

The background of the entire page is a black and white photograph of water ripples. The ripples are concentric circles of varying sizes, creating a textured, organic pattern. The lighting is soft, highlighting the crests and troughs of the waves.

# **“One Team with One Plan for One Person”**

## **California Institute for Mental Health Training and Policy Discussions Co-Occurring Disorders**

**Thursday, February 12, 2004  
Burlingame, California**

### **CO SPONSORS:**

**CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION  
COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATORS ASSOCIATION OF CALIFORNIA  
CALIFORNIA COUNCIL OF COMMUNITY MENTAL HEALTH AGENCIES  
CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS  
CALIFORNIA ASSOCIATION OF SOCIAL REHABILITATION AGENCIES  
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES**

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*The contents of this report reflect the discussion and opinions of the participants in the February 2004 Co-Occurring Disorders conference, “One Team with One Plan for One Person,” and do not specifically reflect the opinions of the California Institute for Mental Health.*

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## Conference Report

*Seven to ten million individuals in the United States ...have at least one mental disorder as well as an alcohol or drug use disorder” (U.S. DHHS, 1999; SAMHSA National Advisory Council, 1998). Further, as indicated by the U.S. Surgeon General in the 1999 report on mental health: “Forty-one to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder” (U.S. DHHS, 1999). Individuals experiencing these disorders simultaneously—in this report, referred to as co-occurring disorders—have particular difficulty seeking and receiving diagnostic and treatment services, even though, separately, these disorders often are as treatable as other chronic illnesses. Clearly, co-occurring substance abuse disorders and mental disorders present significant challenges to the Nation’s public health and to health policy makers as well.*

— **Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Health Disorders**, prepared by the Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services, 2002.

Co-occurring substance abuse and mental health disorders tend to be dynamic, with changes in one disorder affecting the other. Even so, people with co-occurring disorders currently are forced to rely upon two separate service systems even though the two disorders tend to be dynamic, with changes in one disorder impacting the other. During the past decade, California has been working to resolve this disparity. The Governor’s Budget of 1995–96 mandated the state Department of Alcohol and Drug Programs and the state Department of Mental Health to create a Dual Diagnosis Task Force and funded four demonstration projects. The Dual Diagnosis Task Force was replaced in October 2002 by a Co-Occurring Disorders Workgroup, which was designed to bring together high-level representatives of the major substance abuse and mental health constituencies to take the next step in confronting systemic barriers that impede delivery of effective services for persons with co-occurring disor-

ders. The Workgroup completed its assignment in June 2003 and has published a report containing recommendations, including this admonition:

*The Co-Occurring Disorders (COD) Workgroup strongly recommends a comprehensive approach to clinical and administrative improvements that supports coordination/integration of substance abuse and mental health services for persons with co-occurring disorders. Such an approach is one in which training, financing, licensing and certification requirements, and corresponding data/outcome measurement requirements are aligned. Training on best practices alone will not produce results if the infrastructure, financing, licensing, or reporting requirements of the two fields are not consistent and do not support implementation of coordinated/integrated practices... (defined as) “all necessary services and support delivered by a single service team which has all the needed skill sets to develop and follow one client-centered plan that focuses on recovery and the individual person’s goals and strengths.”*

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## Introduction

During February 2004, more than 300 stakeholders from throughout California came together in a conference to learn about and discuss the future of services for persons with co-occurring substance abuse and mental health disorders. The conference included the following:

- Plenary presentation by Charles Curie, Administrator of the U.S. Substance Abuse and Mental Health Services Administration on “Federal Policy Direction: Services for Persons with Co-Occurring Disorders.”
- Plenary presentation by Dr. Stephen Mayberg, Director of the California Department of Mental Health, and Kathryn Jett, Director of the California Department of Alcohol and Drug Programs, on “Partnership for Innovative Systems Change in California.”
- Plenary presentation by Dr. Chris Cline, Medical Director in the Behavioral Health Services Division of the New Mexico Department of Men-

tal Health and President of ZiaLogic Corp., on “Systems Change: The State of the Art in the Treatment of Co-Occurring Disorders.”

Following the plenary presentations, the conference participants then reconvened in workshops. Each workshop included a discussion about policy or procedure changes needed to expedite the development of services for persons with co-occurring disorders, and to dismantle barriers that could impede success. The “Workshop summaries” section of this report contains selected comments elicited during the discussions. The major themes that emerged included concerns about the need for specialized training, and aligning financing structures to support coordinated/integrated services for persons with co-occurring disorders.

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## Where do we go from here? Partners’ commitments

A panel consisting of administrators of the state departments and presidents of the associations that served as co-sponsors concluded the conference. Representatives of each association agreed to make changes to bring about improved services and support for persons with co-occurring disorders. This section delineates the commitments made by each association.

### California Council of Community Mental Health Agencies:

John Buck, President

1. Work with the Legislature to increase funds and identify ways to improve coordination between the two systems.
2. Support more meetings and conferences focused on alcohol and drug abuse in order to ensure adoption of recommendations.
3. Increase collaboration in training.
4. Continue to work together to break down barriers in order to create more integrated services.
5. Confer with each other annually to track our progress.
6. Invite alcohol and drug organizations to form a coalition with mental health contract agencies.
7. Invite alcohol and drug counselors to participate in a mental health coalition.

8. Use AB2034 programs as exemplary models of programs that serve people who are homeless, have physical disabilities and commonly experience co-occurring disorders.

### California Mental Health Directors Association:

Marvin Southard, DSW, President

1. We propose beginning work today and forming a task group with the following goals:
  - A. Identify and clarify what we can already do in order to provide the needed co-occurring disorders services.
  - B. Eliminate discrimination that keeps substance abuse out of mental health and mental illness out of alcohol and drug.
  - C. Develop a team to conceive ways to eliminate barriers that diminish access to mental health services.
  - D. Encourage mental health services providers to augment their staffs with child welfare experts.
2. Staff members of service agencies need incentives to improve the effectiveness of their services designed to produce favorable outcomes more consistently.
3. Develop plans to eliminate barriers that are inherent in the culture of our systems; service providers need to become more vigilant in identifying blind spots. That can be accomplished through cross training and increased coordination between mental health services agencies and other agencies with which their clients may interact, including penal institutions and hospital emergency rooms.
4. Coordinate medical records among both systems.
5. Form a task force consisting of members of these six groups, i.e., the six organizations that are sponsoring this conference, with the addition of a child welfare focus.
6. Identify and clarify corrective steps we can take now with existing resources and regulations.
7. Find ways to eliminate discrimination within the mental health system against people who have both psychiatric disabilities and substance abuse problems.
8. Reconvene in six months to assess our progress.

## **California Department of Mental Health:**

### **Carol Hood, Deputy Director**

1. Encourage Director Steve Mayberg to reconvene the group in six months to review progress, as suggested by Marvin Southard.
2. Maintain conviction that we will make a difference.
3. Assemble and motivate group encompassing Department of Mental Health and Alcohol and Drug Program personnel.
4. Examine and adapt successful child welfare redesign concepts.
5. Apply Integrated Dual Diagnosis Treatment Toolkit pilots in advancing our work.
6. Treat Medi-Cal reform as a strategic opportunity to streamline funding and services.
7. Monitor the findings of the California Performance Review Commission Administration, which examines operation of California government agencies in order to determine whether or not they are achieving their intended outcomes.

## **California Department of Alcohol and Drug Programs:**

### **Carmen Delgado, Deputy Director**

1. The state Co-Occurring Disorders Work Group Report is complete [published in March 2004].
2. A joint policy statement on co-occurring disorders is being developed by the state departments of Mental Health and Alcohol and Drug Programs [publication in February 2004].
3. Participants in this conference must accept the challenge to reconvene in six months to review our progress.
4. Hold us accountable to the recommendations of the state Co-Occurring Disorders Work Group Report.
5. Take expedient action by figuratively grabbing “low-hanging fruit.”
6. We have difficulty but also great opportunities to provide services to persons with co-occurring disorders.
7. Update and support the application for the Co-Occurring Disorders State Incentive Grant.

8. The Department of Alcohol and Drug Programs will continue to participate in the Integrated Dual Diagnosis Treatment Toolkit project.
9. The Department of Alcohol and Drug Programs has submitted an application for participation in a National Policy Academy session.

## **California Alcohol and Drug Program Administrators**

### **Association of California:**

#### **Toni Moore, President**

1. All conference co-sponsoring organizations must provide coordinated and integrated services at the local level. Because we already have sufficient expertise, we don't have to wait for federal and state agencies to get started.
2. Begin by assessing your county's strengths, barriers and opportunities.
3. Both partners, AOD and mental health, must assess readiness for change and must be ready to change.
4. Providers must devote attention to early development of mutual values and working principles to guide their work.
5. Alcohol and drug and mental health providers must perform their own studies to understand their local needs.
6. All systems and providers must define their target population.
7. Alcohol and drug programs serve many people who do not have persistent serious mental illness, but do need psychiatric services.
8. Training is only the beginning; application of knowledge must follow.
9. Data collection and focus on desirable outcomes are essential.
10. Identification of achievable “baby steps” that can be taken one at a time is important.
11. County alcohol and drug, and mental health programs and their providers must take advantage of our existing model programs in California.
12. County alcohol and drug, and mental health programs and providers must get busy at the local level.

## **California Association of Alcohol and Drug Program Executives:**

Ken Bachrach, Representative

1. Alcohol and drug treatment programs need to build capacity, and must help provide access to mental health services.
2. Alcohol and drug program providers need training on how to work with people contemplating suicide, people with psychoses, and other mental health disorders.
3. Local alcohol and drug program providers should support the efforts of the director of the state Department of Alcohol and Drug Programs to provide training.
4. Augment mental health services with substance abuse counseling, and offer substance abuse clients services related to mental health.
5. Our association will continue this dialogue.
6. We discourage fighting over turf; rather, we will encourage collaborative participation in policy forums.
7. Alcohol and drug program providers should endorse hiring mental health staff members in alcohol and drug programs.

## **California Institute for Mental Health:**

Ed Diksa, ScD, Training Director

1. The California Institute for Mental Health (CIMH) will continue to work to bring all the stakeholders to the discussion table.
2. CIMH encourages and supports incorporation of services to accommodate co-occurring disorders in all projects.
3. We will disseminate the conference report widely among providers and administrators of mental health, alcohol and drug treatment agencies and programs.

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## **Workshop summaries**

### **Workshop: Diversity Issues and Co-occurring Disorders**

During this workshop, a diverse panel of consumer and family members described their experiences with

both systems, related stories explaining which services and approaches were effective for them, identified what did not work, and specified what helped them to succeed and remain in recovery.

Presenters: David D., Barbara A., Robbie B., Antonio C. and Robert B.

Moderator: Connie Moreno-Peraza, M.S.W., L.C.S.W., Alcohol and Drug Program Administrator, Stanislaus County Behavioral Health and Recovery Services

### **Participants' comments, reported by Connie Moreno-Peraza**

#### **Policy and procedure changes needed**

1. The state has created a funding roadblock.
  - A. Unnecessary state restrictions should be removed.
  - B. The state should actively work to overcome the cultural folklore that differs between the two systems.
  - C. Consumer involvement in mental health systems is actively promoted, while in drug and alcohol programs the involvement of customers is only in its infancy.
  - D. Language is a critical construct to both state agencies in the provision of services.
  - E. Limitations in access to services attributable to stigma, racism, and discrimination create significant problems for members of racial and ethnic minorities in California.
  - F. Innovative and promising programs for racial and ethnic communities in drug and alcohol programs are often initiated in community-based sites within communities, and in collaboration with community entities—such as churches, schools, Alcoholics Anonymous, Narcotics Anonymous—as well as in other state agencies. This strategy may mitigate the stigma associated with the receipt of drug and alcohol services.
2. Roadblocks at the local levels inhibit staff members from sharing information that would benefit both systems. Such an exchange of information should be encouraged, enabled and revenue-neutral.
3. Policies and procedures should be adopted with

greater consistency across all levels, i.e., state, county, individual programs, etc.

### **Challenges**

1. Clients should be screened for issues arising from co-occurring disorders, including safety, cultural diversity, and expectations.
2. With consideration to special populations, staff members must choose the “right tool for the right person.”
3. Agencies should conduct staff assessments in order to determine potential need to increase skills and information, and to develop an integrated thinking process.
4. To ensure that staff members treat the right disorder, they should ascertain if each client has an addiction.
5. Budget inadequacies must be identified and resolved.
6. The state’s juvenile justice system and adult correctional institutions encompass disproportionately large racial and ethnic minority populations. Many of the individuals in these populations have co-occurring disorders.
7. Poverty and low socioeconomic status are predominant among racial and ethnic minority populations in this state, making them especially vulnerable to development of mental health disorders and substance abuse problems, either separately or concurrently.

### **Barriers**

Inter-system issues exist, including:

1. Co-occurring, mental health, and alcohol and drug treatments in hospital emergency room facilities.
2. High client caseloads and redundant or contradictory regulatory requirements.
3. Program operation focuses more on paperwork than on a thought process, with a resulting tendency for clients to become lost in the paperwork.
4. The two systems have separate identities.
5. Substance abuse and dependence can be mistaken for one another.
6. Program staff may lack basic skill sets.
7. “Scarcity” thinking affects delivery of services.

8. Involvement as consumers in the mental health system is disproportionately low among racial and ethnic minority populations.
9. Racial and ethnic minority populations are underrepresented in the workforces of the state departments of Mental Health, and Alcohol and Drug Programs.
10. Funding for prevention, early intervention, and outreach and education activities remains elusive for both state agencies, even though these activities have been demonstrated as beneficial to racial and ethnic minority populations.

### **Workshop: Working with the Individual and Systems**

The conference included a workshop presentation of strategic planning and implementation strategies that can enhance the capability of systems to respond to the needs of clients with co-occurring disorders.

Presenter: Chris Cline, M.D., M.B.A., P.C., Medical Director of the Behavioral Health Services Division of the New Mexico Department of Mental Health and President of ZiaLogic Corporation.

Moderator: Joan Zweben, Ph.D., Executive Director of the East Bay Community Recovery Project.

### **Participants’ Comments, reported by Dr. Joan Zweben**

#### **Challenges and barriers**

1. Systems need to provide the right tools and process.
2. Training is needed to increase staff skills in formulating treatment plans.
3. The “folklore” needs to be reduced, with concurrent increased reliance on data as the foundation for people’s beliefs and decisions.
4. The process of screening clients’ issues must take on greater consistency and should encompass safety considerations.
5. The capabilities of staff members to assess co-occurring disorders should be elevated.
6. Providers must make certain that they have properly assessed problems—substance abuse vs. dependence—and have initiated treatment recommendations accordingly.
7. To avoid client withdrawal during crisis times,

collaboration among involved agencies must be maintained.

8. Case conferences and cross training are important.

### **Solutions**

1. Reduce reliance on emergency room visits by understanding the skills and resources needed for effective treatments and by bringing natural supports, i.e., friends, family, community, churches, to emergency room.
2. Change unfavorable rules that result in:
  - A. Information overload;
  - B. Excessive paperwork;
  - C. Redundancy in forms.
3. Eliminate unnecessary state restrictions.
4. Implement better strategies for settling feuds between systems, programs and professionals.
5. Teach staff members the basic skills they need to serve clients.
6. Reinstigate a stronger practice of supervision in order to increase skills.
7. Implement the state Co-Occurring Disorders Work Group recommendations.
8. Identify incentives that would encourage state and county agencies and programs to accommodate and serve clients with co-occurring disorders.
9. Seek policy changes and accompanying funding to increase availability of stable housing.

### **Workshop: Medications—Issues and Interventions for Persons with Co-Occurring Disorders**

This workshop identified medication-related conditions to consider when treating persons with co-occurring disorders. When possible, the evidence base for the interventions was presented.

Presenter: John W. Tsuang, M.D., Department of Psychiatry, Harbor-UCLA Medical Center

Moderator: Neal Adams, M.D., Adult Medical Director of the California Department of Mental Health

Participants' comments, reported by Dr. Neal Adams

### **Recommendations**

1. The Institute of Medicine's Report *Crossing the Quality Chasm* proposes four areas of focus: workforce, evidence-based practice, finance, and information technology.
  - A. Workforce: Mental health clinicians don't recognize co-occurring disorders; certification of dual capable programs must occur; the availability of case management and individual motivation must be increased.
  - B. Evidence-based practice: providers must clearly articulate a treatment plan, assure continuity of care, and maintain an open door.
  - C. Funding: A funding structure must be established that eliminates barriers to coordinated/integrated care.
2. Motivational interviewing is a core skill.
3. Mental health training should encompass treatment for addiction disorders.
4. Trainers should be taught how to train others through a 'train the trainers' model.
5. Physicians need training to increase their awareness and skills around prescribing medications for people with co-occurring disorders.

### **Workshop: Evidence-Based Practices and Co-Occurring, Mental Health, Alcohol and Other Drug Conditions in Adolescence**

Participants in this workshop reviewed the rationale behind utilizing an evidence-based practices framework in system planning and service delivery for adolescents with co-occurring conditions.

Presenters: Henry van Oudheusden, M.A., M.S.W., Corporate Director, Substance Abuse and Mental Health Services; and Bill Carter, M.S.W., L.C.S.W., Deputy Director, California Institute for Mental Health

Moderator: Jeronimo Breen, County Alcohol and Drug Program Administrators Association of California

Participants' comments, reported by Jeronimo Breen

## **Recommendations**

1. Invite representatives of social services, juvenile justice and other agencies to be partners.
2. More braided funding is needed.
3. A wealth of information about best practices and costs is available.
4. Co-occurring disorders should be expected rather than viewed as an exception.
5. Need for more training exists.
6. Clients must be given access to a range of services.
7. We must recognize programs that need more case management and mental illness focus for clients.
8. Use information technology to assure clarity of care plan and coordination of care.

## **Barriers**

1. Resistance to change on the part of government agencies, providers, and consumers is evident in continued adherence to non-effective services and attitudes.
2. Eliminate silos that exist: funding, services, training, etc.
3. Cross-cultural training should start in the schools, yet schools are behind the state of the art in terms of the knowledge base of effective practices.
4. Only one in five youth with co-occurring disorders is correctly diagnosed.
5. Not all silos for kids are heard; only two are represented at this conference. Mental health and alcohol and drug services are represented, but social services, child protection services, juvenile justice, and schools are not.
6. Best practices should be a discussion with our collaboration partners—not in isolation.
7. The significant number of uninsured clients creates a burden for mental health services providers.
8. Our record and data systems lack good information about client diagnoses.

## **Workshop: Integrate Trauma-Informed Practice**

Research studies indicate that significant numbers of women with co-occurring disorders also have trauma concordance rates of up to 90 percent. Presenters in

this workshop asserted that mental health and substance abuse service providers must understand the interrelatedness of these disorders in order to provide more effective treatment.

Presenters: Vivian Brown, Ph.D., President/CEO of Prototypes Centers for Innovation in Health, Mental Health and Social Services; Elke Rechberger, Ph.D., Director of the Systems Change Center, Prototypes; and Paula Bjelajac, Consumer Specialist, Systems Change Center, Prototypes

Moderator: Richard Van Horn, President of the Mental Health Association of Los Angeles

## **Participants' comments, reported by Richard Van Horn**

### **Barriers**

1. Our systems are affected by conflicts in culture and by a lack of cross training.
2. There exists inter-systems barriers; for instance, clients may be incarcerated and there is no way to continue treatment and involve families.
3. Access barriers exist at all levels.
4. Faster transfer of science to practice must occur, and both mental health and alcohol and drug service providers need to learn each others' systems.
5. Training in trauma and/or treatment for post-traumatic stress disorder is needed.
6. Mandate consumers as staff in all programs—need federal and state recognition and funding to support this.
7. Agencies must coordinate medical records across systems.
8. Agencies hesitate to inaugurate new programs as a consequence of unwillingness to open a “new can of worms.”

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## **Conclusion**

All the state and association representatives agreed to reconvene in six months to assess their mutual progress toward their commitments to improve services for persons with co-occurring disorders. A follow-up conference is planned for December 2004.



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