evidence-based practices*** for integrated treatment; and

[4]   the identification of ***training resources*** for clinical and supervisory staff.

CEIC concentrated on supporting providers, improving clinical systems of care, and facilitating the integration of services for New Yorkers with co-occurring disorders.

A total of **603** substance abuse (**n=277**) and mental health (**n=326**) clinics completed an initial (baseline) on-site assessment, technical assistance, and implementation supports in a concerted effort to improve the delivery of integrated care statewide. Activities were concentrated in the areas of screening, assessment, and evidence-based interventions, in a process that became known as "***building co-occurring capability***" or simply "***building capability***." The accumulated assessment data from these 603 programs allowed a baseline summary overview of the "co-occurring capability" of the NYS service system to be computed. (Results are provided in **section D**, and have been outlined in the *Executive Summary,* which opens this report.)

B1b.   TRACKING PROGRESS IN PROVISION OF OUTPATIENT INTEGRATED CARE

In April 2011, NYSHealth committed funds to a study of CEIC's effectiveness (Grant #**11-02788**, "*NYSHealth's CEIC: Tracking Progress in NYS Addiction & Mental Health Providers' Provision of Outpatient Integrated Care,*" April 1, 2011 to October 31, 2013; NYSHealth, 2011),[15] an auxiliary project to evaluate the impact of CEIC services on the New York State treatment system. The evaluation had three aims, enumerated in the paragraphs immediately following.

> **AIM 1**—   to assess the overall capability of addiction and mental health outpatient clinics to deliver integrated services for clients with co-occurring mental and substance use disorders

To accomplish this aim, CEIC employed The *Dual Diagnosis Capability in Addiction Treatment* (DDCAT) index for addiction outpatient programs and the *Dual Diagnosis Capability in Mental Health Treatment* (DDCMHT) index for mental health outpatient programs. The goal was to conduct a far-reaching project throughout New York State and to affect a large proportion of the State's outpatient addiction and mental health programs.

> **AIM 2**—   to examine change in the capacity of addiction and mental health outpatient clinics to improve screening, assessment, and evidence-based treatment practices in providing services for clients with co-occurring mental and substance use disorders

The investigators predicted significant improvement in capability for programs that received technical assistance from CEIC, such that the average program would be functioning at a higher level (i.e., "co-occurring capable" or above) at the follow-up assessment than at the initial (baseline) assessment (i.e., closer to "co-occurring capable" than to "Basic"). The evaluation used the same indices as had been used at baseline — The DDCAT index for addiction outpatient programs and the DDCMHT index for mental health outpatient programs. A representative sample of 150 programs was randomly selected and assessed at follow-up (a minimum of 18 months after the baseline site visit); results of the baseline (before technical assistance and implementation supports were received) and follow-up assessments would be compared.

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[15] Ms. Ashley Arner, MS, the Clinical Assessor for the evaluation project, was hired on May 16, 2011 to conduct 150 follow-up assessments; her training began immediately. The first follow-up assessment was conducted on May 21, 2011, and Ms. Arner concluded her work with CEIC on November 20, 2012. Dr. Scheffler conducted the last few site-visits; the final assessment was completed on April 10, 2013, ending 23 months of data collection for the study.

Significant increases were predicted in the proportion of programs adopting New York State recommendations (derived from the specifications and recommendations of the NYS OMH/OASAS *Task Force on Co-occurring Disorders*) in their selection and use of:

[1]   validated screening instruments;

[2]   an assessment process that integrated both substance use and mental health disorder diagnoses, and that captured the domains the State had enumerated; and

[3]   evidence-based treatment interventions.

Scores were analyzed from the DDCA[MH]T assessments to determine these outcomes. In addition, for OASAS programs, data from the OASAS *Local Service Plan* (LSP) *Evidence-Based and Best Practice Interventions Survey* were incorporated, as an independent measure of program change. [A comparable survey for OMH-licensed outpatient mental health programs was not available.] This aspect of the study has the potential to reflect program change in the key areas of screening, assessment, and evidence-based interventions necessary to improve services to clients with co-occurring disorders.

> **AIM 3**— to examine the factors related to program improvement in capability, screening, assessment and evidence-based treatment practices[16]

These analyses were to explore:

■   *subgroup differences* (e.g., OASAS- and OMH-licensed programs, public-versus privately-funded programs, geographical settings [i.e. urban, suburban, rural, or regional areas]);

■   *organizational factors* (e.g., agency climate and readiness for change); and

■   *other factors* (e.g., the percentage of co-occurring clients served, access to dual recovery coordinators, and program size). This facet of the study is notable in its potential to provide plausible explanations of the factors that are related to program change, thereby guiding future program development.

The evaluation study **assessed improvements** in the degree to which NYS outpatient substance abuse and mental health programs were able to deliver integrated care (i.e., their **co-occurring capability**) to their clients with COD, and to assess the system-wide implementation of screening, assessment and evidence-based treatment practices. In sum, the evaluation was designed to determine improvements in care for (and thereby the health of) NYS residents with co-occurring disorders. The project as a whole is particularly important and relevant to the national impetus towards health care reform.

In sharing aggregate results of DDCA[MH]T assessments of co-occurring capability for 603 substance abuse and mental health outpatient programs, and improvements at follow-up for 150 programs, the CEIC project has made significant contributions. As reported here, these CEIC assessments represent the most extensive effort thus far to measure co-occurring capability in a statewide outpatient system of care, and to measure the impact of technical assistance and implementation support in improving behavioral health care. Results from this study will help to clarify overall levels of co-occurring capability among outpatient providers in New York State, to identify specific programmatic strengths and weaknesses, and to formulate recommendations with the greatest potential to advance co-occurring capability.

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[16] In the course of the evaluation project, **Aim 3** was changed to focus on the relationship between DDCAT scores and client outcome in addiction programs; section **D2d** (p45) reports the results. Section **D2c** (p40), immediately preceding, describes comparisons of mental health and addiction programs.

B2. CEIC TECHNICAL ASSISTANCE & IMPLEMENTATION SUPPORTS

In keeping with the interagency efforts of NYS **OMH** and **OASAS** to improve services for co-occurring conditions statewide (see NYS OMH-OASAS 2008a,b), CEIC targeted seven areas in which increases in integrated care could be realized, and delivered a total of eight defined services in each area. The *Dual Diagnosis Capability* indices — one for use in mental health clinics (i.e., the *Dual Diagnosis Capability in Addiction Treatment*; DDCAT), the other for use in substance abuse programs (i.e., the *Dual Diagnosis Capability in Mental Health Treatment*; DDCMHT)— provided the framework for the target areas and guided the technical assistance, in the following categories or dimensions:

Table B2[a] — DDC[MH]T *dimensions and number of items in each dimension*

Item #	Dimension	# of Items	Item #	Dimension	# of Items
[1]	**Program Structure**	4 items	[5]	**Continuity of Care**	5 items
[2]	**Program Milieu**	2 items	[6]	**Staffing**	5 items
[3]	**Clinical Process – *Assessment***	7 items	[7]	**Training**	2 items
[4]	**Clinical Process – *Treatment***	10 items			

The eight services that CEIC delivered are enumerated in **Table B2[b]** and summarized in the paragraphs that follow; details relating to CEIC technical assistance and implementation supports have been compiled in the ***Appendices***.

Table B2[b]— *CEIC Technical Assistance and Implementation Supports*

	The CEIC technical assistance approach provided 8 defined services to outpatient programs—	
1.	**Leadership Forums**	Engages Leadership
2.	**On-site DDCA[MH]T Assessments**	Performs on-site assessments [using either the DDCAT or DDCMHT Index]
3.	**Assessment Summary Reports**	Presents formal written site reports
4.	**Building Capability Forums**	Conducts provider forums
5.	**Peer Recovery Workshops**	Holds workshops, entitled "*Building Integrated, Recovery Oriented Outpatient Services*" to integrate peer supports
6.	**Peer Learning Collaboratives & Communities**	Builds collaborations and informal networks to support shared learning and to promote mutually beneficial service agreements
7.	**Individual Technical Assistance & Implementation Supports**	Supplies ongoing support, guidance, and consultation to individual programs or agencies, as well as to groups of programs
8.	**Resources Linkages**	Links programs to resources, such as: FIT (*Focus on Integrated Treatment*; Center for Practice Improvement [CPI], nd[a]); TIP 42 and related in-service training (Center for Substance Abuse Treatment [CSAT] 2005 & 2007, respectively), as well as other trainings and curricula

B2a. CEIC Technical Assistance Process

Leadership Forums

CEIC accomplished its objectives through the delivery of direct technical assistance in several steps according to an 8-region geographic organization of New York State. In each of the 8 regions, CEIC initiated its technical assistance activities with a ***Leadership Forum***, conducted to introduce CEIC services to leaders selected to represent the region's Counties, OMH and OASAS field sites and, when suitable, provider associations. The *Leadership Forum* was conducted as a consultation, which allowed CEIC to gain an understanding of developments in co-occurring disorders that were planned or that had already taken place, and that afforded an opportunity for CEIC to demonstrate how its technical assistance could complement existing efforts. At its conclusion, the *Leadership Forum* introduced a planning process to identify provider agencies across the region that would be offered an on-site assessment of co-occurring capability.

On-site DDCA[MH]T Assessments

The DDCAT and DDCMHT indices are from a nationally recognized system of measuring and advancing the capacity to deliver integrated treatment. The indices incorporate 35 items across 7 dimensions of care, and assign three levels of "co-occurring" capability (or "dual diagnosis" capability); the anchor points are enumerated in **Table B2[c]**. Often presented as the only option, "full integration" (services that fully treat both mental health and substance use conditions) is rarely

Table B2[c]— *Anchor points on the* DDCA[MH]T *5-point rating system*

score	anchor point	acronym
1.0 =	***Addiction Only Services***	**AOS**
	Mental Health Only Services	**MHOS**
3.0 =	***Dual Diagnosis Capable***	**DDC**
5.0 =	***Dual Diagnosis Enhanced***	**DDE**

achieved. CEIC technical assistance aimed to help providers advance to the next level of integrated care — to "co-occurring capable" (3.0=DDC) for those who are closer to "mental health or addiction only" (1.0=AOS or MHOS) and to "co-occurring enhanced" (5.0=DDE) for those who are already "co-occurring capable" (3.0=DDC). Overall, since most programs we functioning below the capable level but with "striking distance," CEIC placed considerable emphasis on "getting-to-capable."

CEIC technical assistance began with an on-site assessment to determine the program's existing level of capability. As mentioned, the site visits used established assessment tools — the *Dual Diagnosis Capability in Addiction Treatment* (DDCAT; McGovern, Matzkin, & Giard, 2007; McGovern et al., 2010, 2012a) or the *Dual Diagnosis Capability in Mental Health Treatment* (DDCMHT; Brown, Comaty, McGovern, & Riise, nd; Gotham et al., 2013) to conduct a comprehensive assessment of the program's current level of co-occurring treatment capability. The assessment process was, simultaneously, an evaluation of the program's COD status and a technical assistance activity that entailed meetings with staff and clients and direct observation of program activities; immediate feedback was provided at the conclusion of the site-visit, and a summary report was compiled and sent to the Program Director within a week of the site visit.

During the on-site visit, which lasted from 3 to 4 hours, an assigned assessor used either the DDCAT (for addiction programs) or the DDCMHT (for mental health programs) to obtain independent scores for the program. Assessors were senior clinical and research staff who had received training from the developer of the DDCA[MH]T indices, Dr. Mark McGovern. The primary data source was an in-depth semi-structured interview organized along the 7 dimensions of the DDCA[MH]T and administered collectively to a group drawn from key program staff (typically representatives of executive leadership, program directors, clinical supervisors, medical staff, and counselors); consumers were also interviewed whenever possible. The assessor obtained additional information from: observing program activities (such as client groups and staff meetings); talking with other program staff; reviewing program documents (policy and procedure manuals, clinical forms and charts); and touring the program facility.

Assessment Summary Reports

The formal ***Assessment Summary Report***, generated from the DDCA[MH]T data obtained during the site visit, presented the assessor's observations, and the rating score for the 35 items, averaged as a total and for each dimension. The assessor's recommendations for subsequent improvements, derived from his/her observations and interviews, were included. Profile graphs gave a visual representation of the assessment scores, which was an effective means of isolating the program's strengths and weaknesses. The report's recommendations contained links to relevant training/TA resources, including (but not limited to) webinars, curricula, workshops, and in-service training manuals (e.g., Treatment Improvement Protocols [TIPs], Technical Assistance Publications [TAPs]), NYS-level trainings, especially the web-based *Focus on Integrated Treatment* {Center for Practice Improvement [CPI], N.D.[a]), along with other relevant resources (e.g., journal articles, reports, fact sheets).

Documentation of the site visit assessment in the summary report allowed the information to be developed into a implementation plan that would capitalize on programmatic strengths, while respecting resource limitations, in enumerating the steps necessary to advance the program to the next level (cf., "*Building Capability Forums*" below). Receipt of the summary report marked the completion of the assessment, and the program became eligible for follow-up technical assistance delivered in CEIC-sponsored forums — the ***Building Capability Forum*** for groups of about 15 programs, and the ***Peer Recovery Workshop*** for smaller groups of programs (also delivered to individual programs); these are described in more detail below. At the same time, CEIC staff was available for individual technical assistance and implementation support, usually delivered via telephone conference, and occasionally in on-site sessions.

Building Capability Forums

Once a critical mass of programs (by agency, county, or region) had completed an assessment, a cohort (typically of 12 to 15 programs) was formed, and a venue located in geographic proximity to the programs comprising the cohort was selected and booked. As soon as a date had been confirmed, the ***Building Capability Forum*** was scheduled, and invitations were issued. The purpose of the *Building Capability Forum* was to share CEIC's collective observations from the site visits (including a presentation of aggregate results from the DDCA[MH]T), to explore consistent themes (both strengths and opportunities for improvement) emerging from the site visits, and to discuss a number of strategies that could be implemented to advance capability. As a final exercise, presented near the end of the forum, participants were asked to develop an ***implementation plan*** to improve the capability of their program, using the information from their Assessment Summary Report; the resulting plan, which outlined the steps to be taken in advancing to the next level, became the basis for implementing specific changes.

Peer Recovery Workshops

At the conclusion of the *Building Capability Forum*, CEIC offered a supplemental workshop to the participating providers. The *New York Association of Psychiatric Rehabilitation Services* (NYAPRS) delivered the workshop — titled ***Building Integrated, Recovery Oriented Outpatient Services*** (abbreviated to "***Peer Recovery Workshop***")— was designed to compensate for the demonstrated inability of outpatient service providers' to integrate peer supports. The *Peer Recovery Workshop* imparted a working knowledge of a number of factors that could facilitate the recovery of individuals with co-occurring mental health and substance use conditions. The workshop taught the clinical leaders of participating OMH- and OASAS-licensed outpatient programs to self-assess their recovery programming across specific dimensions, and to develop concrete implementation plans for improvement.

Peer Learning Collaboratives & Communities

Building Capability Forums and *Peer Recovery Workshops* provided an environment in which providers were introduced to one another, contributing to discussions, asking questions, and working together to complete various exercises and activities. CEIC used these events to encourage participants to form professional

networks that would support peer learning collaboratives and peer communities; guidance from CEIC was available to these networks as needed. Within such structures, providers can share information, and promote person-centered, recovery-oriented, and culturally competent enhancements. Cohorts of programs that work together collaboratively can support each other in continuing to build their co-occurring capability, and can identify agencies with which formal agreements can be executed to bridge gaps in integrated care.

Individual Technical Assistance & Implementation Supports

Finally, CEIC continued to support programs through off-site, individual technical assistance, much of which pertained to monitoring implementation activities and assisting staff in advancing their program's COD capability. CEIC staff developed resource documents to support building capability (e.g., "*Quick Guides*" that summarized the most common recommendations), along with detailed program guidelines that provided a roadmap to achieving "Capable" or "Enhanced" levels of care. The primary emphasis was on "*Getting-To-Capable*"; i.e., changes that were easy to implement, required few resources, and circumvented barriers, yet could have a potent effect (e.g., welcoming clients; posting educational material; screening; starting a dual recovery group). At times, a program or group of programs would contact CEIC to request individual technical assistance relating to a specific need. In these cases, CEIC devised a plan of technical assistance combining on- and off-site consultations that responded to the identified obstacles, problems or deficiencies, and that were delivered over time to ensure that the recommended solutions were supported until fully adopted.

Linkages to Other Resources, Supports & Training

Finally, CEIC recommended a number of resources to assist programs in implementing improvements in COD capability. Primary resources are organized in **Table B2[d]** below.

Table B2[d]— *Resources for improving integrated care — Knowledge, Training, Evidence-based Practices (EBPs), and Reference source materials*

resource		description | url to download or to order	source citation
Focus on Integrated Treatment	FIT	An online training resource, FIT consists of 35 individual modules that provide a firm foundation in evidence-based, integrated treatment for COD, including screening and assessment, stage-wise treatment, motivational interviewing, and more. Other modules help clinical supervisors to develop supervision skills and guide agency leaders through changes to ensure the sustainability of integrated treatment. Modules also include inspiring personal recovery stories, clinical vignettes, interactive exercises, and expert panel presentations. FIT also offers online implementation supports through live chats, webinars, "Ask the Expert" forums, and discussion threads.	
		http://www.practiceinnovations.org/CPIInitiatives/FocusonIntegratedTreatmentFIT/tabid/186/Default.aspx	Center for Practice Improvement [CPI], nd[a]
Treatment Improvement Protocol 42 — Substance Abuse Treatment for Persons with Co-Occurring Disorders	TIP 42	A resource for building team competency, TIP 42 can be used to review prioritized areas of co-occurring development. TIP 42, which is can be downloaded from SAMHSA's website (below); SAMHSA will mail hard copy orders at no charge. TIP 42 should be available to all outpatient staff as a resource reference. The most knowledgeable staff member[s] can lead individual counselors or groups in sessions that review material chapter-by-chapter or by section, selected to suit the particular situation. Staff can review this material on its own or as a companion to the in-service training.	
		http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf	Center for Substance Abuse Treatment [CSAT], 2005
[based on TIP 42]		http://store.samhsa.gov/shin/content/SMA08-4262/SMA08-4262.pdf	CSAT, 2007

Table B2[d] *continues on next page*

Table B2[d]— *continued*

resource	description | url to download or to order	source citation
Substance Abuse Treatment for Persons With Co-Occurring Disorders In-service Training	A staff training curriculum that is based on TIP 42. Configured in eighteen 45-minute modules, the *Inservice Training* is designed for on-site delivery at convenient times (i.e., during staff meetings). The manual includes presentation instructions, PowerPoint slides (that can be copied onto overhead transparencies), trainer scripts, and participant handouts. The training approach includes presentations, discussion sessions, and practice exercises for participants, and can be downloaded at the url below.	
TIP 35 — Enhancing Motivation for Change in Substance Abuse Treatment TIP 35	is a *Motivational Interviewing* resource that discusses conceptualization, motivational interviewing as a counseling style, building readiness, and implementation from preparation through stabilization. Measuring motivation components and integration motivational approaches into treatment are also covered. TIP 35 can be downloaded or ordered at the url below. The *Motivational Interviewing* website is another resource for TIP 35 and its inservice training, as well as other information and materials relating to *Motivational Interviewing* are available at the second url below.	
	http://www.ncbi.nlm.nih.gov/books/NBK64967/	CSAT, 1999; revised 2012
	http://www.motivationalinterview.org/index.html	Miller & Moyers, 2006
Enhancing Motivation for Change Inservice Training *w/ Trainer's Orientation* [based on TIP 35]	A *Motivational Interviewing* training curriculum companion to TIP 35, which opens with a *Trainer's Orientation*, can be downloaded or ordered at the url below. Refer also to the Motivational Interviewing website at the url immediately above.	
	http://162.99.3.213/products/manuals/tipcurriculum/pdf/p_complete_manual.pdf	
	http://store.samhsa.gov/product/Enhancing-Motivation-for-Change-Inservice-Training/SMA12-4190	CSAT, 2006; reprinted 2008
Contingency Management | Motivational Incentives [MI] [*a proven approach to treatment*]	A collection of SAMHSA- & NIDA- (National Institute on Drug Abuse) endorsed resources for increasing motivation and improving outcomes, promoted through the ATTC network. The suite consists of: PAMI [*Promoting Awareness of Motivational Incentives* (MI), an introductory training to introduce MI and evidence of clinical effectiveness; MI:PRESTO [*MI: Positive Reinforcers to enhance Successful Treatment Outcomes*], a free, self-directed online course; and MIIS [*MI Implementation Software*], to support implementation. Information, all found at the url below.	
	http://www.bettertxoutcomes.org/bettertxoutcomes/	NIDA | SAMHSA Blending Initiative, nd
Seeking Safety	A readily available trauma curricula that should be incorporated into all programs. The developer, Dr. Lisa Najavits, has created a website (www.seekingsafety.org) to disseminate information about the model; some material can be viewed or downloaded online, while forms can be downloaded to order other items (e.g., training DVDs and manuals) and to request training from Dr. Najavits or her staff	
	http://seekingsafety.org	Najavits, 2006, 2007, 2009; Najavits et al., 2009
Trauma Recovery & Empowerment Model TREM	Originally developed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse, TREM is a fully manualized group intervention that draws on cognitive restructuring, psychoeducational, and skills-training techniques. Gender-specific for men or women, TREM is organized in 24 to 29 sessions that concentrate on improving coping skills and developing social supports in dealing with the short- and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been implemented successfully in mental health, substance abuse, and co-occurring disorders outpatient, residential and criminal justice settings, and among diverse racial and ethnic populations. Purchase information is at the url below.	
	http://www.communityconnectionsdc.org/web/page/593/interior.html	SAMHSA's National Registry of Evidence-based Programs & Practices [NREPP], 2006

Table B2[d] *continues on next page*

Table B2[d]— *continued*

resource		description | url to download or to order	source citation
Wellness Self-Management	WSM	An adaptation of *Illness management and Recovery* (IMR), a nationally recognized evidence-based practice for adults with serious mental health problems, *WSR* is a "strength-based, curriculum-supported program that provides consumers with information, skills and strategies to self manage mental health challenges and to engage in recovery supporting actions." OASAS and OMH have both endorsed the *WSR* curriculum, which was developed in a collaboration that included CPI, OMH, the Urban Institute for Behavioral Health in NYC, and the leadership, staff, and consumers of the numerous mental health agencies across New York State. CPI received SAMHSA's 2010 *Science to Service Award* for its work in developing practical resources, tools, training materials and evaluation methods that have been successful in assisting agencies to adopt and sustain the wellness self management program. The url below Instructs on obtaining materials; no charge to download, but bound copies must be purchased.	
		http://www.practiceinnovations.org/CPIInitiatives/WellnessSelfManagementWSM/tabid/189/Default.aspx	CPI, nd[b]
Wellness Self-Management Plus	WSMP	Working with NYS OMH and OASAS, CPI developed the *Wellness Self Management Plus* curricula specifically for persons with COD. The training contains 57 lessons, each structured and designed to impart useful information, to assist participants with their recovery. Each lesson includes important information about the topic, a personalized worksheet and an action step to allow participants to personalize the information. OASAS has information about WSMP and free training for OMH- and OASAS-licensed programs, at the url below; a brochure is also available for download at the same url.	
		http://www.oasas.ny.gov/wellness/wsmplus.cfm	CPI, nd[c]

the SAMHSA website (http://samhsa.gov; publications and order forms are at http://store.samhsa.gov/home) is an excellent source for high quality educational and training materials that are, for the most part, available free of charge.

C. CEIC Methods

C1. SAMPLE | PARTICIPANTS

C1a. INITIAL ASSESSMENTS — BASELINE

Within its overall strategy for integrating the care of people with co-occurring disorders, CEIC engaged a critical mass of NYS OMH- and OASAS-licensed mental health and substance use outpatient programs. When CEIC began, NYS listed **1,202** licensed providers or programs. To facilitate program recruiting, CEIC divided New York State into 8 geographic regions, and approached programs region by region. Some programs did not respond to multiple outreach attempts, while others declined the offer for CEIC technical assistance, often because, at the time, other programmatic initiatives took precedence. As shown in **Table C1[a]**, CEIC completed DDCA[MH]T assessments of co-occurring capability at **603** of the **1,202** (**50.2%**) officially listed clinics. Substance abuse programs comprise **49.6%** (496/1,000 or 596/1,202) and mental health programs comprise **50.4%** (504/1,000 or 606/1,202) of the total number of OASAS- and OMH-licensed programs. The table also shows the number and percent completed by region. The data from this sample of **603** outpatient programs (**326** mental health programs and **277** substance abuse programs) were collected over almost **5 years** (56 months) of project activities (data collection began November 20, 2008 to June 27, 2013). [17] The 50.2% of programs assessed is considered to be a conservative estimate in that a single on-site assessment often incorporated all of the facility's specialized services, although each specialty service was licensed (and counted) as a separate program.[18]

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[17] The first of the 603 assessments (award 2008-2496857) was completed on November 20, 2008, and the last on June 27, 2013, a data collection term of 4 years and 7 months, or 56 months (data collection for the second award, 2009-3426912 overlapped for 49 months). For the subset of 150 programs that received a second assessment (award 11-02788), the first follow-up assessment was completed on May 16, 2011, and the last on April 10, 2013, a total of 1 year and 11 months, or 23 months.

[18] For example, OASAS issues separate outpatient service licenses to substance abuse clinics, day rehabilitation centers, and specialized services (e.g., "*Traumatic Brain Injury*") but, in practice, such specialty services are delivered to only a small portion of the total clinic population and are absorbed within the functioning of the clinic as a whole —specialty services are likewise included within a single assessment (i.e., several licenses can be represented in only one assessment).

Table C1[a]— *Penetration in New York State of CEIC Technical Assistance at project's end by Region and type of program* (*mental health and substance abuse*) (**n=603**)

#	Region	Substance Abuse (SA)			Mental Health (MH) Programs			SA & MH Programs combined		
		# of SA programs estimated	# of DDCAT assessments #	%	# of MH Programs estimated	# of DDCMHT assessments #	%	total # programs estimated	DDCA[MH]T assessments #	%
1	**Western**	73	36	49%	78	47	60%	**151**	**83**	**55%**
2	**Finger Lakes**	21	13	62%	22	17	77%	**43**	**30**	**70%**
3	**Central**	34	15	44%	35	20	57%	**69**	**35**	**51%**
4	**North Country**	14	11	79%	15	12	80%	**29**	**23**	**79%**
5	**Northeast**	36	22	61%	28	11	39%	**64**	**33**	**52%**
6	**Mid-Hudson**	64	18	28%	83	35	42%	**147**	**53**	**36%**
7	**Long Island**	91	65	71%	63	59	94%	**154**	**124**	**81%**
8	**NYC**	263	97	37%	282	125	44%	**545**	**222**	**41%**
	Totals	**596**	**277**	**46.5%**	**606**	326	**53.8%**	**1,202**	**603**	**50.2%**

CEIC used a regional structure to organize the **62 counties** of New York State. Since the OMH and OASAS used different regional breakdowns, CEIC elected to use the regional system that the *Conference of Local Mental Hygiene Directors* (**CLMHD**, or "the Conference") had developed. The CLMHD system has the advantage of grouping county mental health and substance abuse directors into regions, each of which had an elected chair who served as the pivotal contact person during forum planning consultations. Mid-way through the project, CLMHD reconfigured these regions, eliminating the *Mohawk Valley Region*, and bringing the total number of regions from 9 to 8. The 4 counties that had formed the *Mohawk Valley Region* were allocated either to the *Central Region* (Herkimer and Oneida) or the *Northeastern Region* (Fulton and Montgomery). The 603 programs that CEIC assessed were located in all **8 regions** and in **52** (**84%**) of the **63 counties**. **Figure C1[a]** (below) displays a map of New York State, marked with the 8 regions and the counties in each; those shaded in orange contain programs that have been assessed.

Figure C1[a] — *Map of New York State Regions* [8] *and Counties* [62] *— On-site Assessments completed in 8 Regions & 52 Counties*

1 Western Region—
101 Cattaraugus
102 Chautauqua
103 Erie
104 Genesee
105 Livingston
106 Monroe
107 Niagara
108 Orleans
109 Wyoming

2 Finger Lakes Region—
201 Allegany
202 Chemung
203 Ontario
204 Schuyler
205 Seneca
206 Steuben
207 Tompkins
208 Wayne
209 Yates

3 Central Region—
301 Broome
302 Cayuga
303 Chenango
304 Cortland
305 Delaware
306 Steuben
307 Madison
308 Oneida
309 Onondaga
310 Oswego
311 Otsego
312 Tioga

4 North Country Region—
401 Clinton
402 Essex
403 Franklin
404 Hamilton
405 Jefferson
406 Lewis
407 St. Lawrence

5 Northeastern Region—
501 Albany
502 Columbia
503 Fulton
504 Greene
505 Montgomery
506 Rensselaer
507 Saratoga
508 Schenectady
509 Schoharie
510 Warren
511 Washington

6 Mid-Hudson Region—
601 Dutchess
602 Orange
603 Putnam
604 Rockland
605 Sullivan
606 Ulster
607 Westchester

7 Long Island Region—
701 Nassau
702 Suffolk

8 New York City Region—
801 Bronx
802 Kings
803 New York
804 Queens
805 Richmond

C1b. Second Assessment — Follow-up

A follow-up sample of 150 programs was randomly selected to evaluate the impact of technical assistance (TA) and implementation support. The sampling universe consisted of 282 programs that had completed a baseline DDCA[MH]T assessment on or before June 30, 2011, which would allow 12-month follow-up assessments to be administered on or before October 31, 2012 (the end of the 4th year of data collection). The study sample was stratified by:

[a] New York State region (8 regions in all);
[b] program type (mental health or substance abuse); and
[c] baseline DDCA[MH]T score (an equal number of programs above and below the mean score).

Table C1[b] (next page) depicts the number of DDCA[MH]T assessments conducted in each of the state's eight regions.

The percent of programs in each stratum reflected the statewide distribution of programs to the extent possible within the sampling universe. Random numbers were applied to a list of eligible programs (i.e., those assessed on or before June 30, 2011) in each region, and were then used to draw a random sample divided equally between mental health and substance abuse programs and between programs above and below the mean DDCA[MH]T score. Statewide DDCA[MH]T scores for addiction (OASAS) and mental health (OMH) programs did not differ significantly ($t_{1, 282} = 0.10$), so the combined baseline mean of **2.71** (standard deviation [SD]=0.52) defined "Low" and "High" baseline scores for both types of programs.

Of the first 150 programs approached to participate in the follow-up site-visit evaluation, 120 (80%) agreed to participate. Of those programs that refused a second site visit, 12% (n=18) cited time and resource limitations; while 8% (n=12) had closed, consolidated, or restructured their services, reducing the overall number of programs available for re-assessment. When substitutions were necessary, characteristics of the substituted programs were matched (i.e., region, program type, and baseline score). In four instances, a replacement program with the most similar characteristics (program type and baseline score) was selected from an alternate region because, after all programs had been approached, the original region's target sample had not been met. Of the 150 outpatient treatment programs that participated in follow-up assessments, **68** (**45.3%**) were substance abuse programs, while the remaining **82** (**54.7%**) were mental health clinics.

Table C1[b]— *New York State mental health and substance abuse outpatient programs* (**n=150**) *that completed **follow-up assessments** in each region and overall*

	Type of Outpatient Program	Substance Abuse (SA)		Mental Health (MH)		SA & MH combined	
		# of DDCAT assessments		# of DDCMHT assessments		DDCA[MH]T assessments	
	Region	#	% [of 68]	#	% [of 82]	#	% [of 150]
1	**Western**	8	11.8%	7	8.5%	**15**	**10.0%**
2	**Finger Lakes**	3	4.4%	4	4.9%	**7**	**4.7%**
3	**Central**	7	10.3%	8	9.8%	**15**	**10.0%**
4	**North Country**	3	4.4%	3	3.7%	**6**	**4.0%**
5	**Northeast**	5	7.4%	5	6.1%	**10**	**6.7%**
6	**Mid-Hudson**	4	5.9%	4	4.9%	**8**	**5.3%**
7	**Long Island**	16	23.5%	10	12.2%	**26**	**17.3%**
8	**NYC**	22	32.4%	41	50.0%	**63**	**42.0%**
	Totals[19]	**68**	**45.3%**	**82**	**54.7%**	**150**	**100.0 %**

Inter-rater Reliability

Assessors consisted of senior clinical and research staff from CEIC who had received training from the developer of the DDCA[MH]T indices, Dr. Mark McGovern, conducted all on-site assessments; a different assessor conducted independent follow-up assessments on a subset of clinics (n=10). Inter-rater reliability (Intra-class Correlation Coefficient [ICC]) was 0.961 for the overall score, with ICCs for the individual dimension ranging from 0.690 to 0.945.

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[19] The total percent figures shown for substance abuse and mental health programs (numerators) are calculated using the combined total of 150 programs as the denominator (i.e., 68/150=45.3%; 82/150=54.7%).

Analytic Plan

Analyses focused on the outcomes — primary (the improvement in COD capability, measured with the DDCA[MH]T indices), and secondary (the relationship between time elapsed from baseline to follow-up, and improvements in COD capability). For the primary outcome, a paired sample (repeated measures t-test) was used to determine whether DDCA[MH]T scores (overall, by dimension, and for each item) increased significantly. For the secondary outcome, a Pearson correlation coefficient was used to determine the strength and direction of the association between time elapsed and improvement in COD capability. ANOVAs were then employed to examine the same relationship using a categorical breakdown of time elapsed.

C2. LEADERSHIP FORUMS

C2a. FORMAT, OBJECTIVE, SUMMARY OF ACCOMPLISHMENTS

Leaders from County, OASAS, OMH and, in some cases, provider agencies were invited to attend a *Leadership Forum* to introduce a region to CEIC and its technical assistance services. The *Leadership Forum* took the form of a consultation, whereby attendees learned about CEIC, while CEIC gained an understanding of regional developments in co-occurring disorders that had been adopted and that were in progress. After a presentation that described CEIC, its mission and technical assistance services, leaders were engaged in a discussion that gave CEIC information about the current status of co-occurring services integration in the region. This knowledge was used to determine how CEIC could best complement existing efforts so that the integration of services for co-occurring disorders would be optimized. At the conclusion of the *Leadership Forum*, a strategy was devised to identify individual programs and to encourage them to participate in a CEIC on-site assessment of co-occurring capability (the primary method that CEIC employed to deliver technical assistance). As part of its individual technical assistance (available on request), CEIC also conducted *Leadership Forums* in large agencies with multiple programs/clinics.

Leadership forums were intended to:

[1] present NYS recommended components of screening, assessment, and selected evidence-based treatment practices (EBPs);

[2] generate county leadership "buy-in" to the implementation of the State recommendations;

[3] discuss the potential change process to be followed (e.g., *The Change Book*, Addiction Technology Transfer Center [ATTC], 2004);

[4] build relationships between CEIC and the Regions, Counties, and clinics;

[5] introduce the tools CEIC will be making available to assist with implementation; and

[6] review the current status of co-occurring disorders developments in the region, existing plans for future activity, and Technical Assistance (TA) needs.

When possible, informal advisory groups were initiated at the conclusion of the forum or immediately following. These advisory groups helped CEIC to identify programs and served as a long-term liaison regarding local needs. CLMHD became a vital partner in organizing Leadership Forums and in providing information and introductions to suitable providers in each region. **Table C2[a]** depicts the number of Leadership Forums (n=13) CEIC conducted in each region.

Table C2[a]— *Leadership Forums* conducted from 2008 through 2013

Leadership Forums	2008 – 2009	2009 – 2010	2010 – 2011	2011 – 2012	2012-2013	2008 – 2013
Region	year 1	year 2	year 3	year 4	year 5 NCE	total
1 **Western**	1		2			3
2 **Finger Lakes**		1				1
3 **Central**		1				1
4 **North Country**	1					1
5 **Northeastern**	1					1
6 **Mid-Hudson**			1			1
7 **Long Island**	1					1
8 **New York City**	1	3				4
total	**5**	**5**	**3**	**0**	**0**	**13**

Additional details can be found in Appendix 2

C3. Assessments of Co-occurring [Dual Diagnosis] Capability

C3a. Format, Objective, Summary of Accomplishments

Programs whose history and culture are much closer to single service (delivering services primarily for one condition, with few, if any, services for the other condition) do not achieve an intermediate level of integration ("*Dual Diagnosis Capable*," or "DDC," also called "co-occurring capable"). As the CEIC initiative began, the co-occurring capability of most outpatient clinics was somewhere between single-service ("*Addiction or Mental Health Only Services*," "AOS" or "MHOS") and DDC. Ultimately, New York State is expected to have a system of outpatient care where most providers deliver services rated as co-occurring capable (DDC), with some rated between co-occurring capable and enhanced (DDE). **Table C2[a]** depicts the anchor point ranges for the DDC[MH]T 5-point rating system

Table C3[a]— *Anchor point ranges for the* DDC[MH]T *5-point rating system*

score	anchor point	acronym
1.00 – 1.99 =	*Addiction Only Services*	AOS
	Mental Health Only Services	MHOS
2.00 – 2.99 =	*Addiction Only Services – Dual Diagnosis Capable*	AOS – DDC
	Mental Health Only Services – Dual Diagnosis Capable	MHOS – DDC
3.00 – 3.49 =	*Dual Diagnosis Capable*	DDC
3.50 – 4.49 =	*Dual Diagnosis Capable – Dual Diagnosis Enhanced*	DDC – DDE
4.50 – 5.0 =	*Dual Diagnosis Enhanced*	DDE

Dual Diagnosis Capability in Addiction [or *in Mental Health*] *Treatment* (DDCA[MH]Y — surveys are conducted to measure capability of individual mental health and substance abuse programs. Programs were recruited in Regions/Counties, initially in conjunction with a *Leadership Forum* and consultation with CLMHD, and regional field representatives of OMH and OASAS. An independent objective assessor from CEIC visited each participating program site, spending 3 to 4 hours conducting interviews, touring the facility, and observing program activities; this information was then used to rate the program. The primary source of data was an in-depth interview of key program staff, which typically included executive leadership, program directors, clinical supervisors, clinicians, and medical staff; whenever possible, consumers were also interviewed. Additional information was gathered through observations of program activities, a review of clinical documentation as well as a tour of the program's physical space. At the end of the site visit, the CEIC assessor provided preliminary information on the assessment, and a formal report was compiled and sent to the program director within a week (on average). Reports include a total score and dimension-by-dimension results of the DDCA[MH]T, along with all of CEIC's observations and recommendations for advancing the program's co-occurring capability. **Table C3[b]** lists and briefly describes each of the dimensions. Reports also contained the program's score sheet plus a graphic profile designed to help identify existing strengths while isolating the areas where improvements are needed. The information provided in these reports helps programs to plan how they can advance their COD capability.

Table C3[b]— *Dimensions and items of the* DDCA[MH]T *indices*

#	Dimension	# of Items	Content of Items
I	**Program Structure**	4 items	Program mission, structure & financing, format for delivery of mental health or addiction services
II	**Program Milieu**	2 items	Physical, social & cultural environment for persons with psychiatric or substance use problems
III	**Clinical Process — *Assessment*** (includes *Screening*)	7 items	Processes for access & entry into services, screening, assessment & diagnosis
IV	**Clinical Process — *Treatment***	10 items	Processes for treatment including pharmacological & psychosocial evidence-based formats
V	**Continuity of Care**	5 items	Discharge & continuity for both substance use and psychiatric services, peer recovery supports
VI	**Staffing**	5 items	Presence, role & integration of staff with mental health and/or addiction expertise, supervision process
VII	**Training**	2 items	Proportion of staff trained & program's training strategy for co-occurring disorder concerns

With assistance from CLMHD, CEIC identified suitable programs within regions, and recruited programs for baseline on-site assessments in cohorts (groups of around 15). CEIC scheduled on-site *Dual Diagnosis Capability in Addiction* [*Mental Health*] *Treatment* (DDCA[MH]T) assessments with each agency in the cohort. The site visit lasted approximately 3 to 4 hours; the written report, sent to the program director within a week of the site-visit, detailed observations and recommendations for increasing co-occurring capability. The assessment report included: t (**1**) a narrative review of the assessor's observations and recommendations for improving the program's COD capability in each dimension; (**2**) a program score sheet denoting the score received on each of the 35 items, summary scores for each dimension and overall; and (**3**) a line graph of dimension scores, depicting the program's profile such that the provider could readily identify strengths and opportunities for enhancement. The report's recommendations contained links to relevant training/TA resources, including (but not limited to) webinars, curricula, workshops, and in-service training manuals (e.g., TIPs), NYS-level trainings, particularly the web-based *Focus on Integrated Treatment* (CPI, N.D.[a]), along with other relevant resources (e.g., journal articles, reports, fact sheets). **Table C3[c]** depicts the number of assessments completed in each of the state's eight regions.

Table C3[c]— DDCA[MH]T *Baseline Assessments* (**n=603**) *conducted from 2008 through 2013*

	DDCA[MH]T Assessments Region	2008 – 2009 year 1	2009 – 2010 year 2	2010 – 2011 year 3	2011 – 2012 year 4	2012-2013 year 5 NCE	2008 – 2013 total
1	**Western**	5	4	63	11	0	83
2	**Finger Lakes**	0	20	8	2	0	30
3	**Central**	0	29	6	0	0	35
4	**North Country**	21	0	2	0	0	23
5	**Northeastern**	20	13	0	0	0	33
6	**Mid-Hudson**	4	2	7	33	7	53
7	**Long Island**	30	42	49	3	0	124
8	**New York City**	6	55	61	77	23	222
	total	**86**	**165**	**196**	**126**	**30**	**603**

Additional details can be found in Appendix 2

C4. BUILDING CAPABILITY FORUMS & PEER RECOVERY WORKSHOPS

C4a. FORMAT, OBJECTIVE, SUMMARY OF ACCOMPLISHMENTS

When all agencies in a cohort[20] were assessed, CEIC convened a "***Building Capability Forum"*** for these providers. Early in the forum, aggregate assessment results were reviewed to isolate a number of shared themes and to provide practical assistance on how to improve capability. Next, provider agencies met in breakout groups to discuss the status of their attempts at program improvement. As a final exercise, presented near the conclusion of the forum, participants were asked to develop an ***implementation plan*** to improve the capability of their program, using the information from their *Assessment Summary Report*; the resulting plan, which outlined the steps to be taken in advancing to the next level, became the basis for implementing specific changes. These events also enabled CEIC to encourage participants to form professional networks in the form of peer learning collaboratives and peer communities; CEIC provided guidance to such networks as needed. At the conclusion of the *Building Capability Forum*, participating providers were offered a workshop in recovery services, entitled "***Building Integrated Recovery-Oriented Outpatient Services***"; the workshop became known as the "***Peer Recovery Workshop***" (or "***Building Recovery Workshop***"). Subsequently, CEIC continues to support programs in building their co-occurring capability through off-site technical assistance.

The project conducted **24 *Building Capability Forums*** and **15 *Peer Recovery Workshops***; the annual distribution of forums and workshops by region is shown in **Table C4[a]** below.

Table C4[a]— *Building Capability Forums* (BCF) *& Peer Recovery Workshops* (PRW) *by region and year*

Forums & Workshops Region		2008 – 2009 year 1		2009 – 2010 year 2		2010 – 2011 year 3		2011 – 2012 year 4		2012-2013 year 5 NCE		2008 – 2013 total	
		BCF	PRW	BCF	PRW	BCF	PRW	BCF	PRW	BCF	PRW	BCF	PRW
1	Western							2	3			2	3
2	Finger Lakes					1						1	0
3	Central			1		1	1		1			2	2
4	North Country	2			1							2	1
5	Northeastern	1							1			1	1
6	Mid-Hudson			1								1	
7	Long Island	1		4	1	3	2	1				9	3
8	New York City			2	1	4			3		1	6	5
	total	4	0	8	3	9	3	3	8	0	1	24	15

BCF=*Building Capability Forum* **| PRW**=*Peer Recovery Workshop* [also known as a *Building Recovery Workshop*]

Additional details can be found in Appendix 2

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[20] A typical cohort was composed of 12 to 15 providers or programs.

D. CEIC Results

D1. INITIAL ASSESSMENTS — BASELINE

AIM 1— to assess change in the overall capability of addiction and mental health outpatient clinics to deliver integrated services for clients with co-occurring mental and substance use disorders

D1a. OVERALL SCORES AT BASELINE

Figure D1[a] — *Average baseline* DDCA[MH]T *scores* (**n=603**) *by dimension and overall obtained from on-site assessments*

DDCA[MH]T Summary Profile —
All Participating Programs (N = 603 programs)

Overall Score = 2.71

	Program Structure	Program Milieu	Clinical Process Assessment	Clinical Process Treatment	Continuity of Care	Staffing	Training
DDE (A) upper	4.00	4.50	4.57	4.40	4.60	4.80	5.00
Score	2.53	2.44	3.17	2.57	2.76	3.08	2.42
lower	1.00	1.00	1.57	1.00	1.00	1.00	1.00
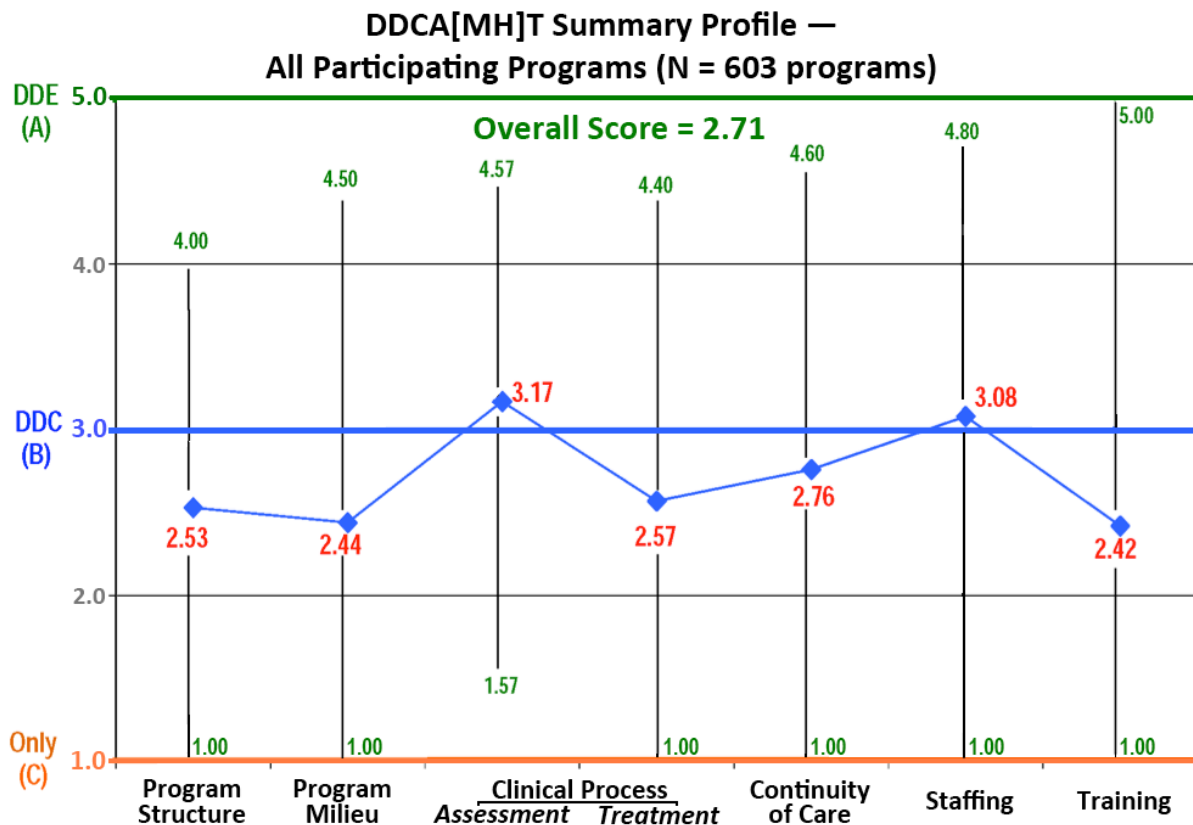
Figure D1[a] (above) shows the DDCA[MH]T averages (on a scale of 1-5) for overall score and across 7 dimensions for a large, "convenience" sample (i.e., a sample selected "for convenience" from programs slated to receive technical assistance, rather than a sample selected to be surveyed specifically for its "representativeness") of **603 programs** from all **8 regions** in New York State. In achieving an **average Overall Score of 2.71** in service delivery, ranging from 2.44 to 3.17 (the vertical line for each dimension depicts the range of scores), the profile illustrates that programs were functioning, on average, closer to "*Dual Disorder Capable*" (**DDC**) than to single disorder (i.e., "*Addiction Only Services*" [**AOS**] or "*Mental Health Only Services*" [**MHOS**]). The highest ratings were achieved in the dimensions of "**Assessment**" (which includes screening) and "**Staffing**"; programs need more development in the other five dimensions to reach *Dual Disorder Capable* ratings in all dimensions.

Table D1[a] displays results from DDCA[MH]T assessments in each domain, which yielded an overall average score of **2.71** (standard deviation [SD]=**0.43**), demonstrating that the 603 participating outpatient programs are, on average, operating much closer to "co-occurring capable" ("*Dual Diagnosis Capable*" or **DDC**) than they are to "basic" (addiction or mental health only services, **AOS** or **MHOS**). Overall, 24% (n=143) of programs (not shown) were scored as co-occurring capable (i.e., 3.0 or higher), while another 20% (n=123) of programs were considered to be approaching co-occurring capable (i.e., a score of 2.75 to 2.99). In other words, nearly half (44%) of the 603 assessed New York State outpatient programs were considered to be providing services that approach or meet the criteria for co-occurring capable. For those programs scoring below co-occurring capable, CEIC's technical assistance recommended improvements that, if implemented, would help programs to reach the co-occurring capable level. These recommendations were site-specific, based on results from the DDCA[MH]T assessment, and built upon existing strengths, while taking into account resource limitations and other programmatic barriers to ensure that implementation would be feasible. Programs that had reached or exceeded the co-occurring capable level received recommendations that would help them to advance towards the "co-occurring enhanced" (*Dual Disorder Enhanced*, **DDE**) level.

Table D1[a] — DDCA[MH]T *results, overall and by dimension for baseline assessments* (**n=603**)

#	Dimension	Mean	(SD)	Minimum	Maximum
	Total Capability	**2.71**	**(0.43)**	**1.22**	**4.06**
1	Program Structure	2.53	(0.46)	1.00	4.00
2	Program Milieu	2.44	(0.62)	1.00	4.50
3	**Assessment** [includes Screening]	**3.17**	**(0.49)**	**1.57**	**4.57**
4	Treatment	2.57	(0.50)	1.00	4.40
5	Continuity of Care	2.76	(0.51)	1.00	4.60
6	**Staffing**	**3.08**	**(0.66)**	**1.00**	**4.80**
7	Training	2.42	(0.68)	1.00	5.00

The line graph (**Figure D1[a]** on the previous page) for all 603 programs plots the mean score for each dimension, producing a program profile of co-occurring capability; the DDCA[MH]T *Assessment Summary Report* included this profile plot, calculated for each individual program. The graphic depiction of capability helped programs to identify their strengths as well as opportunities for advancement. More specifically, the profile allowed programs to isolate areas that needed immediate attention as well as identifying areas where improvements would have the greatest impact on their overall capability. **Figure D1[a]**, along with the information in **Table D1[a]**, revealed that most programs registered their highest scores in the dimensions of **Assessment** and **Staffing**, while the remaining five dimensions (**Program Structure**, **Program Milieu**, **Treatment**, **Continuity of Care**, and **Training**) were all in need of improvements. CEIC generally made recommendations in each of the 7 dimensions, whether scores were high or low, because all dimensions held the potential for advancement, even those that received the highest ratings.

D1b. CAPABILITY BY DIMENSION AT BASELINE

The following sub-sections describe aggregate CEIC findings in each of the 7 DDCA[MH]T dimensions, along with the common themes and guidance that CEIC typically offered to programs that scored below the co-occurring capable (**DDC**) level. For these programs, the mantra was to "get-to-capable"; recommendations were geared to achieving that aim. For those programs that had already attained a COD capable level (overall or in a particular domain), CEIC's recommendations were designed to help the program advance toward the "co-occurring enhanced" (**DDE**) level. Because relatively few programs scored above co-occurring capable, these recommendations have not been emphasized in the descriptions below.

Program Structure

The **Program Structure** dimension measures capability in terms of the agency mission statement, licensing, the existence and structure of collaborations with other outpatient services, and billing practices. Ratings for *Program Structure* (**Table D1[b]**) averaged **2.53** (SD=0.46), which, along with training, received the lowest scores of the 7 domains. In New York State, one agency can be licensed to operate separate mental health and substance abuse programs, but an individual program can hold a license from only one or the other (OMH for mental health clinics, or OASAS for substance abuse clinics), not both. Despite this restriction, almost every program, whether licensed as a mental health or as a substance abuse program, reported the capacity to deliver treatment services for co-occurring disorders, and billed accordingly. In other words, within the context of a primary license, programs that provided services for the co-occurring disorder reported billing for both types of service, substance abuse and mental health. Advancements in these areas of program structure largely depend on changes at the system level (i.e., in existing regulations). CEIC recommendations for improving capability in program structure generally relate to the mission statement or the addition of an "individual service statement" (a program-specific mission statement) and to inter-agency collaboration to foster the delivery of integrated services (e.g., adding collaborative relationships when beneficial, and developing mechanisms to formalize both new and existing collaborative associations).

Table D1[b] — *Item-by-item COD Capability scores at Baseline for* ***Program Structure***

Dimension | *Item*	Baseline n=603	
[1.00] Program Structure	**2.53**	**(0.46)**
1.01 *Mission Statement*	1.75	(1.13)
1.02 *Organizational certification & licensure*	2.94	(0.39)
1.03 *Coordination and collaboration*	2.54	(0.91)
1.04 *Financial incentives* (*billing*)	2.91	(0.45)

Mission and Service Statements. The single item that measures the "co-occurring focus" of the mission statement received an average rating of **1.75** (SD=1.13); two-thirds (65%) of the programs were rated 1, indicating that the mission statement included only the primary addiction or mental health disorder. Despite the fact that most programs have advanced beyond delivering mental health (MHOS} or addiction only services {AOS), and have integrated at least some services for the co-occurring disorder, agency mission statements were rarely revised to reflect these developments. Revising a long-standing mission statement is a complex task for most agencies, because they must consider not only the history of the agency, but also the many competing constituencies, each with a different perspective of what should (or should not) be emphasized. When an agency operates numerous programs, its mission statement is intentionally broad to encompass the wide range of services offered, and to allow the agency the flexibility to meet emerging challenges. If revising the mission statement is either too difficult or impractical, **individual service statements** should be developed to highlight program-specific services. This is especially important for a large agency so that its multiple programs (and their related services) are effectively distinguished. A program's service statement should be posted in common areas — wherever patients congregate (e.g., waiting room, group/classrooms, and staff offices). The service statement should not imply that the program fully treats the other (co-occurring) disorder, but should acknowledge the potential for a mental health or substance use disorder to co-occur and to affect the recovery process. The statement should also state the program's commitment to addressing the co-occurring

disorder and its related problems and concerns throughout the course of treatment. If these guidelines are followed, the resulting service statement will communicate to clients that the program is receptive and committed to treating co-occurring disorders, a key consideration for many whose prior treatment experiences include being denied services because they had a co-occurring disorder. A service statement that encompasses co-occurring disorders (and related issues) could well encourage clients to disclose pertinent information about their co-occurring disorder at the outset.

Interagency Collaboration. The average score on the single item that measures the extent to which collaboration with other providers has been formalized was **2.54** (SD=0.91); of the 603 programs assessed, more than half (57%) could be characterized as lacking entirely or having vague, undocumented or informal cooperative relationships with other agencies. Within the four quadrant system (NASMHPD & NASADAD, 1999), to increase a program's capability, technical assistance first seeks to integrate services for the other disorder such that mental health programs are well-equipped to treat *Quadrant II* clients (high severity mental health disorder and mild to moderate severity substance use disorder), and substance abuse programs are well-equipped to treat *Quadrant III* clients (high severity substance use disorder and mild to moderate severity mental health disorder). Because most of the outpatient programs that CEIC has assessed would struggle to treat *Quadrant IV* clients (high severity of both disorders), CEIC technical assistance concentrates on building collaborations with complementary programs to integrate care for both disorders. For example, programs are encouraged to increase their communication with agencies providing complementary services, towards developing Memoranda of Understanding (MOU) to formalize the relationship and to specify how information is to be shared. Other examples of particular recommendations include holding joint case conferences when common clients are discussed, sharing treatment goals with client permission, and identifying opportunities to cross-train staff.

Program Milieu

The **Program Milieu** dimension captures the program's environment, measuring capability according to the degree to which:

[a] a program accepts clients with co-occurring conditions; and

[b] literature and patient educational material relating to co-occurring disorders is displayed and distributed.

As shown in **Table D1[c]**, the mean score in this domain is **2.44** (SD=0.62). Ninety-two percent of the 603 programs assessed received a rating of 3 or higher (mean=**3.19**; SD=0.68) on *receptivity to clients with both mental health and substance use disorders* (item 1), which indicates that these programs routinely expected incoming clients to have both disorders, and welcomed them to treatment. This suggests that, as a rule, individuals with a co-occurring condition were not excluded at intake; instead, a co-occurring mental health or substance use condition was viewed as the expectation, not the exception. Programs with this attitude not only would be more likely to identify co-occurring problems during intake, but also would tend to be more receptive to recommendations for improving services to treat these clients

Table D1[c] — *Item-by-item COD Capability scores at baseline for* **Program Milieu**

Dimension | *Item*	Baseline n=603	
[2.00] Program Milieu	**2.51**	**(0.46)**
2.01 *Program receptivity to patients with COD*	3.19	(0.68)
2.02 *Display/distribution of patient educational materials*	1.70	(0.95)

For the second item — *the distribution and display of literature and education material focused on mental health, substance use, and co-occurring conditions* — the assessed programs received an average score of **1.70** (SD=0.95); of these programs, more than three-quarters (79%) did not routinely offer or display such materials. Enhancing this area is one of the easiest to implement; for example, a substance abuse treatment program with a basic ("1") rating (i.e., the program distributes materials on substance use only) could

improve their rating to "5," simply by routinely offering a balance of mental health and substance use materials, along with some materials that discuss the interaction between the two disorders. While easy-to-implement, this recommendation affects a substantial change to the environment that the client experiences. CEIC provides resources to enable programs to access educational materials online at no cost, and encourages programs to assign a staff member to monitor this material, its availability, ordering, and distribution.

Clinical Process: Assessment

Screening for COD

The **Assessment** dimension measures 7 items, one of which captures whether or not the program uses a standardized screening tool as part of their intake process. CEIC elected to separate the **Screening** item from the Assessment domain in its reports and recommendations, primarily because NYS had issued specific guidelines and recommendations related to screening to its licensed programs. Acting on the 2007 report of the NYS OMH/OASAS *Task Force on COD*, the Commissioners of OMH and OASAS jointly developed materials to introduce statewide changes that promoted integrated services for COD. These materials were sent in two packages (NYS OMH & OASAS, 2008a,b), along with a letter from the Commissioners, to the directors of all licensed outpatient programs in New York State. Both letters named the 6 screening instruments (three recommended for mental health programs, and 3 recommended for substance abuse programs); the second package, issued on July 31, 2008, included a *Guidance Document* (NYS OMH & OASAS, 2008b) containing additional information on implementation. The three screening tools recommended for use in mental health programs to detect a substance use disorder are the *Modified Simple Screening Instrument for Substance Abuse* (MSSI-SA), the CAGE-*Adapted to Include Drugs* (CAGE-AID), and the *Alcohol, Smoking, Substance Involvement Screening Test* v3 (ASSIST v3); the three screening tools for use in substance abuse programs to detect a mental health disorder are the *Modified MINI Screen* (MMS), *Mental Health Screening Form III* (MHSF-III), and the *K6 Screening Scale* (K6). Each of these screening instruments is in the public domain (available at no cost), brief, line counselor staff can administer, and has demonstrated accuracy in detecting the presence of substance use or mental health disorders.

Table D1[d] — *Item-by-item COD Capability scores at baseline for* **Screening** [item **3.01** of the *Clinical Process—* **Assessment** dimension]

Dimension | *Item*	Baseline n=603
[3.00] Clinical Process — Assessment	**3.17 (0.49)**
3.01 *Routine **Screening***	3.50 (0.82)

In attaining an average score of **3.50** (SD=0.82; **Table D1[d]**) for **Screening**, 89% of the programs assessed achieved a capable rating, which indicates that every client is asked a standard set of questions during intake, typically as part of the biopyschosocial assessment. While satisfying the criteria for a capable rating, this falls short of the State directive to administer a recommended standardized screening tool prior to the assessment. A smaller number of programs, but the majority (56%) still achieved a rating of 4 or more, indicating that a standardized screener was being administered during intake.

When providing recommendations to programs, CEIC emphasizes that screening is an event that is separate from assessment, intended to precede and inform the assessment process. Although programs that are conducting a comprehensive assessment would likely detect a co-occurring disorder, using a standardized screener provides a discrete step that can guide an effective/efficient clinical process, "screening in" those with, and "screening out" those without, a co-occurring disorder. When screening is separate, a protocol should be established that prescribes a course of action for all who have a positive score for further assessment of their co-occurring conditions (e.g., meet with the psychiatrist for an evaluation). For those with a negative score on the screener, the usual single disorder assessment procedure can be followed. Ultimately, the use of a screening tool has quality assurance benefits, ensuring that all those with a positive score complete an integrated assessment, which results in formulating and recording a diagnosis for the other disorder, developing a treatment plan goal for the co-occurring disorder, along with the identification

of a treatment intervention specifically for their co-occurring disorder, and including their co-occurring disorder in the discharge plan.

Assessment

The full **Assessment** dimension includes 7 individual items (one of which is **Screening**), related to intake and assessment. **Table D1[e]** presents results from the 603 programs assessed, with **Assessment** receiving one of the highest ratings, an average score[21] of 3.17 (SD=0.49); two-thirds (66%) of the programs achieved a capable rating (i.e., scored 3 or higher). Overall, co-occurring disorders have been emphasized in most assessment processes, with 93% of programs routinely documenting histories for both mental health and substance use problems in the clinical record (data, not shown); of these, 83% were able to provide a formal mental health assessment, if needed; and a similar proportion (86%) demonstrated an increased capacity to formulate and record a diagnosis for the other disorder, although the latter is routine in only 57% of all programs assessed. The **Assessment** dimension indicates that, in fact, substance abuse programs are admitting *Quadrant III* clients (high severity of substance abuse, and low-to-moderate severity mental health disorder), while mental health programs are admitting *Quadrant II* clients (high severity mental health disorder, low-to-moderate severity substance use). More specifically, approximately 95% of programs generally admit and treat clients presenting with low to moderate symptom severity and acuity for the other disorder.

Table D1[e] — *Item-by-item COD Capability scores at baseline for **Clinical Process: Assessment***

Dimension | Item		Baseline n=603	
[3.00]	*Clinical Process:* **Assessment**	**2.51**	**(0.46)**
3.01	*Routine **Screening***	3.50	(0.82)
3.02	*Routine Integrated Assessment*	3.33	(0.88)
3.03	*Documentation of diagnoses for both disorders*	3.60	(1.03)
3.04	*COD history reflected in medical record*	3.09	(0.48)
3.05	*Program acceptance based on acuity*	3.30	(0.63)
3.06	*Program acceptance based on severity*	3.32	(0.66)
3.07	*Stage-wise assessment*	2.01	(0.92)

The technical assistance emphasis in this dimension has been to encourage programs to formulate and record a diagnosis routinely, to address the interaction of both conditions from the consumer's perspective within the assessment, and to incorporate a more formalized determination of the stages of change for both substance use and mental health conditions. With regard to the latter, the average score for the stage of change item was **2.01** (SD=0.92); of the programs assessed, only 28% achieved a capable rating, while a mere 2% formally determined the stage of change for the other disorder (i.e., a mental health treatment program assessing the stage of change for substance use conditions, or a substance abuse treatment program assessing stage of change for mental health conditions). To assist programs in improving this common shortcoming, CEIC recommended to programs that staff competencies in the Stages of Change model would be developed, and that their assessment protocol would be revised to accommodate a more formal evaluation of the stages of change for both mental health and substance use conditions. Programs should then continue to develop staff competencies in *Motivational Interviewing* to help increase client treatment engagement.

Clinical Process: Treatment

The **Treatment** dimension uses 10 separate items to capture the various types of treatment services the program offers, and the extent to which COD services have been integrated. As depicted in **Table D1[f]**, the treatment dimension received one of the lowest ratings, an average score of **2.57** (SD=0.50); of the 603 programs assessed, only 23% achieved a capable rating. Despite the very real progress that addiction and mental health programs have made in advancing regular programming and the inclusion of a comprehensive

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[21] The score reported for the **Assessment** dimension includes the score for the **Screening** item, which was cited separately in the preceding section.

assessment, many programs have not yet allocated sufficient resources to enhancing treatment services for clients with co-occurring disorders.

Table D1[f] — *Item-by-item COD Capability scores at baseline for **Clinical Process: Treatment***		
Dimension | Item	**Baseline**	**n=603**
[4.00] *Clinical Process*: **Treatment**	**2.57**	**(0.50)**
4.01 *Integrated treatment planning*	2.98	(0.60)
4.02 *Monitor interactive course of both disorders*	2.73	(0.71)
4.03 *Procedures for emergencies*	2.57	(0.68)
4.04 *Stage-wise treatment*	2.03	(0.98)
4.05 *Policies for medication evaluation and management*	2.59	(1.20)
4.06 *Specialized COD interventions*	2.94	(1.01)
4.07 *Psycho-education*	2.69	(0.76)
4.08 *Family education and support*	2.19	(0.78)
4.09 *Specialized interventions to facilitate peer support*	2.62	(0.87)
4.10 *Availability of COD peer recovery supports*	2.32	(0.96)

CEIC recommendations emphasized the integration of COD services within the existing program structure, as well as the implementation of select evidence-based practices for the treatment of co-occurring disorders. First, CEIC recommended that clients be permitted to discuss freely problems related to the co-occurring disorder in any activity, group or individual session, whether or not the activity was focused on co-occurring disorders. In so doing, the program lets clients know that their concerns and questions relating to the other disorder can be managed as they emerge, rather than waiting for a specialized session. Second, CEIC encouraged programs to review their existing treatment schedule to identify opportunities for integrating co-occurring content. Specifically, modules with COD content should be developed to ensure that group and individual counseling sessions routinely incorporate material related to COD. Targeting all interventions, rather than instituting isolated co-occurring interventions, broadens exposure to co-occurring disorders across the treatment population, reaching those clients who have not yet disclosed any concerns or problems related to a co-occurring disorder, or who have not been identified as having a co-occurring disorder. This "all-inclusive" approach has the potential to initiate a critical dialogue and to motivate certain clients to engage in treatment related to the co-occurring disorder. Finally, programs are encouraged to create a "home" for co-occurring disorders as a defined component[s] within the treatment schedule. Normally, this would be the addition of a "Dual Recovery" group and a psychoeducational class, offered to clients diagnosed with co-occurring disorders either as a combined single session or as two separate activities that would cover topics such as medication management and compliance, the symptoms, courses, and interactions of both disorders, and the effect of co-occurring disorders on everyday life.

Higher scores demonstrated that programs had already integrated COD content into the treatment schedule, and that groups and individual counseling sessions generally exhibited a strong focus on COD. For these programs, CEIC's recommendations focused on the integration of more evidence-based practices and specialized co-occurring interventions. For example, programs were advised to organize treatment with a stage-wise approach, which would focus more on education for those who are in early recovery, then shift to relapse prevention strategies in the later stages of recovery. Higher scoring programs were encouraged to adopt curriculum-driven interventions (e.g., in the areas of trauma and wellness self-management) to encourage the further integration of co-occurring content and routine exposure. Programs were also advised to gradually build staff competencies in *Motivational Interviewing*, *Cognitive Behavioral Therapy* and other State recommended evidence-based treatment practices from the substance abuse field that could significantly improve a clinician's capacity to deliver both group and individual counseling for clients with COD.

Other items measured in the **Treatment** domain included the extent to which a program had integrated peer recovery supports, and whether a focus on COD was evident; most of the 603 programs assessed had real limits in these areas. For example, 60% either did not have access to peer recovery supports for patients with COD, or rarely referred clients to the few peer recovery resources available off-site. Similarly, a large

majority (88%) had limited or no access to any specialized interventions to facilitate use of peer support groups during treatment (data, not shown); where access was available, either the resource did not have a COD focus, or client referrals were variable. Only 12% of programs had specialized on-site interventions to facilitate the use of peer support groups with a focus on co-occurring disorders. To bridge this common gap, which was apparent early in the project, CEIC partnered with NYAPRS in offering a separate technical assistance activity (the *Peer Recovery Workshop*) to disseminate various strategies for integrating peer recovery supports and developing peer roles in outpatient services.

Continuity of Care

The **Continuity of Care** dimension consists of 5 items that measure the extent to which co-occurring disorders are accommodated in discharge planning. Programs scored **2.76** (SD=0.51) on average (shown in **Table D1**[g]), with less than half (47%) achieving a co-occurring capable rating in the domain. Overall, programs that routinely included the co-occurring disorder in their treatment planning continued to do so during their discharge planning. Specifically, of the 603 programs assessed, over three-quarters (82%) systematically considered COD in their discharge planning for off-site referral (data, not shown). Similarly, 79% routinely ensured the appropriate linkages to community-based mental health or substance abuse treatment services at discharge. Almost two-thirds (64%) of substance abuse treatment programs were able to ensure a sufficient supply of psychotropic medication to last until the client was able to connect with a mental health provider in the community, while only 48% of mental health providers were likewise able to ensure a short-term supply of substance use medications sufficient to span the gap from discharge to the receipt of comparable services in the community.

Table D1[g] — *Item-by-item COD Capability scores at baseline for **Continuity of Care***

Dimension | Item		Baseline n=603	
[5.00]	**Continuity of Care**	**2.76**	**(0.51)**
5.01	*COD addressed in discharge plan*	2.93	(0.59)
5.02	*Capacity to maintain treatment continuity*	2.89	(0.73)
5.03	*Focus on ongoing recovery issues for both disorders*	2.97	(0.62)
5.04	*Facilitate connections to community peer support*	2.63	(0.68)
5.05	*Sufficient supply and compliance plan for medications*	2.33	(1.10)

Programs scored **2.63** (SD=0.80) on average in facilitating peer support groups; 67% achieved a co-occurring capable rating (data, not shown). Yet, while peer support groups for addiction (e.g., AA, NA) were readily available in most communities, co-occurring disorders self-help groups (e.g., *Double-Trouble in Recovery* [DTR]; *Dual Recovery Anonymous* [DRA]) were not. To bridge this gap, programs were encouraged to explore more traditional self-help groups, identifying those that were receptive to COD clients, and collaborating with other community substance abuse and mental health providers to develop a self-help group for COD similar to DTR/DRA.

Staffing

The **Staffing** dimension consists of 5 items to measure:

- [a] the capacity of a program to prescribe addiction or psychotropic medication;
- [b] staff credentials;
- [c] staff supervision structure;
- [d] case review procedures; and
- [e] the involvement of alumni peer supports.

Of the 7 dimensions, **Staffing** received the second-highest rating with an average score of **3.08** (SD=0.66), as shown in **Table D1**[h]. Overall, about 81% of programs had access to a psychiatrist or physician who could prescribe medication (i.e., access to a prescriber of pharmacological therapies for addiction in mental health programs, and of psychotropic medications in substance abuse treatment programs); the prescriber was a

staff member in 45% of these programs, and a consultant or contractor in the remaining 36% (data, not shown).

Table D1[h] — *Item-by-item COD Capability scores at baseline for **Staffing***

Dimension | Item		Baseline n=603	
[6.00]	**Staffing**	**3.08**	**(0.66)**
6.01	*Access to a prescriber*	3.06	(1.35)
6.02	*Clinical staff members with licensure*	3.33	(1.29)
6.03	*Access to COD supervision and consultation*	3.57	(0.81)
6.04	*Case review procedures that emphasize COD*	3.17	(0.72)
6.05	*Availability of COD peer/alumni supports*	2.26	(1.04)

Staffing patterns were significantly different in mental health and substance abuse treatment programs. In more than one-third (38%) of the substance abuse programs assessed, 50% or more of the clinical staff members held mental health licensure, while only 21% of the mental health programs had a corresponding 50% or more of the clinical staff members that held substance abuse licensure, certification or competency. Clearly, the high prevalence of mental disorders within their client population has prompted substance abuse outpatient programs to recruit licensed social workers (i.e., with competency in mental health conditions). Conversely, while mental health outpatient programs have acknowledged the high prevalence of substance use problems in their client population, the majority of the licensed social workers on staff have not pursued a substance abuse credential (e.g., a Certified Addiction Substance Abuse Counselor [CASAC]), at least partly because they consider their mental health licensure to be the higher standard in the field. Where program clinical staff members lack competency in the co-occurring disorder, CEIC recommends that staff strengthen their skills in the other disorder, pursuing additional training and certification.

With regard to the supervision structure, 91% of programs achieved a capable score, indicating that the on-site supervision of clinicians had a focus on co-occurring disorders. Less than half (46%) of these programs used an informal model of supervision, with most clinical supervisors employing an open-door policy that enabled clinicians to discuss their concerns and problems relating to the co-occurring disorder as needed, but supervision was not regularly scheduled. The remaining programs (56%) provided regularly scheduled supervision, which typically involved individual and group sessions. CEIC technical assistance emphasizes the fact that clinical supervision is likely to play a significant role in the development of staff competencies in the co-occurring disorder. Consequently, CEIC recommends a formal supervision model for all programs, in which clinicians receive regular individual and group supervision. Programs are also encouraged to ensure that issues related to the co-occurring disorder are considered in every supervisory session and, whenever possible, the medical staff (e.g. psychiatrist, medical director, nurse practitioner) should be available to provide expert advice. The case review procedures of the vast majority of programs (88%) scored at the capable level, indicating that case reviews maintained a COD perspective, routinely considering needs, concerns and problems arising from the co-occurring disorder.

Another item in the **Staffing** domain rated programs on the availability of co-occurring disorders peer and alumni supports. Programs had a mean score of **2.26** (SD=1.04) for this item (**Table D1**[h]), with 48% of programs achieving a capable rating, indicating that less than half of the programs were able to offer peer or alumni supports to their clients, whether through informal or formal relationships (e.g., with peer support groups in the community). The same proportion of programs (50%) had no connections to peer or alumni COD supports in the community. Technical assistance from CEIC in this area encourages programs to begin by developing informal roles for alumni within the program (e.g., to present their experiences to new clients during orientation), followed by the introduction of formal arrangements (e.g., paid positions for graduates). Programs are advised to consult the Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005), for guidance on this type of development, to collaborate with providers in developing a shared resource (e.g., a Double Trouble in Recovery Group), and to attend a workshop on the integration of peer supports, hosted by CEIC's partner, the New York Association of Psychiatric Rehabilitation Services (NYAPRS).

Training

The **Training** dimension consists of two items that measure whether staff has received basic training in the common signs and symptoms of substance use and mental health disorders as well as advanced specialized training in the treatment of persons with co-occurring disorders. The average program score was **2.42** (SD=0.68), as shown in **Table D1[i]**, with only 26% of programs achieving at a co-occurring capable rating (data, not shown). More specifically, 40% of programs had instituted a strategic training plan to ensure that clinical staff receives basic training in COD, while only 29% of programs reported that at least half of their clinical staff had received advanced specialized training in the treatment of COD.

Table D1[i] — *Item-by-item COD Capability scores at baseline for **Training***

Dimension | Item	Baseline n=603	
[7.00] Training	**2.42**	**(0.68)**
7.01 *Staff have received basic COD training*	2.52	(0.72)
7.02 *Staff have received advanced specialized training*	2.31	(0.85)

Recommendations in this area highlight in-service training resources to enable programs to provide regular training in COD as needed. One highly recommended resource is the in-service training based on TIP 42 (CSAT, 2007). The TIP 42 *In-Service Training Manual* is composed of 45-minute modules, which can be selected according to prioritized areas of co-occurring development and delivered by program staff. Another resource that CEIC routinely recommends is the NYS OMH- and OASAS-funded *Focus on Integrated Treatment* (FIT), which is delivered online by the Center for Practice Innovations (CPI, N.D.[a]) at Columbia University. FIT offers 35 individual co-occurring disorders modules in the areas of screening and assessment, stage-wise treatment, and motivational interviewing, along with modules to assist clinical supervisors to enhance their clinical skills and to guide agency leaders through changes to ensure sustainability of integrated treatment. Inspiring personal recovery stories, clinical vignettes, interactive exercises and expert panel presentations have been incorporated into the FIT series. This online learning course gives practitioners the flexibility to choose when and where training occurs. Finally, CEIC also advises staff to engage in professional exchanges with other outpatient providers so that program staff members share their expertise, providing in-service training sessions on co-occurring disorders topics of interest.

The complete summary of average scores by dimension and item within dimension are provided in **Table D1[j]** on the next page.

Table D1[j] — *Average* DDCA[MH]T *COD capability scores at baseline by dimension and item* [**n=603**]

Dimension & Item		Baseline n=603	
[1.00]	**Program Structure**	**2.53**	**(0.46)**
1.01	Mission Statement	1.75	(1.13)
1.02	Organizational certification and licensure	2.94	(0.39)
1.03	Coordination and collaboration	2.54	(0.91)
1.04	Financial incentives (billing)	2.91	(0.45)
[2.00]	**Program Milieu**	**2.44**	**(0.62)**
2.01	Program receptivity to patients with COD	3.19	(0.68)
2.02	Display/distribution of patient educational materials	1.70	(0.95)
[3.00]	*Clinical Process* — **Assessment**	**3.17**	**(0.49)**
3.01	Routine Screening	3.50	(0.82)
3.02	Routine Integrated Assessment	3.33	(0.88)
3.03	Documentation of diagnoses for both disorders	3.60	(1.03)
3.04	COD history reflected in medical record	3.09	(0.48)
3.05	Program acceptance based on acuity	3.30	(0.63)
3.06	Program acceptance based on severity	3.32	(0.66)
3.07	Stage-wise assessment	2.01	(0.92)
[4.00]	*Clinical Process* — **Treatment**	**2.57**	**(0.50)**
4.01	Integrated treatment planning	2.98	(0.60)
4.02	Monitor interactive course of both disorders	2.73	(0.71)
4.03	Procedures for emergencies	2.57	(0.68)
4.04	Stage-wise treatment	2.03	(0.98)
4.05	Policies for medication evaluation and management	2.59	(1.20)
4.06	Specialized COD interventions	2.94	(1.01)
4.07	Psycho-education	2.69	(0.76)
4.08	Family education and support	2.19	(0.78)
4.09	Specialized interventions to facilitate peer support	2.62	(0.87)
4.10	Availability of COD peer recovery supports	2.32	(0.96)
[5.00]	**Continuity of Care**	**2.76**	**(0.51)**
5.01	COD addressed in discharge plan	2.93	(0.59)
5.02	Capacity to maintain treatment continuity	2.89	(0.73)
5.03	Focus on ongoing recovery issues for both disorders	2.97	(0.62)
5.04	Facilitate connections to community peer support	2.63	(0.68)
5.05	Sufficient supply and compliance plan for medications	2.33	(1.10)
[6.00]	**Staffing**	**3.08**	**(0.66)**
6.01	Access to a prescriber	3.06	(1.35)
6.02	Clinical staff members with licensure	3.33	(1.29)
6.03	Access to COD supervision and consultation	3.57	(0.81)
6.04	Case review procedures that emphasize COD	3.17	(0.72)
6.05	Availability of COD peer/alumni supports	2.26	(1.04)
[7.00]	**Training**	**2.42**	**(0.68)**
7.01	Staff have received basic COD training	2.52	(0.72)
7.02	Staff have received advanced specialized training	2.31	(0.85)
	Total	**2.71**	**(0.43)**

D2. FOLLOW-UP ASSESSMENTS

D2a. OVERALL SCORES AT FOLLOW-UP *versus* BASELINE

> **AIM 2**— to examine change in the capacity of addiction and mental health outpatient clinics to improve screening, assessment, and evidence-based treatment practices in providing services for clients with co-occurring mental and substance use disorders

Baseline DDCA[MH]T assessments of 150 outpatient programs (depicted in **Figure D2[a]**) had an average overall score of **2.68** (standard deviation [SD]=0.42), demonstrating that these programs were closer to "Capable" (3.0=DDC) than to "Basic" (1.0= AOS or MHOS). The *Assessment* and *Staffing* dimensions, with the highest scores, were above "Capable," while *Program Structure*, *Program Milieu*, *Treatment*, *Continuity of Care*, and *Training* were all below "Capable." [**Note**: *The full Baseline sample* (**n=603**) *had a total score of* **2.71**.]

Follow-up assessments, conducted at least one-year post-baseline, indicated that:

- the average overall score had increased significantly to 3.04, shown in **Figure D2[a]**;
- significant gains were achieved overall and in each of the dimensions, ranging from a low of 0.16 for *Assessment* to a high of 0.68 for *Training*, shown in **Figure D2[a]**; and
- 78 of the 150 programs (52%) were rated "Capable" or above, more than double the 33 programs (22%) that were rated "Capable" or above at baseline, shown in **Figure D2[b]** (next page).

Figure D2[a]— *Average baseline and follow-up* DDCA[MH]T *scores* (**n=150**) *by dimension and overall obtained from on-site assessments**
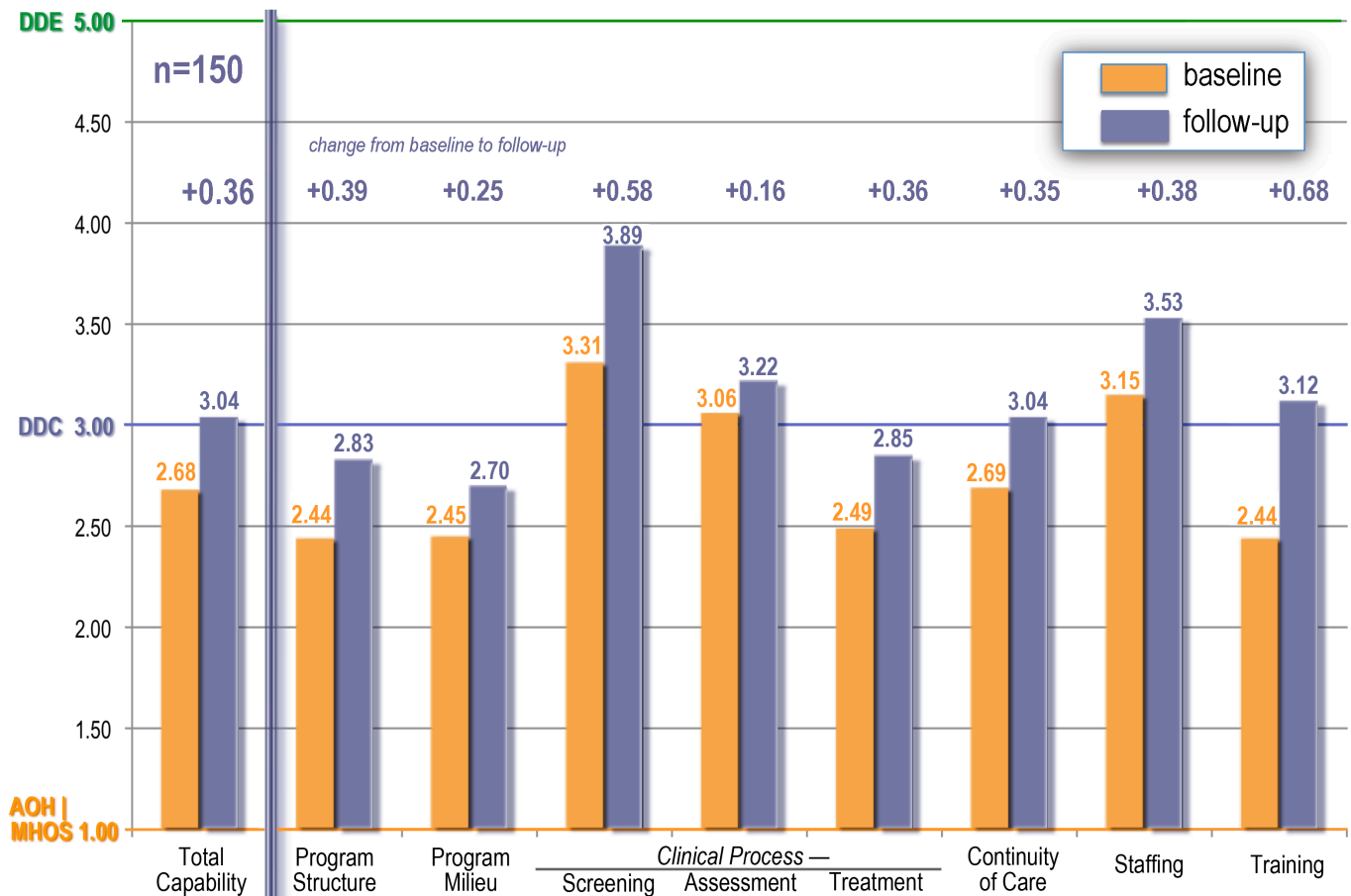
*The **Screening** item has been separated from the **Assessment** dimension and is presented separately.*

Figure D2[b]— *Proportion of clinics (**n=150**) with ratings of DDC ("Capable") or higher before (at baseline) and after (at follow-up) receiving technical assistance & implementation supports*
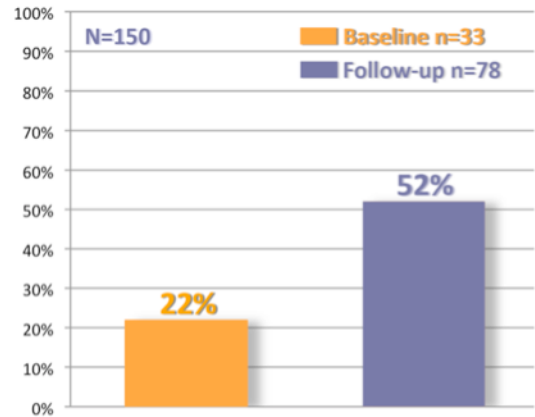
D2b. GAINS IN CO-OCCURRING DISORDERS CAPABILITY

Gains Overall and by Dimension

Table D2[a] illustrates improvements for each of the indices' 35 items. Significant increases were shown for 26 items, for all 7 dimensions, and for the majority of items in each dimension except *Assessment* (where 6 of 7 item scores at baseline were already above the 3.0 "Capable" level; 3 of 7 items had significant increases at follow-up). Of the 9 items that had non-significant changes, 4 increased slightly and 5 had small decreases (ranging from 0.01 to 0.11 on the 5-point scale).

Table D2[a]— *Item-by-item improvements in COD Capability [**n=150**] from baseline to follow-up (**n=150**)*

Dimension | *Item*	Baseline n=150		Follow-up n=150		p<
[1.00] Program Structure	**2.44**	**(0.40)**	**2.83**	**(0.48)**	**0.001**
1.01 Mission Statement	1.56	(0.97)	2.24	(1.15)	0.001
1.02 Organizational certification and licensure	2.89	(0.46)	3.01	(0.38)	0.018
1.03 Coordination and collaboration	2.49	(0.81)	3.03	(0.97)	0.001
1.04 Financial incentives (billing)	2.84	(0.52)	3.05	(0.29)	0.001
[2.00] Program Milieu	**2.45**	**(0.62)**	**2.70**	**(0.60)**	**0.001**
2.01 Program receptivity to patients with COD	3.22	(0.68)	3.17	(0.44)	ns
2.02 Display/distribution of patient educational materials	1.67	(0.93)	2.23	(1.04)	0.001
[3.00] Clinical Process — Assessment	**3.06**	**(0.49)**	**3.22**	**(0.35)**	**0.001**
3.01 Routine Screening	3.31	(0.85)	3.89	(0.50)	0.001
3.02 Routine Integrated Assessment	3.23	(0.89)	3.65	(0.76)	0.001
3.03 Documentation of diagnoses for both disorders	3.49	(1.09)	3.53	(0.83)	ns
3.04 COD history reflected in medical record	3.15	(0.56)	3.14	(0.49)	ns
3.05 Program acceptance based on acuity	3.17	(0.59)	3.13	(0.43)	ns
3.06 Program acceptance based on severity	3.19	(0.61)	3.11	(0.49)	ns
3.07 Stage-wise assessment	1.86	(0.97)	2.09	(0.87)	0.009

Continued next page

Table D2[a]—*continued*

Dimension	Item	Baseline n=150		Follow-up n=150		p<
[4.00]	***Clinical Process* — Treatment**	**2.50**	**(0.50)**	**2.85**	**(0.43)**	**0.001**
4.01	Integrated treatment planning	2.91	(0.61)	3.12	(0.52)	0.001
4.02	Monitor interactive course of both disorders	2.66	(0.77)	2.73	(0.51)	ns
4.03	Procedures for emergencies	2.45	(0.66)	3.08	(0.70)	0.001
4.04	Stage-wise treatment	1.85	(1.05)	2.21	(1.05)	0.001
4.05	Policies for medication evaluation and management	2.69	(1.18)	2.65	(0.96)	ns
4.06	Specialized COD interventions	2.77	(0.95)	3.38	(0.84)	0.001
4.07	Psycho-education	2.64	(0.84)	2.94	(0.71)	0.001
4.08	Family education and support	2.06	(0.84)	2.75	(0.62)	0.001
4.09	Specialized interventions to facilitate peer support	2.55	(0.89)	3.15	(0.64)	0.001
4.10	Availability of COD peer recovery supports	2.34	(1.07)	2.45	(0.94)	ns
[5.00]	**Continuity of Care**	**2.70**	**(0.53)**	**3.04**	**(0.38)**	**0.001**
5.01	COD addressed in discharge plan	2.86	(0.66)	3.13	(0.41)	0.001
5.02	Capacity to maintain treatment continuity	2.88	(0.73)	3.33	(0.59)	0.001
5.03	Focus on ongoing recovery issues for both disorders	2.92	(0.65)	3.11	(0.43)	0.001
5.04	Facilitate connections to community peer support	2.55	(0.71)	2.88	(0.59)	0.001
5.05	Sufficient supply and compliance plan for medications	2.26	(1.12)	2.74	(0.93)	0.001
[6.00]	**Staffing**	**3.16**	**(0.64)**	**3.53**	**(0.49)**	**0.001**
6.01	Access to a prescriber	3.37	(1.34)	3.68	(1.05)	0.009
6.02	Clinical staff members with licensure	3.36	(1.36)	3.93	(1.07)	0.001
6.03	Access to COD supervision and consultation	3.58	(0.85)	3.48	(0.54)	ns
6.04	Case review procedures that emphasize COD	3.19	(0.69)	3.83	(0.60)	0.001
6.05	Availability of COD peer/alumni supports	2.25	(1.14)	2.74	(0.90)	0.001
[7.00]	**Training**	**2.44**	**(0.70)**	**3.13**	**(0.65)**	**0.001**
7.01	Staff have received basic COD training	2.56	(0.74)	3.25	(0.79)	0.001
7.02	Staff have received advanced specialized training	2.32	(0.88)	2.99	(0.71)	0.001
	Total	**2.68**	**(0.42)**	**3.04**	**(0.35)**	**0.000**

Time Elapsed between Site Visits & Gains in COD Capability

On average, programs (n=150) received a follow-up assessment nearly two years (mean=650 days; SD=197.31) after their baseline assessment, with a range of from one to three years (373 to 1,190 days).

Table D2[b] — *Relationship between days elapsed and gains in COD Capability* [**n=150**]

Time Elapsed between Site Visits	N	Mean Gain		Lower bound 95% CI	Upper bound 95% CI
Shortest — 12–18 months (365-550 days)	52	0.3800	(0.28)	0.30	0.46
Intermediate — 18-24 months (551-730 days)	54	0.2561	(0.25)	0.19	0.32
Longest — 24-36 months (≥731 days)	44	0.4820	(0.37)	0.37	0.59
Total	**150**	**0.3653**	**(0.31)**	**0.32**	**0.42**

CI=Confidence Interval

- ■ Pearson correlation coefficients (not shown) revealed that the interval between assessments was significantly associated with the improvement in overall DDCA[MH]T score (r=0.166; p=0.043), indicating that more time between site visits meant more improvement in COD capability.

■ **Table D2[b]** shows that programs with the longest time between baseline and follow-up (2 to 3 years) achieved the largest gain in capability (0.48). Conversely, gains for programs with the shortest (1 to 1.5 years) interval (0.38) were greater than the gains for programs in the intermediate (1.5 to 2 years) interval (0.26) (F=7.003).

■ Increases were significantly less for "*Capable*" programs (mean=0.15, SD=0.17) than for programs below "***Capable***" (mean=0.42, SD=0.32; p<0.001) (t=4.717).

D2c. COMPARING MENTAL HEALTH (MH) OUTPATIENT PROGRAMS [n=326] & SUBSTANCE ABUSE (SA) OUTPATIENT PROGRAMS [n=277] AT BASELINE

As shown in **Figure D2[c]**, substance abuse outpatient treatment programs (n=278) had an average DDCAT score of 2.74, while their mental health counterparts (n=325) had an average DDCMHT score of 2.68; although the marginal mean difference (0.06) was not statistically significant (p=0.064). In other words, prior to receiving CEIC technical assistance and implementation supports, overall capability scores demonstrated that substance abuse and mental health treatment programs were comparable (statistically equivalent) in the degree to which they were able to deliver integrated services to their clients with COD.

The scores for the 7 individual dimensions revealed that substance abuse and mental health treatment programs had similar profiles on four [**4**] dimensions—*Program Structure*, *Program Milieu*, **Clinical Process**—*Assessment*, and *Training*; whereas, substance abuse programs had significantly higher scores (demonstrating increased capability) on the other three [**3**] dimensions—**Clinical Process**—*Treatment* (2.64 vs. 2.50; p=0.001), *Continuity of Care* (2.82 vs. 2.70; p=0.006) and *Staffing* (3.18 vs. 2.99; p=0.006) .

Figure D2[c] — *COD Capability of Mental Health* [**MH**] *and Substance Abuse* [**SA**] *outpatient programs at baseline* (**n=601**)

Summary Profile Comparison [n=601]

Mental Health [DDCMHT; n=325] *versus* Substance Abuse [DDCAT; n=278] outpatient programs

	Program Structure	Program Milieu	Clinical Process Assessment	Treatment	Continuity of Care	Staffing	Training
SA=	2.52	2.44	3.20	2.64	2.82	3.18	2.42
MH=	2.55	2.45	3.14	2.50	2.70	2.99	2.42
	n.s.	n.s.	n.s.	p=0.001	p=0.006	p=0.006	n.s.

DDE — Dual Diagnosis Enhanced: Full capability for providing services to any client with COPSD and the ability to address both disorders fully and equally. 5.0

325 Mental Health Oupatient Programs Baseline total score = **2.68**

278 Substance Abuse Outpatient Programs Baseline total score =**2.74** p=0.064

Baseline

DDC — Dual Diagnosis Capable: Some capability for providing services to individuals with COPSD, while retaining a primary emphasis on serving individuals with mental health disorders only. 3.0

MHOS | AOS — Mental Health [Addiction] Services Only: providing serivces to clients with only mental health [addiction] disorders 1.0

Experience among CEIC staff conducting assessments suggests several reasons that could account for these differences.[22]

Regarding the **Clinical Process —** *Treatment* dimension, only in recent years have mental health programs begun to shift their method of treatment delivery from a traditional reliance on individual counseling; group therapy has been provided less frequently. Conversely, group therapy has been the primary method of treatment delivery in substance abuse treatment programs, with support from more limited individual counseling. Without the benefit of group therapy, mental health programs face several unique challenges when implementing integrated treatment services. In the main, substance abuse treatment programs found the incorporation of mental health content within the context of substance abuse treatment groups to be feasible and easily achieved; as a result, SA programs were much more likely to be providing, or to be developing specialized groups targeted to client with co-occurring mental health problems. Content that has been incorporated within group therapy can be widely disseminated to clients using fewer staff resources. In mental health programs, the equivalent dissemination of substance use content would require all staff members to be trained in deliver a group intervention, which would, in turn, likely be implemented with great variability and limited fidelity due to variations among clinicians in their commitment to, and comfort with, the intervention. For those mental health programs that had already implemented a group treatment schedule, integrated substance abuse treatment content appeared to be more commonly incorporated with fewer barriers.

Differences between substance abuse and mental health programs in the ***Continuity of Care*** dimension could be attributed to two factors.

> ***First***, substance abuse treatment providers were more likely to incorporate medication (i.e., psychotropics) linkages in discharge plans. That is, most substance abuse programs had the capacity to prescribe psychotropic medication, often via a psychiatrist on staff, and routinely issued a 30-60 day supply of psychotropic medication to discharged clients, which would be a sufficient quantity to last until a new prescription could be obtained from a community mental health treatment provider or a private physician. The provision of addiction pharmacology in mental health programs was rare, and not as widely accepted as was the use of medication to control psychiatric symptoms. As a consequence, mental health programs had little capacity to bridge the gap in addiction medication at discharge.

> ***Second***, during the discharge process, substance abuse treatment programs were more likely to emphasize connecting with peer support and mutual self-help groups in the community. This included more traditional addiction-focused groups, such as *Alcoholics Anonymous* (AA) and *Narcotics Anonymous* (NA), as well as groups specifically for co-occurring disorders, such as *Double Trouble in Recovery* (DTR) and *Dual Recovery Anonymous* (DRA), and mental health-focused groups, such as the *National Alliance for Mental Illness* (NAMI) and *Emotions Anonymous*. In mental health programs, clinicians were less likely to promote, and inconsistent in promoting client participation in mutual self-help groups within the discharge plan and at discharge. This situation is understandable, since mutual self-help approaches originated in the substance use field.

Differences between substance abuse and mental health programs in the *staffing* dimension could also be attributed to two main factors.

> **First**, as was mentioned above, substance abuse treatment programs were more likely to have access to a psychiatrist or physician who could prescribe psychotropic medication; on the other hand, mental health programs were less likely to have access to a prescriber of addiction pharmacology.

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[22] The authors caution that much of what follows is limited and somewhat speculative in nature, but these observations are offered as an impetus for further discussion.

Second, staff teams in substance abuse treatment programs were typically multidisciplinary. That is, in substance abuse treatment, especially in more urban and suburban areas, staff members typically included licensed mental health professionals, such as LMSWs, LCSWs, psychiatric nurse practitioners and psychiatrists. Conversely, while some mental health programs employed personnel who had experience working in substance abuse treatment settings and with substance abusers, only a tiny proportion of mental health staff had substance abuse credentialing (e.g., *Certified Addiction and Substance Abuse Counselor* [CASAC]), in part because licensed social workers have little professional incentive to obtain addiction credentialing in that their existing licensure represents a higher standard in the field. Still, a lack of credentialing can be a barrier to integrated care as many social work programs do not include formal addictions training as part of their degree programs. For this reason, a license in social work does not in and of itself impart the expertise in addiction treatment that is needed to deliver effective treatment to mental health clients with co-occurring substance use disorders.

As a final observation, the scores are obtained on two indices that, although related, are still separate instruments and the ability of each to measure capability on any single dimension or overall would not necessarily be equivalent.

Evaluation Study Subset (n=150) — Baseline Capability for 82 MH & 68 SA Programs

Figure D2[d] below compares COD capability at baseline for the subset of programs (**n=150**) that participated in the evaluation study. Similar to the full sample (**N=603**) presented in **Figure D2[c]** above, overall COD capability scores for mental health (2.65) and substance abuse (2.71) outpatient treatment programs were not significantly different. Comparing scores obtained on individual dimensions, substance abuse and mental health treatment programs produced similar profiles on five [**5**] of seven dimensions— *Program Structure*, *Program Milieu*, **Clinical Process–***Assessment*, *Continuity of Care*, and *Training*. Substance abuse programs had significantly higher scores on the remaining two [**2**] dimensions— **Clinical Process–***Treatment* (2.60 vs. 2.40; p=0.015) and *Continuity of Care* (2.84 vs. 2.57; p=0.001). Thus, with the exception of the ***Staffing*** dimension, baseline comparisons between mental health and substance abuse programs for the full sample (n=603) and the evaluation study subset (n=150) were similar. The same reasons cited above for the discrepancies between the mental health and substance abuse treatment systems would apply to the follow-up sample.

Figure D2[d]— *COD Capability **at baseline** for the subset (**n=150**) of mental health (MH; **n=82**) and substance abuse (SA; **n=68**) outpatient programs that participated in the evaluation study*

Summary Profile Comparison [n=150 Evaluation Study]

Mental Health [DDCMHT; n=82] *versus* Substance Abuse [DDCAT; n=68] outpatient programs

DDE 5.0
Dual Diagnosis Enhanced: Full capability for providing services to any client with COPSD and the ability to address both disorders fully and equally.

**82 Mental Health Ouapatient Programs
Baseline total score = 2.65**
**68 Substance Abuse Outpatient Programs
Baseline total score =2.71**   p=0.369   **Baseline**

DDC 3.0
Dual Diagnosis Capable: Some capability for providing services to individuals with COPSD while retaining a primary emphasis on serving individuals with mental health disorders only.

MHOS | AOS
Mental Health [Addiction] Services Only: providing serivces to clients with only mental health [addiction] disorders 1.0

	Program Structure	Program Milieu	Clinical Process Assessment	Clinical Process Treatment	Continuity of Care	Staffing	Training
SA=	2.45	2.38	3.06	2.60	2.84	3.21	2.42
MH=	2.44	2.50	3.05	2.40	2.57	3.10	2.46
	n.s.	n.s.	n.s.	p=0.015	p=0.001	n.s.	n.s.

Figure D2[e]— *COD Capability **at follow-up** for the subset (**n=150**) of mental health (MH; **n=82**) and substance abuse (SA; **n=68**) outpatient programs that participated in the evaluation study*

Summary Profile Comparison [n=150 Evaluation Study]

Mental Health [DDCMHT; n=82] *versus* Substance Abuse [DDCAT; n=68] outpatient programs

DDE 5.0
Dual Diagnosis Enhanced: Full capability for providing services to any client with COPSD and the ability to address both disorders fully and equally.

**82 Mental Health Ouapatient Programs
Baseline total score = 3.06**
**68 Substance Abuse Outpatient Programs
Baseline total score =3.01**   p=0.390   **Follow-up**

DDC 3.0
Dual Diagnosis Capable: Some capability for providing services to individuals with COPSD, while retaining a primary emphasis on serving individuals with mental health disorders only.

MHOS | AOS
Mental Health [Addiction] Services Only: providing serivces to clients with only mental health [addiction] disorders 1.0

	Program Structure	Program Milieu	Clinical Process Assessment	Clinical Process Treatment	Continuity of Care	Staffing	Training
SA=	2.82	2.65	3.25	2.93	3.08	3.34	3.01
MH=	2.83	2.74	3.19	2.78	3.01	3.69	3.21
	n.s.	n.s.	n.s.	p=0.043	n.s.	p=0.001	n.s.

Figure D2[e] compares COD capability at follow-up for the subset (**n=150**) of mental health (MH; **n=82**) and substance abuse (SA; **n=68**) outpatient 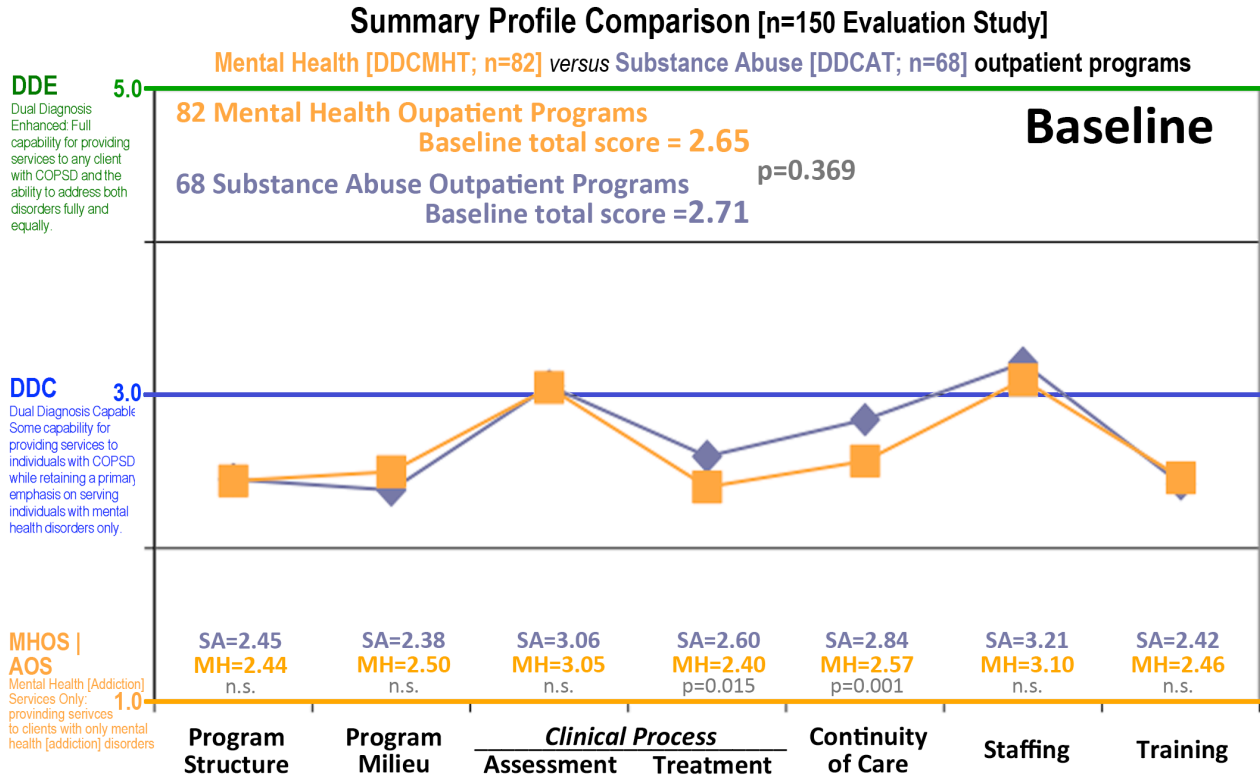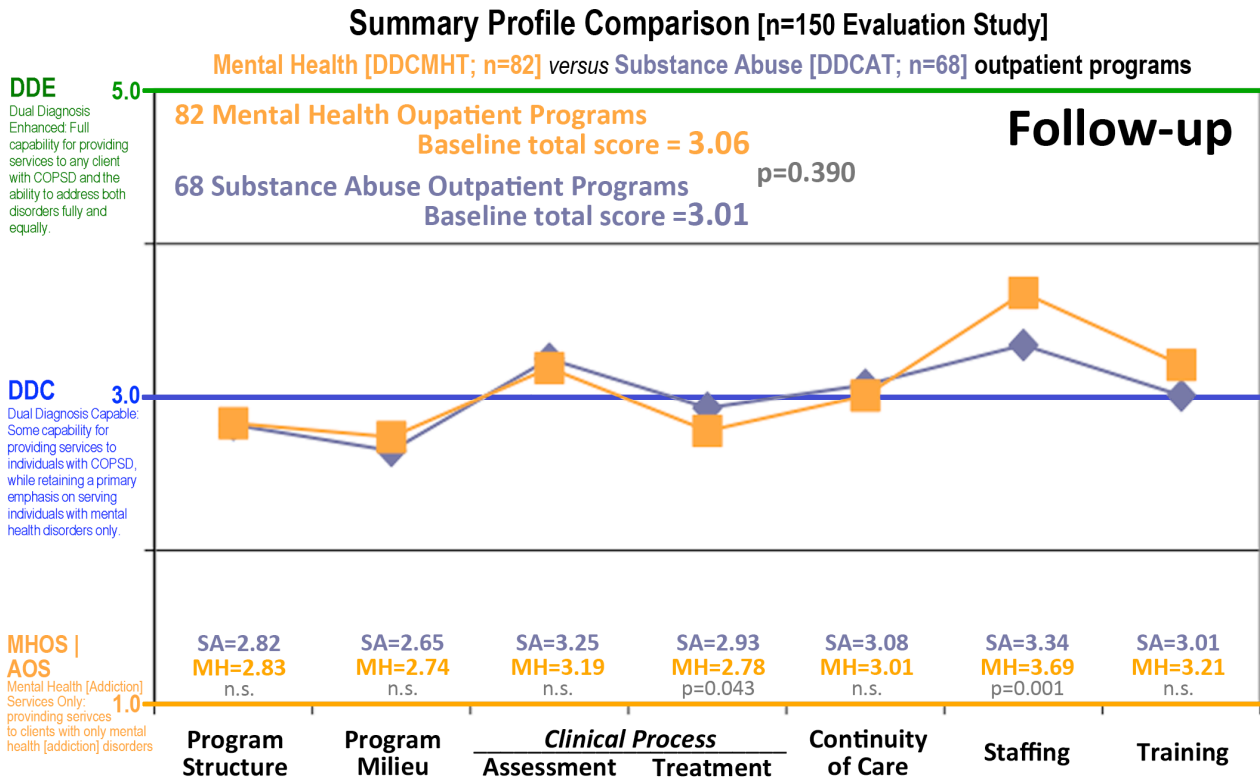programs that participated in the evaluation study. Similar to both the full sample (N=603) and the evaluation study subset (n=150) at baseline, overall COD capability scores for mental health (**3.06**) and substance abuse (**3.01**) outpatient treatment programs were not significantly different. Further, substance abuse and mental health treatment programs had similar profiles on five (**5**) of 7 dimensions— *Program Structure*, *Program Milieu*, **Clinical Process–*Assessment***, *Continuity of Care*, and *Training*. The follow-up score on the **Clinical Process–*Treatment*** dimension for substance abuse programs (2.93) was significantly higher (p=0.043) than for mental health programs (2.78); while the *Staffing* dimension score was significantly higher (p=0.001) for mental health programs (3.69) than for substance abuse programs. The latter represents a trend reversal where, at baseline (for both the full sample and the evaluation subset), substance abuse programs had higher scores on this dimension. Overall, comparisons between substance abuse and mental health programs at follow-up for the evaluation sample, with a couple of exceptions, are similar to baseline profiles for both the full (n=603) and the evaluation (n=150) sample.

More important, for the evaluation sample (n=150), **Figures D2[d]** and **D2[e]**, when baseline and follow-up scores are examined side by side, significant increases in COD Capability (after receiving CEIC technical assistance and implementation support) for both mental health and substance abuse treatment programs are apparent. **Table D2[c]** below provides a breakdown of increases in COD capability from baseline to follow-up for the overall sample, and separately for mental health and substance abuse programs. Overall, increases were evident for each of the seven dimensions as well for the overall score, which was true for both mental health and substance abuse treatment programs. Gains in COD capability for the first four [**4**] dimensions—*Program Structure*, *Program Milieu*, **Clinical Process–*Assessment***, and **Clinical Process–*Treatment***—are similar for both substance abuse and mental health treatment programs (i.e., within 0.05 points on the scale). Interestingly, gains in COD capability for the remaining three [**3**] dimensions— *Continuity of Care*, *Staffing* and *Training*—were greater for mental health programs (ranging from 0.15 to 0.45). These large gains for mental health programs, in part, could be attributed to lower scores at baseline, but improvements were large enough for mental health programs to exceed the capacity of substance abuse programs in two [**2**] dimensions— *Staffing* and *Training*.

Table D2[c]— *Increases in COD Capability from baseline to follow-up for the subset (**n=150**) of mental health (MH; **n=82**) and substance abuse (SA; **n=68**) outpatient programs that participated in the evaluation study*

# Dimension	Baseline			Follow-up			Mean Difference		
	Total	SA	MH	Total	SA	MH	Total	SA	MH
1 Program Structure	2.44	**2.45**	2.44	2.83	**2.82**	2.83	+0.39***	**+0.37***	**+0.39***
2 Program Milieu	2.45	**2.38**	2.50	2.70	**2.65**	2.74	+0.25***	**+0.27**	**+0.24**
3 Clinical Process — Assessment	3.06	**3.06**	3.05	3.22	**3.25**	3.19	+0.16***	**+0.19***	**+0.14**
4 Clinical Process —Treatment	2.49	**2.60**	2.40	2.85	**2.93**	2.78	+0.36***	**+0.33***	**+0.38***
5 Continuity of Care	2.69	**2.84**	2.57	3.04	**3.08**	3.01	+0.35***	**+0.24***	**+0.44***
6 Staffing	3.15	**3.21**	3.10	3.53	**3.34**	3.68	+0.38***	**+0.13***	**+0.58***
7 Training	2.44	**2.42**	2.46	3.12	**3.01**	3.20	+0.68***	**+0.59***	**+0.74***
Total Capability	2.68	**2.71**	2.65	3.04	**3.01**	3.06	+0.36	**+0.30***	**+0.41***

*p<0.05; **p<0.01; ***p<0.001

In summary, outpatient addiction and mental health programs were similar in their ratings of capability at baseline and at follow-up; both showed significant increases overall and on all 7 dimensions at follow-up. Addiction programs scored significantly higher on 4 of 7 dimensions at baseline (*Program Structure*, *Program Milieu*, **Clinical Process —*Assessment***, and *Training*) and mental health programs showed

significantly greater improvements on three of seven dimensions at follow up (***Continuity of Care***, ***Staffing*** and ***Training***). In fact, at follow-up, mental health programs achieved a slightly higher total capability score, reversing the baseline findings.[23]

D2d. VALIDATING THE DDCAT

> **AIM 3**—   to examine the predictive validity of the DDCAT; that is, the relationship between DDCAT scores and client outcomes

Objective

The study examined the degree to which licensed outpatient substance abuse treatment programs were capable of delivering integrated services for individuals with co-occurring substance use and psychiatric disorders. Aggregate measures of client retention were also obtained, and their relationship with capability scores was explored.

Measures

The co-occurring or dual diagnosis capability of each program was measured with the *Dual Diagnosis Capability in Addiction Treatment* (DDCAT) index, a 35-item rating tool organized into seven dimensions that categorizes programs along a continuum where 1 = "*Addiction Only Services*" (AOS); 3 = "*Dual Diagnosis Capable*" (DDC); and 5 = "*Dual Diagnosis Enhanced*" (DDE). Admission and discharge data were obtained from a state regulatory agency database for clients with co-occurring disorders who received services from state-licensed outpatient substance abuse clinics, and who had been discharged from treatment over a 6-month period defined as the three months before and after the DDCAT assessment. Admission and discharge data were then aggregated to the program level and their relationship with the DDCAT data was examined.

Results

A total of 185 state-licensed outpatient substance abuse clinics were included in the analysis. Generalized linear models showed a significant positive relationship between DDCAT scores and length of stay (odds ratio=1.209; $p<0.001$), which indicated that clients with co-occurring disorders stayed longer in treatment programs with higher DDCAT scores. Analyses also demonstrated that five DDCAT dimensions were significantly related to length of stay (odds ratios ranged from 1.057 to 1.155; $p<0.01$); the two exceptions were the screening/assessment and treatment dimensions.

Conclusions

Clients with co-occurring disorders who received outpatient treatment from programs with higher DDCA[MH]T scores were found to stay in treatment longer; retention in treatment has long been an important predictor of positive outcomes, in that more time in treatment has consistently resulted in better outcomes (e.g., Fuller, 2009; Greenfield, et al., 2006; Joe, Simpson, & Broome, 1998; Ouimette, 2003; Simpson, Joe, & Brown, 1997). Since prior research has firmly established treatment retention as a predictor of long-term outcomes (e.g., relapse to drug use), this study represents an important first step towards demonstrating a relationship between a program's co-occurring capability and client outcomes; thereby providing initial evidence of the validity of the DDCAT. Further validation of the DDCAT should consider incorporating a broader range of treatment quality indicators and client outcomes.

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[23] The authors plan additional presentations of these data, and are considering developing a fourth manuscript for publication in a peer-reviewed journal.

D3. ANALYSIS OF THE OASAS LSP SURVEY[24]

D3a. SURVEY

Background

In 2009, over 40% of the 166,407 clients discharged from New York State outpatient treatment settings were identified to have co-occurring disorders (COD; the co-occurrence of at least one mental health disorder with a substance use disorder). Only one quarter of these clients completed treatment, and half left treatment against advice. Since 2005, a variety of initiatives have been launched to improve the capacity of the behavioral health care system to provide appropriate and effective services for persons with COD, including NYS OASAS and OMH efforts to promote systematic screening and assessment (beginning in 2005) and the use of **Evidence-based Practices** (**EBPs**) for COD through the *Focus on Integrated Treatment* (FIT; CPI, n.d.[c]) initiative (beginning in 2009). Another of these was the 2008 initiative, wherein NYSHealth funded NDRI-USA, Inc. (an arm of NDRI, formerly NDRI-State, Inc.) to increase the integration of behavioral health care through the *Center for Excellence in Integrated Care* (**CEIC**).

Concurrently, OASAS developed a biennial statewide web-based *Local Service Planning* (**LSP**) survey of providers as a means of delivering regular monitoring of system wide quality of care, and to guide its policy and training initiatives. In March 2010 and March 2012, the LSP survey included specific questions to elicit the extent to which **EBPs** for COD had been implemented. Virtually all OASAS-licensed programs (95%) responded to the 2010 and 2012 LSP surveys, which provided a statewide data source that could be analyzed to evaluate changes in the implementation of evidence-based care for COD over a term roughly contemporaneous with the operation of CEIC.

Method

The 2010 and 2012 LSP survey results were analyzed to describe the adoption of EBPs for COD in outpatient treatment programs, and the corresponding contribution of CEIC during the same timeframe.

Evidence-based Practice (EBP) Implementation items

Programs were asked about their implementation of a comprehensive list of practices. In those two years, both EBPs and promising approaches for clients with COD were queried in areas that included *screening*, *assessment*, and five EBPs for clinical treatment; specifically —

> [1] *Motivational Interviewing* (**MI**);
> [2] *Cognitive Behavioral Treatment* (**CBT**);
> [3] *Contingency Management* (**CM**);
> [4] use of *Psychotropic Medications*; and
> [5] *Mutual Self Help* (**MSH**);

along with the development of the basic infrastructure required for *Service Integration*.

For each practice, providers indicated whether or not a series of prerequisites (required for the stage of implementation selected) had been implemented. Prerequisites for *Screening*, *Assessment*, and *Clinical Practices* included documented plans for implementing the practice, staff training, feedback and supervision, documentation of the practice in clinical records, quality assurance procedures, and organizational service agreements where relevant (e.g., assessment referrals, or access to a medication prescriber). Implementation anchors for *Service Integration* included—

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[24] Analyses and narrative completed by Mary Jane Alexander, PHD, with other NKI staff (Gary Haugland, MA; Dei-In Tang, PHD; and Christina Pratt, PHD in collaboration with CEIC staff (Stan Sacks, PHD and Michael Chaple, PHD)

[a] participation in an external consortium;

[b] use of a program model for care integration;

[c] a single treatment plan that reflects coordinated treatment for both conditions;

[d] mental health specialist consultation has been integrated with care;

[e] staff within the program coordinate delivery of care for both conditions; and

[f] a broadly trained staff who deliver a variety of services for both conditions to a single individual.

Scoring

Response categories were based on Fixsen and colleagues' (2005) implementation phases, which reflect a pre-contemplation stage (when a program first considers implementing a practice) through actual and sustainable implementation. A program met criteria for ***Implementation*** when at least 50% of currently employed staff/clinicians concurrently performed the new practice/intervention and its functions/activities acceptably, including measurable fidelity to the original innovation. Actual Implementation is reported here.

Clinic Sample

This analysis of statewide changes in adoption includes 376 medically supervised outpatient clinic programs that had not completed a CEIC site-visit DDCAT assessment by March 2010, and who responded to both 2010 and 2012 LSP survey questions about implementation of evidence-based care for COD. Clinic programs that received CEIC assessments prior to the March 2010 LSP survey (n= 60) were excluded from this analysis. In the final study sample (n=376), **CEIC programs** (n=127) were those that received a baseline CEIC assessment by March 2012; **non-CEIC programs** (n=249) were those that had not received a CEIC assessment by March 2012.

Analysis

Rates of ***Implementation*** were calculated for *Screening*, *Assessment*, for the ***Service Integration*** approach, for each EBP (evidence-based practice), and for the five EBPs combined. Denominators for combined rates reflected all opportunities each of the 376 programs had to implement each of these practices. Aggregate ***Implementation*** scores represent the average of reported implementation level (from 0 to 5) across all 8 practices – *Screening*, *Assessment*, five EBPs and *Service Integration*.

A McNemar *t*-test was used to assess whether the correlated rates of ***Implementation*** in 2010 and in 2012 for all programs were significantly different. Logistic regression models were used to examine the effect of CEIC on the probability of implementing each practice at the time of the 2012 survey, controlling for level of *Implementation* (dichotomized) for the 2010 survey. Aggregate implementation scores were examined for differences between CEIC and non-CEIC programs, and to determine whether the timing of CEIC implementation affected implementation improvement.

Results

Population served

According to the NYS OASAS client data system, discharges during 2012, the 436 OASAS-licensed outpatient programs who responded to both LSP surveys served 166,407 NYS residents. More of these clients were men (70%), the majority was under age 35 (54%), and few (37%) were employed at the time of admission. A greater proportion were White non-Hispanic (52%) compared to Black non-Hispanic (27%), and Hispanic (17%). A majority (61%) was covered under Medicare or Medicaid; only 20% had private insurance. Over half (60%) had a criminal justice status such as parole, probation or diversion at the time of their admission. About a quarter (26%) had been arrested in the 6 months prior to their admission, and 37% had been referred to treatment directly from the criminal justice system. **Forty-one percent** of clients being treated in these programs were identified as having **COD** (co-occurring disorders), a diagnosis that was assigned if a

person had ever been: overnight in a hospital for an emotional problem; treated for an emotional problem; or taken medication for an emotional problem.

Overall Changes in Implementation of EBPs for COD in all Programs

Figure D3[a] shows that ***Screening*** and ***Assessment*** were implemented extensively across the OASAS Outpatient system. At the time of the 2010 LSP survey, 70% or more of programs met criteria for *Implementation*; in 2012, over 80% of programs were implementing these two practices, a significant increase. In 2010, over half of the outpatient programs had implemented *Service Integration*, and almost half (47%) had implemented at least one of the five EBPs. In 2012, the system as a whole registered implementation rates (i.e., for implementing at least one of the 5 EBPs) that had increased significantly (from 47% to 57%), but *Service Integration* did not change.

Figure D3[a] — *Improvement in Implementation of Screening, Assessment, and 5 EBPs for all programs* (**n=376**) *between 2010 and 2012*
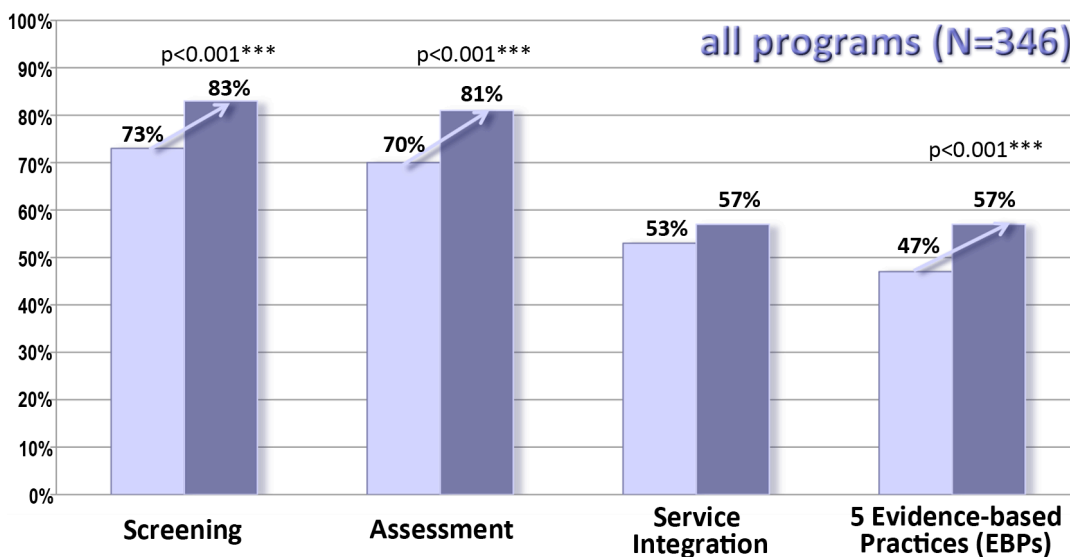
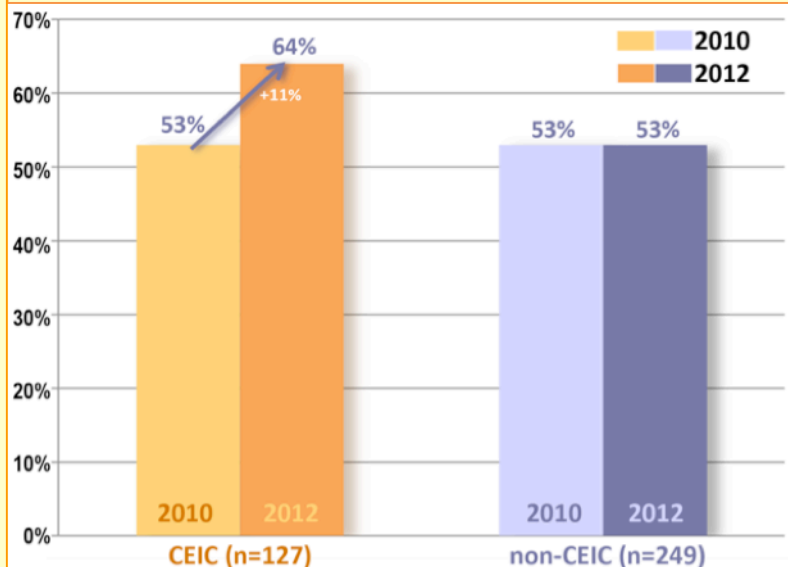| Key Finding — Changes in Implementation for CEIC & non-CEIC Programs	Figure D3[b] —*Significantly greater* (p<0.05*) *improvement in* ***Service Integration*** *for CEIC* (**n=127**) *than for non-CEIC* (**n=249**) *programs*
Logistic regression analyses comparing CEIC with non-CEIC programs (controlling for baseline levels of implementation for each of the *Clinical Practices* and for *Services Integration*) showed a significant increase in implementation of Services Integration for CEIC programs. **Figure D3[b]** shows that, by March 2012, the implementation of *Service Integration* for CEIC programs increased 11% (from 53% to 64%) while non-CEIC programs showed no increase in implementation.	

Figure D3[c] — *Improvements in CEIC* (n=**127**) *vs non-CEIC programs* (n=**249**) *from 2010 to 2012*
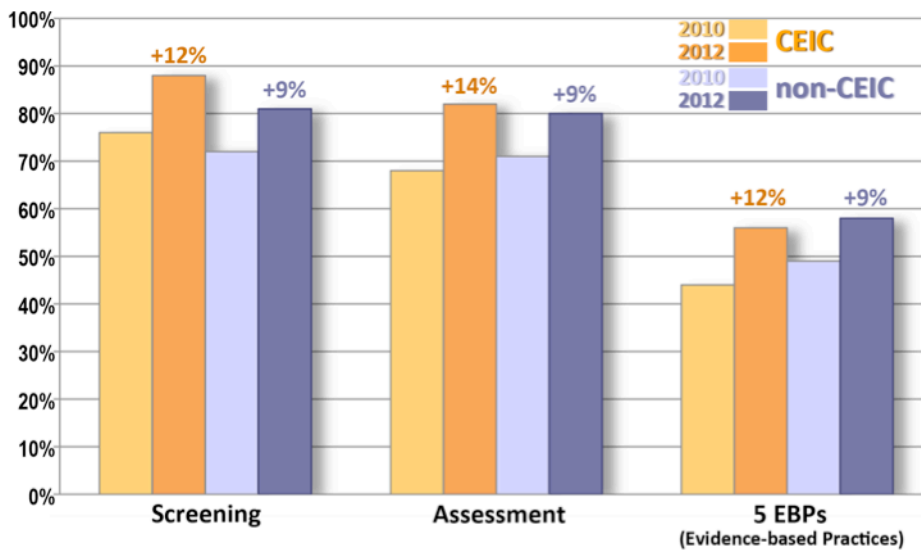
As shown in **Figure D3[c]**, CEIC programs showed greater overall rates of improvement in implementation of *Screening*, *Assessment,* and the five EBPs than did non-CEIC programs, although the differences did not reach statistical significance. Specifically, **Figure D3[c]** shows that, in 2012, implementation in CEIC programs was 12% higher for *Screening*, 14% higher for *Assessment* and 12% higher for the five EBPs; whereas, implementation in non-CEIC programs was only 9% higher for *Screening*, *Assessment* or the 5 EBPs.

Based on an aggregate score for all 8 EBPs, **Figure D3[d]** shows that 65% of CEIC programs improved their level of implementation across all 8 practices, compared to 58% of non-CEIC programs. CEIC programs showed an average improvement of 1.3 implementation levels, and programs with a shorter time between receipt of CEIC and the 2012 LSP showed greater gains than programs with a longer time lapse.

Table D3[a] shows the consistent improvement in implementation of the five EBPs for both CEIC and Non-CEIC programs between March 2010 and March 2012. Non-CEIC programs showed a significantly larger increase in implementation of CBT with 15% more programs implementing this practice compared to 8% more CEIC programs.

Figure D3[d] — *Improvement in level of implementation of all 8 practices for CEIC* (**n=127**) *versus non-CEIC* (**n=249**) *programs*
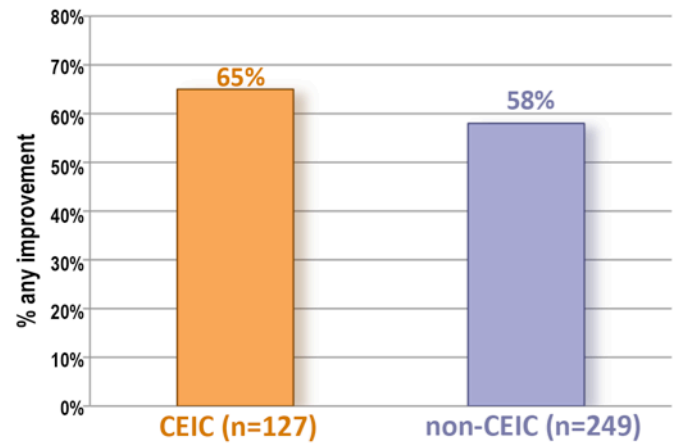
- CEIC programs that improved reported an average of 1.3 implementation levels gained;
- programs with a shorter time to follow-up had greater gains than programs with more time to follow-up

Table D3[a] — *CEIC* [**n=127**] *vs non-CEIC* [**n=249**] *cha... for other evidence-based practices* (EBP...

		CEIC (n=127)		Non-CEIC (n=249)		CEIC vs non-CEIC
	EBP (Evidence-based Practice)	2010	2012	2010	2012	p
1	MI (*Motivational Interviewing*)	59%	78%	61%	76%	Ns
2	CBT (*Cognitive Behavioral Therapy*)	64%	72%	66%	81%	0.05*
3	CM (*Contingency Management*)	11%	25%	17%	26%	Ns
4	*Mutual Support*	27%	31%	35%	36%	Ns
5	*Psychotropic Medications*	61%	72%	62%	71%	Ns

*$p < 0.05$

D3b. DISCUSSION

The results show continuing improvement system wide in the implementation of screening, assessment and evidence-based treatment practices. Because over 95% of OASAS providers participated in the OASAS LSP online survey in 2010 and 2012, it was an efficient means of evaluating changes in the system's capacity to deliver COD services over that 2-year span.

Programs that received CEIC services (compared with programs that did not), were significantly more likely to implement Service Integration, where treatment for both conditions was delivered through clinical coordination, collaboration, and specialized training. These activities reflect the basic dimensions of program and staff activation required to address both disorders capably, and are foundational to additional efforts to develop resources and infrastructure to deliver EBPs for COD, which is a high bar for providers to clear (Sacks et al., 2013). While more CEIC programs met implementation criteria for many of the practice outcomes examined in 2012, these gains were not necessarily statistically significant. On the other hand, programs that did not receive CEIC services showed significant increases in the use of Cognitive Behavioral Treatment that was not observed for programs that did.
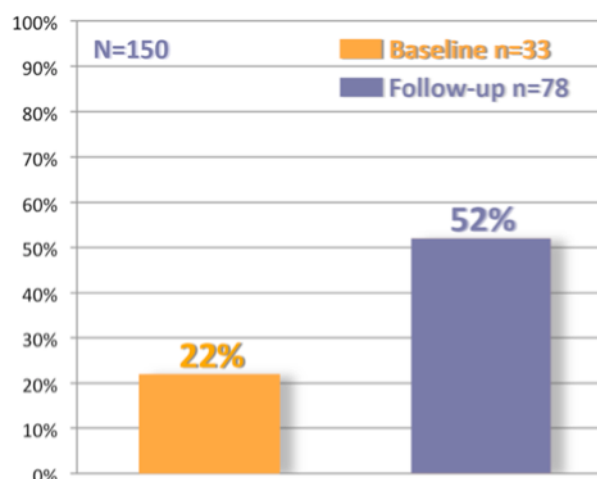
In conclusion, while OASAS programs received support from other statewide policy and training initiatives, these results offer evidence that CEIC services also contributed to improvements in the delivery of integrated care among OASAS-licensed programs.

E. CEIC Discussion

E1. SUMMARY OF FINDINGS

A large number of addiction and mental health outpatient clinics (N=**603**) participated in this far-reaching effort to improve integrated services for persons with co-occurring substance abuse and mental health conditions in New York State. At baseline, these 603 programs had an average overall score of 2.71, measured with the DDCA[MH]T indices, which is below "Capable," but closer to "Capable" than to "Basic" (AOS | MHOS). Baseline results for a randomly selected sub-sample (n=**150**) likewise scored somewhat below the "Capable" level (**2.68**). At follow-up, an average of two years after the baseline assessment, and after having received technical assistance and implementation support from CEIC specialists, the sub-sample had realized significant gains, scoring above the "Capable" level (**3.04**) and the percent of programs at the "Capable" level **had more than doubled from 22% to 52%**. Significant improvement was evident for all 7 dimensions, and for the majority of items (**26** of **35**).

Figure E1[a] — *Proportion of clinics (**n=150**) with ratings of DDC ("**Capable**") or higher before (at baseline) and after (at follow-up) receiving CEIC technical assistance & implementation support*

Addiction and mental health programs had similar overall Capability scores at baseline and both showed significant improvement at follow up. Further, an analysis using data from the OASAS *Local Service Plan Survey* (LSP) revealed greater increases in "*Service Integration*" for programs that received CEIC services than for programs that did not make use of CEIC technical assistance. Also, clients with co-occurring disorders who received outpatient treatment from programs with higher DDCA[MH]T scores were found to stay in treatment longer; retention in treatment has long been an important predictor of positive outcomes, in that more time in treatment has consistently resulted in better outcomes (e.g., Fuller, 2009; Greenfield, et al., 2006; Joe, Simpson, & Broome, 1998; Ouimette, 2003; Simpson, Joe, & Brown, 1997). CEIC has disseminated findings from the project in many presentations throughout New York State as well as at State and national conferences, and has three manuscripts (two have been published in peer-reviewed journals and the third is in review) (Chaple & Sacks, 2013; Chaple et al., 2013; Sacks et al., 2013)

E1a. THE IMPACT OF TECHNICAL ASSISTANCE | IMPLEMENTATION SUPPORT

Over the life of the project, NYS enacted a number of state-level systemic changes with the potential to facilitate services integration. Foremost, OMH and OASAS jointly issued directives and guidance documents to promote the use of evidence-based screening, assessment, and treatment services; changes in licensing and financing that affected billing and reimbursement for services followed. Other curricula-driven training and technical assistance activities occurred simultaneously (e.g., *Trauma-informed Care*; *Wellness Self Management*; and *Recovery*). One major State initiative was the *Focus on Integrated Treatment* (FIT), a web-based training system to advance COD competencies (Center for Practice Improvement, n.d.[a]).

The influence of such factors could not be measured or tested, but an examination of average scores for baseline assessments in each of four years revealed that COD capability was essentially constant (Year 1=2.62, n=86; Year 2=2.75, n=166; Year 3=2.68, n=196; Year 4=2.72, n=125). The fact that baseline scores did not increase over time, along with other evaluation findings, lend credence to the inference that the project's technical assistance and implementation support had a positive effect on the implementation of integrated care, although other factors — NYS policy directives, other initiatives in staff training and technical assistance — were operative at the same time. Further, CEIC programs demonstrated greater increase in Service Integration as compared with programs that did not use CEIC services using the OASAS Local Service Plan Survey (LSP) based on analysis of the latest OASAS LSP in 2012.

Limitations

While study results demonstrated substantial and significant improvements in COD capability among participating programs, several limitations should be noted.

The baseline sample was not randomly selected from the universe of outpatient providers; rather, was comprised of programs that, once approached, volunteered to participate. These programs could have been early adopters, or those that were, for whatever reason, especially amenable to technical assistance. Ultimately, the large baseline sample size served to ensure that the follow-up sample represented the full spectrum of capability, ranging from 1.52 to 4.06.

Interviewer bias could have artificially inflated follow-up scores. Although follow-up and baseline assessors differed, and unaware of the baseline score, assessors were still members of the same research staff and were certainly aware of the project's goals. As a partial check on interviewer bias, an inter-rater reliability (ICC) of 0.961 for the overall score was established for a subset of 10 follow-up clinics.

Although considerable efforts have gone into developing the DDCA[MH]T indices and establishing their psychometric properties, further study is required to determine: the factor structure of the measures; the importance and proper weighting of each dimension; and the validity of the measure in relation to client outcomes. With regard to the latter, CEIC's recent study found a significant positive relationship between DDCAT scores and length of stay (a known predictor of longer term outcomes), which indicated that clients with COD stayed longer in treatment programs that had higher scores (Chaple et al., 2013).

Implications for Behavioral Health

The evaluation study presented in this report represents the most extensive effort to measure COD capability in a State outpatient system of behavioral health care, and the largest scale evaluation of the impact of technical assistance on COD capability conducted to date. Results from this study demonstrate that significant gains can be made in the delivery of integrated behavioral health services and, ultimately, that achievement of a "Capable" rating is a feasible goal. In so doing, this initiative offers specific guidance to behavioral health providers on how to improve COD capability, which in turn, will improve the quality of behavioral health care provided to individuals with COD.

Furthermore, this study has implications for the integration of behavioral health with primary care, promulgated under the Affordable Care Act (H.R. 3590, 2010). That is, the activities, approaches and successes in integrating substance abuse and mental health services provide a foundation for the additional integration with medical services. A new measure — the *Dual Diagnosis Capability in Healthcare Settings* — holds promise for measuring this integration (McGovern, Urada, Lambert-Harris, Sullivan, & Mazade, 2012b), as a basis for determining the improvements that are needed in healthcare settings such as *Federally Qualified Health Centers* (FQHCs) and *Health Homes*. CEIC conducted a pilot study in FQHCs that revealed lower baseline integration (total score=2.0), but comparable increases (up to 2.3) in integrated services using a similar process of assessment, technical assistance, and implementation support as was reported here. CEIC's work to foster integrated care continues with funding from SAMHSA under the auspices of the NeC-ATTC (*Northeast & Caribbean Addiction Technology Transfer Center*) and from The Nicholson Foundation of New Jersey for a pilot project in Federally Qualified Health Homes (FQHCs).

E2. LESSONS LEARNED

CEIC was an ambitious and far-reaching project (almost to scale from the outset) and yet requiring one-to-one work with individual clinics. It took place in a fluid behavioral health environment where the initial focus on integrated care for people with co-occurring mental health and substance abuse disorders in addiction and mental health settings merged with the need to further integrate behavioral and physical health services under the Affordable Care Act. In addition, CEIC s sought to both deliver its services and evaluate their effectiveness. We learned some things that reinforced some of our existing beliefs and approaches and others that expanded our knowledge and experience

■ The activities, approaches and successes in integrating substance abuse and mental health services provide a foundation for the further integration with medical services. Thus, NDRI, project staff has undertaken the activity cited in the section immediately above.

■ Implementation work is multi-faceted (involving leadership, networks, and individual agencies), and requires a variety of approaches. Thus, CEIC articulated a technical assistance and implementation support model as described in section **B2**, *Methods*.

The project could have benefited from the use of:

[a] structured, topic-specific, time-limited learning communities;
[b] the training and incorporation of other assessors within and across programs;
[c] the dedication of resources to fostering provider networks; and
[d] further integration of direct and web-based methods

The project enjoyed the dual benefits of being the opportunity of a professional lifetime to make a difference in the care of clients and the availability of staff from NYSHealth who offered tremendous interest, encouragement, and support, as well as good cheer. We are deeply grateful.

E3. CONCLUSIONS

- **First**, the results provide evidence that significant program gains can be achieved in the delivery of integrated services for persons with co-occurring conditions; even system change can be realized, with sufficient funding.

- **Second**, the achievement of a "Capable" rating (i.e., "*Dual Diagnosis Capable*" or **DDC**) is a realistic and feasible goal because, for the most part, barriers to this level of integration are easily circumvented, implementation is feasible, and extensive new resources are not required, yet services will be improved, and continued gains can be fostered.

- **Third**, some corroboration of the efficacy of a multifaceted, direct, "hands on" approach to technical assistance and implementation support can be construed.

- **Fourth,** the fact that baseline capability scores remained stable for cohorts assessed in each of the five years, as well as the main findings from the evaluation studies, tend to confirm that CEIC's technical assistance and implementation support contributed to the observed improvements in integrated care.

- **Finally**, it seems reasonable to infer that other state-wide activities (e.g., NYS mandates and policy changes; NYS-level trainings, especially the web-based *Focus on Integrated Treatment* (CPI, N.D.[a]) also played an important role in producing the positive effects observed.

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