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Adoption of Integrated Care for People with Co-Occurring Mental Health and Substance Use Disorders

Prepared for
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by
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ADOPTION OF INTEGRATED CARE FOR PEOPLE WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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KEY FINDINGS

- Co-occurring mental health and substance use disorders (SUDs) are common, yet only about 6 percent of people with co-occurring disorders (CODs) receive both mental health and substance use treatment. The Substance Abuse and Mental Health Services Administration recommends integrating mental health and SUD treatment to improve access to care and outcomes for people with CODs.
- In 2020, about half of outpatient mental health and SUD treatment facilities had a program to provide integrated care for people with CODs. This finding reflects no substantial change since 2014 for mental health treatment facilities but a 10-percentage point increase for SUD facilities over the same period.
- In the past decade, motivated states and providers have led efforts to integrate care for people with CODs in outpatient behavioral health settings. Using established principles and shared treatment components, they have tailored approaches for varying client and community contexts.
- Integrated care programs for people with CODs share features, including a comprehensive approach to screening, assessment, treatment planning, service delivery, and continuing care.
- Providers continue to encounter barriers to delivering integrated care for CODs, including separate licensing and reimbursement processes for mental health and SUDs. Some providers point to the reimbursement mechanisms and core components of the Certified Community Behavioral Health Clinic model as supporting integrated care.
- Federal, state, and local partners could advance the adoption of integrated care for people with CODs by: (1) strengthening measurement, data collection, and reporting of the prevalence of CODs and their treatment; (2) streamlining licensing and reimbursement processes to reduce administrative barriers to adopting integrated treatment; (3) enhancing financial support to providers to cover initial and ongoing costs of delivering integrated treatment; and (4) supporting workforce development and continuing education related to CODs.

ABSTRACT

Co-occurring mental health and substance use disorders (substance use disorders (SUDs)--known and referred to in this report as co-occurring disorders (CODs)--affect an estimated 6.6 percent of adults in the United States (SAMHSA 2021). Yet, people with CODs rarely receive both mental health and substance use treatment. For this study, Mathematica conducted a targeted environmental scan, interviewed key informants, prepared case studies of integrated care programs for people with COD, and analyzed national survey data. Overall, findings examined: (1) changes over time in the adoption of integrated care for COD in outpatient settings; (2) key components of integrated treatment programs; (3) factors that impede the adoption of integrated care; and (4) key opportunities to advance the adoption of integrated treatment. In 2020, we found that only about half of outpatient mental health and SUD facilities had a specific program for CODs; this finding reflected no change since 2014 for mental health facilities but a 10-percentage point increase for SUD facilities. Findings from the environmental scan and key informant interviews pointed to limited progress in widespread adoption of integrated treatment for people with CODs in the past decade, with advancements driven by motivated states and providers. Providers continue to encounter several barriers to providing integrated care for CODs, including lack of community and clinical data; separate regulatory, licensing, and reimbursement processes for mental health conditions and SUDs; significant financial investments and staff time required to implement integrated treatment; and limited workforce training related to CODs. Integrated care programs interviewed for the case studies overcame many of these barriers and shared some common components, including a comprehensive approach to screening, assessment, treatment planning, service delivery, and continuing care. Opportunities for addressing structural barriers to widespread adoption of integrated treatment include: (1) enhancing routine data collection and monitoring of CODs and integrated treatment; (2) streamlining state regulatory, licensing, and reimbursement processes; (3) expanding reimbursement, funding, and technical assistance mechanisms for integrated treatment for people with CODs; and (4) supporting formal and on-the-job training to equip behavioral health providers with skills to deliver integrated care.

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ACA	Affordable Care Act
ASAM	American Society of Addiction Medicine
ACT	Assertive Community Treatment
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
CADRE	Change Agents Developing Recovery Excellence
CCBHC	Certified Community Behavioral Health Clinic
CCISC	Comprehensive Continuous Integrated System of Care
CFBHN	Central Florida Behavioral Health Network
CFR	Code of Federal Regulations
COC	Co-Occurring Capable
COD	Co-Occurring Disorder
COVID-19	Novel Coronavirus
CRF	Community Research Foundation
DCMH	Westchester County Department of Community Mental Health
EHR	Electronic Health Record
HHS	U.S. Department of Health and Human Services
IDDT	Integrated Dual Disorder Treatment
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and More
LOCUS	Level of Care Utilization System
MHSA	California Mental Health Services Act of 2004
N-MHSS	National Mental Health Services Survey
N-SSATS	National Survey of Substance Abuse Treatment Services survey
OASAS	New York Office of Addiction Services and Supports
OMH	New York Office of Mental Health
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TIP	Treatment Improvement Protocol
WJCS	Westchester Jewish Community Services

EXECUTIVE SUMMARY

Co-occurring mental health and substance use disorders (SUDs) affect an estimated 6.6 percent of adults in the United States (SAMHSA 2021). Only 6 percent of adults with co-occurring disorders (CODs) receive both mental health and SUD treatment (SAMHSA 2021). The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends integrating mental health and SUD treatment for people with CODs to increase access to care and improve outcomes. In this study for the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, Mathematica analyzed national survey data, conducted a targeted environmental scan, interviewed key informants, and conducted case studies of clinics with integrated treatment services for people with CODs. The goals of this study were to examine: (1) changes over time in the adoption of integrated care for CODs in outpatient settings; (2) barriers to the adoption of integrated care; (3) key components of integrated care programs; and (4) opportunities to advance integrated treatment. Key informant interviewees included individuals with expertise in clinical practice and administration, research, advocacy, policy, and technical assistance. Case study sites included five clinics providing outpatient behavioral health services in diverse communities across the United States. These clinics implemented integrated treatment with technical assistance and support from different types of partner organizations.

Changes in the Availability of Integrated Care for Co-Occurring Disorders

Using data from the 2014 and 2020 National Mental Health Services Survey and National Substance Abuse Treatment Survey, we found that 54 percent of outpatient mental health facilities and 53 percent of outpatient SUD facilities reported having a special program to provide integrated care for people with CODs in 2020. This represented no change from 2014 to 2020 for mental health facilities but a 10-percentage point increase for SUD facilities over the same period. Special programs were more common in mental health and SUD facilities with Joint Commission accreditation, and among facilities with a wider range of other special programs for specific populations. Among SUD facilities but not mental health facilities, special programs for people with CODs were more common among non-profit (versus for-profit) facilities and those that accepted Medicaid. These findings could inform efforts to promote the integration of care for CODs within facilities with specific characteristics.

Findings from the environmental scan and key informant interviews suggested limited advancement in widespread adoption of integrated care for CODs in the past 10 years. Where there has been progress, key informants cited states and providers as leading the development and implementation of new approaches.

Key Components of Integrated Care Programs

There is no single approach for integrating care for people with CODs. However, integrated care programs tend to share some common features. Such programs typically address mental health and SUD concerns within a single setting and care team, combining interventions intended to treat the whole person and offering a comprehensive approach to screening, assessment, treatment planning, service delivery, and continuing care (Morisano, Babor, & Robaina 2014; SAMHSA 2020; Torrens et al. 2012). To deliver this comprehensive approach, they may offer a standard set of services ranging from pharmacotherapy to therapeutic peer recovery groups (SAMHSA 2020).

Barriers to Integrating Care

Providers continue to encounter barriers to integrating treatment. The environmental scan and key informant interviews highlighted a longstanding separation between mental health and SUD services and limited progress in integrated treatment delivery over the past decade in outpatient behavioral health clinics. Findings from the environmental scan and key informant interviews, and case study clinics, illustrate the multiple structural barriers that limit widespread adoption of integrated treatment. Barriers we found are: (1) a lack of

community and clinical data that could motivate state and behavioral health agency leaders to adopt and continuously improve integrated treatment for people with CODs; (2) complex regulatory, licensing, funding, and reimbursement processes; (3) the significant financial investment and staff time required to adopt integrated treatment; (4) an under-resourced behavioral health workforce with limited preparation related to integrated treatment; and (5) limited organizational awareness and commitment.

Opportunities to Overcome Barriers

Key opportunities for overcoming barriers include: (1) improving data collection and measurement of COD prevalence and the delivery of integrated treatment; (2) streamlining state regulatory, licensing, and reimbursement processes; (3) expanding reimbursement, grant funding, and technical assistance resources to allow more providers the means to offer sustained integrated treatment; and (4) supporting and incentivizing formal and on-the-job training to ensure a cross-trained behavioral health workforce equipped to apply integrated treatment principles on an everyday basis. Local, state, and federal agencies and other partners can take advantage of these opportunities to address overarching barriers to widespread adoption of integrated treatment. These actions would help behavioral health providers gain the awareness, organizational commitment, and resources required to redesign services and routinely deliver high-quality integrated care to clients with co-occurring needs.

I. INTRODUCTION

A. Background and Purpose

Co-occurring mental health and substance use disorders (SUDs)--known and referred to in this report as co-occurring disorders (CODs)--affect an estimated 7.6 percent of adults in the United States (SAMHSA 2021). Forty-five percent of people with a serious mental illness (SMI) have a SUD, and 43 percent of people with a SUD have a mental illness (SAMHSA 2021). While knowledge is still evolving (Hunt et al. 2019), compared to non-integrated approaches, integrated approaches to care for CODs have been associated with greater client satisfaction with care (Schulte, Meier, & Stirling 2011), improved quality of life (Drake et al. 2016), and reduced health care costs (Morse & Bride 2017). Unfortunately, only 6 percent of adults with CODs received treatment for both mental health and SUD in the past year (SAMHSA 2021).

Since the 1990s, researchers and government agencies have recommended integrating mental health and SUD services to increase access to care and improve outcomes for people with CODs. These recommendations emerged in response to the historical separation between mental health and SUD treatment systems. For several decades following the deinstitutionalization of people from psychiatric hospitals, SUD treatment primarily existed outside the mental health system (Burnam & Watkins 2006). During that time, SUD and mental health services had distinct funding streams, administrative structures, leadership, and licensing and credentialing standards. In the late 1990s, researchers and federal agencies began to study and promote evidence-based approaches for integrated treatment, including approaches to treating mental health and SUD concurrently, in the same treatment setting, and by the same team of providers (Minkoff & Covell 2019).

In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) published overarching principles to guide the development of integrated systems of care for people with CODs, building on recommendations from previously published principles and consensus reports (SAMHSA 2007). These principles emphasized alignment between policies, regulations, and funding to support the clinical integration of care and ensure that people with CODs can access comprehensive services (***Exhibit I.1***). Recognizing the need for strategies to propel integrated systems and services, SAMHSA invested resources in technical assistance, including the Co-Occurring Center of Excellence and Co-Occurring State Infrastructure Grants to support states' efforts to develop, implement, and evaluate statewide approaches to integrating service delivery for CODs (Minkoff & Covell 2019). These efforts emphasized adoption of models such as Integrated Dual Disorder Treatment (IDDT), a suite of evidence-based interventions encapsulated within a team-based model to treat people with serious CODs (Minkoff & Covell 2019). SAMHSA continued to fund these activities through around 2009, when there was a shift toward financing the integration of primary care and behavioral health to address the shorter life expectancy of people with SMI due, in part, to comorbid medical conditions (Minkoff & Covell 2019). Behavioral health treatment facilities may have been slow to adopt integrated care for CODs; for example, a 2010 study of a sample of behavioral health facilities found that only 18 percent of SUD facilities and 9 percent of mental health facilities were prepared to treat people with CODs (McGovern et al. 2014).

In the past decade, the passage of the Affordable Care Act (ACA) and greater attention to behavioral health parity laws have increased pressure on health plans and providers to treat both mental health and SUDs. In 2014, regulations implementing provisions of the ACA defined mental health and SUD treatment as essential health benefits in the individual and small-group markets and expanded Medicaid coverage. Overall, the ACA increased access to mental health and SUD treatment and extended coverage to several million people with SUDs (Shover et al. 2019; Mee-Lee 2014; Pro et al. 2021), but there is limited evidence expanding coverage has translated into significantly more people with CODs receiving both mental health and SUD treatment. Nationwide, in recent years federal grant programs, foundations, and advocates have also bolstered efforts to divert people with behavioral health needs away from the criminal justice system wherever possible,

increasing the demand for community-based behavioral health services to address CODs among these populations (Minkoff & Covell 2019; Lindquist-Grantz et al. 2021).

Exhibit I.1. Principles that Guide Systems of Care for Persons with CODs

1. CODs are to be expected in all behavioral health settings, and system planning must address the need to serve people with CODs in all policies, regulations, funding mechanisms, and programming.
2. An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.
3. The integrated system of care must be accessible from multiple points of entry (that is, no wrong door) and be perceived as caring and accepting by the consumer.
4. The system of care for CODs should not be limited to a single "correct" model or approach.
5. The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence-based and consensus-based practices for persons with CODs and the evaluation of the efforts of existing programs and services.
6. Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields to meet the complex needs of persons with CODs.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2007). *Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders*. COCE Overview Paper 3, DHHS Publication No. (SMA) 07-4165. Rockville, MD: SAMHSA. https://radarcart.boisestate.edu/library/files/2017/07/OverarchingPrinciplesOP3.pdf.

SAMHSA's systems-oriented principles for integrating care for CODs remain relevant today as policymakers consider strategies to improve access to care for CODs in response to the ongoing opioid crisis as well as to higher rates of polysubstance use, suicide, and mental health challenges following the COVID-19 pandemic (Panchal et al. 2022). Gaps in knowledge continue to hinder the adoption of integrated care for CODs. While some studies have suggested mental health facilities have advanced in their adoption of SUD treatment (Spivak et al. 2020), more recent data could provide insights into whether this trend has continued and identify the characteristics of facilities that offer integrated care for CODs. Policymakers also need information to quantify the availability of integrated care for CODs and identify the types of clinics that would benefit from resources and support to implement integrated care. To inform efforts by providers, communities, and government agencies, more information is also needed to better understand factors that may impede the adoption of integrated care for CODs, as well as promising practices and opportunities.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) engaged Mathematica to study promising strategies to expand the delivery of integrated care for people with CODs. We analyzed national survey data to examine changes in the adoption of integrated care for CODs in outpatient mental health and SUD treatment facilities. We also conducted an environmental scan, key informant interviews, and case studies of outpatient behavioral health clinics to understand key components of integrated treatment and those factors that impede the implementation of integrated care and key opportunities to address them.

B. Overview of Methods

This report synthesizes findings from: (1) quantitative data analyses; (2) an environmental scan of peer-reviewed and grey literature; (3) key informant interviews; and (4) case studies of clinics that provide integrated care for CODs. ***Exhibit I.2*** summarizes the data sources and methods. ***Appendix A*** provides additional details on data sources.

Exhibit I.2. Summary of Data Sources and Methods			
Component	**Objective**	**Data Source**	**Analysis**
Quantitative data analyses	Examine changes from 2014 to 2020 in the availability of integrated treatment for people with CODs within outpatient mental health and SUD facilities in the United States, including all states, territories, and jurisdictions; examine correlates of integrated treatment for people with CODs.	2014 and 2020 National Mental Health Services Survey (N-MHSS) and National Survey of Substance Abuse Treatment Services (N-SSATS).	Descriptive statistics and multi-variable regression modeling.
Environmental scan	Describe integrated treatment for people with CODs in outpatient behavioral health settings to understand the current landscape of integrated treatment and inform key informant interviews and case studies.	Scan of English-language peer-reviewed and grey literature, focusing on the past 5 years (2018-2022), in addition to formative articles and reports prior to 2018 identified in supplemental searches.	Reviewed articles and wrote analytic summaries spotlighting key information; organized findings into synthesis of integrated treatment for people with CODs, including history, settings of care, integration definitions, models of care, principles of care, and challenges and opportunities.
Key informant interviews	Gather varying perspectives on the current landscape of integrated treatment, approaches for integrating mental health and SUD treatment for people with CODs in outpatient behavioral health settings, barriers and opportunities, and promising approaches.	Semi-structured, recorded interviews with 6 key informants representing clinical practice and administration, research, advocacy, policy, and technical assistance perspectives.	Analytic summaries of responses to interview questions and thematic analyses.
Case studies	Gather clinic and community-specific information on approaches for integrating mental health and SUD treatment for people with CODs in outpatient behavioral health settings, barriers and opportunities, and promising approaches.	Semi-structured, recorded interviews with frontline providers, clinic leaders, and administrators at 5 clinics in communities across the United States that provide integrated mental health and SUD treatment, as well as interviews with technical assistance and government staff from partner organizations that provide funding or technical assistance.	Analytic summaries of responses to interview questions and thematic analyses.

C. Case Study Clinics

We conducted case studies at five clinics delivering integrated treatment for people with CODs in different communities (***Exhibit 1.3***). We identified these case study clinics through our environmental scan and key informant interviews. All case study clinics provided integrated mental health and SUD treatment within one physical site, with one team or a primary clinician addressing both disorders concurrently. Community Research Foundation (CRF), Gracepoint Wellness, and Westchester Jewish Community Services (WJCS) primarily provided mental health services before integrating SUD treatment, whereas AllHealth and Samaritan Daytop Village primarily provided SUD services before integrating mental health treatment. All sites reported an emphasis on serving underserved clients, especially populations enrolled in Medicaid. For each clinic, we

also interviewed a partner organization that provides funding, technical assistance, monitoring or other support for the clinic or agency. We developed a brief profile of each case study clinic, describing a unique feature of approach toward delivery of care for CODs (***Appendix B***). In each profile, we also expand upon each site's system-level support for integrated treatment and describe a partner organization that supports integrated treatment for the clinic and others in the communities through policy development, funding, and/or technical assistance.

Exhibit I.3. Case Study Clinics and Partner Organizations

Clinic	Location	Partner Organization	Partner Organization Description
AllHealth Network	Englewood, CO (Arapahoe and Douglas Counties)	Signal	Managed services organization that provides funding, credentialing, technical assistance, referrals; acts as intermediary between the state behavioral health agency and provider organizations in several Colorado counties. Referred by case study clinic interviewee.
Community Research Foundation (CRF)	Chula Vista, CA (San Diego County)	County of San Diego Behavioral Health Services, Change Agents Developing Recovery Excellence (CADRE)	Technical assistance initiative developed between county and providers to address needs of clients with CODs. CADRE is housed under County of San Diego Behavioral Health Services and offers provider training, funding, and other supports. Referred by key informant.
Gracepoint Wellness	Tampa, FL (Hillsborough County)	Central Florida Behavioral Health Network (CFBHN)	Provider-supported network that provides funding and technical assistance. Referred by key informant.
Samaritan Daytop Village	Huntington Station, NY (Suffolk County)	New York Office of Mental Health (OMH) and New York Office of Addiction and Alcohol Services (OASAS)	OMH and OASAS are state agencies that manage SUD and mental health regulations and policies across the state and work together to oversee Certified Community Behavioral Health Clinics. Referred by key informant.
Westchester Community Jewish Services	White Plains, NY (Westchester County)	Westchester County Department of Community Mental Health (DCMH)	DCMH addresses regulatory licensing issues, provides training to help establish a co-occurring capable workforce, and advocates for providers at the state level. Referred by case study interviewee.

D. Study Limitations

Given the targeted focus of this project, this report represents a broad examination of strategies to advance integrated treatment for people with CODs in outpatient behavioral health treatment settings. The findings reflect the published literature and the views of a limited number of key informants and case study clinics. However, we sought to include key informants with a range of backgrounds and geographically diverse case study clinics with differing backgrounds (for example, some sites originally focused on SUD care and others originally focused on mental health) and varying policy and community contexts. Notably, this project focused on gaps in implementation of integrated treatment for people with CODs rather than gaps in the evidence base around integrated treatment. Therefore, recommendations do not extend to research communities and related funders of research.

II. Current State of Integrated Treatment

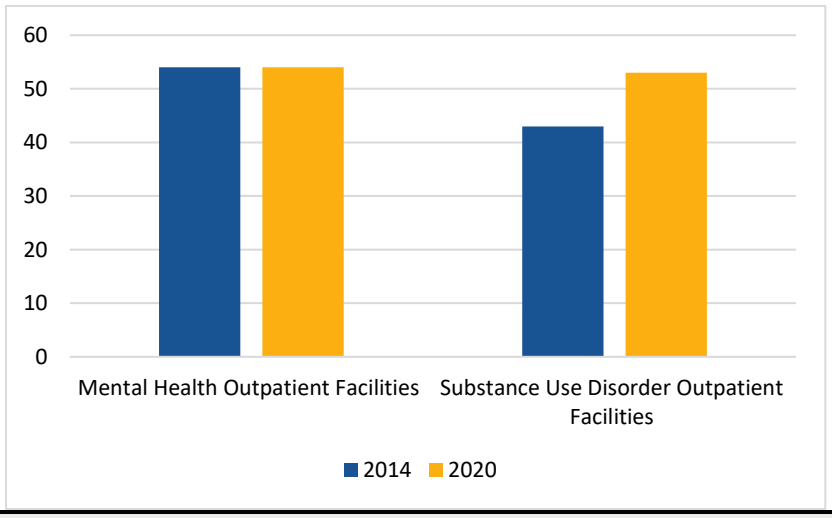
Overall, there is limited evidence that integrated care for CODs is much more widely available today relative to 10 years ago. Our analysis of national survey data (***Exhibit II.1***) found that about half of outpatient mental health and SUD treatment facilities had a special program for CODs in 2020. This reflects no change from 2014 for mental health treatment facilities but a 10-percentage point increase for SUD treatment facilities.

Exhibit II.1. Availability of Integrated Treatment for People with CODs in Specialty Mental Health and SUD Treatment Facilities

We analyzed data from 2 national surveys of mental health and SUD treatment facilities to examine changes between 2014 and 2020 in the proportion of outpatient mental health and SUD treatment facilities with special programs for people with CODs, and facility-level correlates of integrated treatment.

- 54% of outpatient mental health facilities and 53% of outpatient SUD facilities reported a special program to provide integrated care for people with CODs in 2020 (***Figure 1***). This represented no change from 2014 to 2020 for mental health facilities but a 10-percentage point increase for SUD facilities over the same period.
- Special programs for people with CODs were more common in mental health and SUD facilities with Joint Commission accreditation. Facilities with a program for CODs also tended to offer a wider range of other special programs (for example, programs for adolescents).
- Among SUD facilities but not mental health facilities, special programs for people with CODs were more common among non-profit (versus for-profit) facilities and those that accepted Medicaid.

Figure 1. Change in Percentage of Outpatient Facilities with a Special Program for CODs



Source: N-SSATS and N-MHSS data, 2014 and 2020. Please see issue brief for detailed findings.

Key informants cited several reasons for the lack of adoption of integrated care for CODs, including: a lack of focus on integrated treatment at the national or state level, few funded initiatives focus on CODs, and insufficient systematic measurement efforts documenting the prevalence of CODs and the availability of integrated treatment. They also discussed how siloed mental health and SUD systems continue to slow the adoption of integrated treatment. For example, having separate mental health and SUD agencies may create administrative burden for clinics because of their differing processes related to licensure and billing. In addition, several non-clinical services necessary to providing high-quality integrated treatment (for example, coordination between providers to address clients' unmet social needs) are considered unbillable time for providers and are not reimbursed by insurers or funded through federal block grants or other sources.

Key informants had differing perspectives about whether it is easier to integrate mental health into facilities that primarily provide SUD treatment or integrate SUD treatment into facilities that primarily provide mental health treatment. Some key informants perceived mental health outpatient settings may be more likely than SUD treatment setting to have the mix of staff needed to implement integrated care, but they could have fewer screening practices in place to identify CODs and more cultural resistance among staff if they are more comfortable treating clients traditionally within their scope of practice.

Key informants described promising areas of progress for integrated treatment in the past decade. Providers may have more general awareness of CODs and states are creating expectations around identifying and addressing CODs. Multiple key informants noted how greater attention to physical-behavioral health integration has had some positive spillover to address integrated care for CODs, but the focus on physical-behavioral health integration has also competed for resources and attention. Several key informants pointed to the Certified Community Behavioral Health Clinic (CCBHC) model as a step in the right direction because it requires participating clinics to provide both mental health and SUD care (SAMHSA 2023). They specifically described the payment model for the CCBHC demonstration as a promising approach for expanding the adoption of integrated treatment. Clinics participating in the CCBHC demonstration receive a fixed bundled payment that covers the cost of delivering both mental health and SUD services. ***Exhibit II.2*** provides more details on the CCBHC demonstration and its potential for advancing integrated treatment for people with CODs.

Exhibit II.2. Key Components of the CCBHC Demonstration to Support Integrated Treatment for People with CODs

The CCBHC demonstration allows states to test a new strategy for delivering and reimbursing services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of ambulatory services provided in community behavioral health clinics by establishing a standard definition for CCBHCs and developing a new Medicaid prospective payment system in each state that accounts for the total cost of providing comprehensive services to all individuals who seek care, regardless of their ability to pay, including but not limited to those with SMI, serious emotional disturbance, and SUDs. Clinics participating in the demonstration must provide coordinated care that addresses both mental health and SUDs (SAMHSA 2023).

Key informants and case study clinics identified components of the CCBHC model that support integrated care for CODs:

- **Team-based care**. Ability to employ and bill for multiple disciplines under one roof, including physical health screening and monitoring, mental health, and SUD treatment.
- **Wraparound services**. Employment and housing services, peer support, care management, and collaboration with pharmacies to access lower-cost prescriptions.
- **Bundled rates and increased reimbursement for mental health and SUD services**. Allows clinics to operate a sliding scale, support undocumented and uninsured clients, and provide multiple services on the same day, according to clients' needs and schedules.

According to key informants, motivated provider communities and states have driven efforts to advance integrated care for CODs over the past decade. In some states, policymakers and state agencies have worked on policy and systems improvements including reducing barriers to financing integrated treatment, streamlining licensing practices, and testing new models of care. As an example of a state policy change, in California in 2020, Assembly Bill 2265 clarified use of Mental Health Services Act (MHSA) funds for COD care by clarifying that MHSA funds can be used for COD assessment and treatment; this bill also created county-level reporting requirements intended to incentivize COD treatment (California Department of Health Care Services 2021). Some providers have spearheaded implementation practice improvement efforts (for example, changes to clinical processes and electronic health record [EHR] design), coalitions, and learning communities to advance and share best practices for integrated treatment for people with CODs. For example, Catholic

Charities of Baltimore recently engaged in a comprehensive implementation practice improvement plan to help prepare staff for organizational change to integrate SUD treatment into their outpatient community mental health clinics. Specifically, the behavioral health provider agency developed a systematic practice improvement strategy that included a competency-based curriculum and supervision plan for psychiatric providers and therapists (Oviedo et al. 2023). To illustrate state and provider-level activities to advance integrated treatment for people with CODs, ***Exhibit II.3*** provides examples from key informant interviews and case studies of state and provider-led activities to advance integration in New York State.

Exhibit II.3. State and Provider-Led Strategies to Advance Integrated Care for CODs in New York State

- **Reducing licensing barriers**. The state licenses mental health and SUD providers through separate processes, which some providers found challenging to navigate when offering integrated treatment. The Office of Mental Health and the Office of Addiction Services and Supports increasingly report working in coordination to support integrated care in the state, through ensuring alignment when issuing guidance to providers on billing and provision of integrated treatment. The two agencies also describe launching a new interagency workgroup to redesign processes for licensure related to the integrated outpatient services license.
- **Testing and expanding strategies for integrated treatment**. The state expanded the number of CCBHC demonstration clinics. Other providers are adopting new models for integrated treatment, like Encompass, to reach specific populations, including adolescents. Encompass, an approach for treating CODs originally designed for children and youth, uses cognitive behavioral therapy and motivational enhancement approaches.
- **Quality improvement learning collaboratives**. Providers from the Mid-Hudson Region participate in a Co-occurring System of Care Committee to share best practices for integrated treatment of CODs.

III. Key Components and Promising Approaches to Integrating Care for COD in Outpatient Behavioral Health Clinics

A. Core Components of integrated treatment and promising approaches

Although there are various models for integrating care for COD, they share some common features. These programs offer a comprehensive approach to screening, assessment, treatment planning, service delivery, and continuing care (Morisano et al. 2014; SAMHSA 2020; Torrens et al. 2012). To deliver this comprehensive approach, a program may offer a common set of services, ranging from medication management to therapeutic peer recovery groups (SAMHSA 2020). They typically provide mental health and SUD treatment within a single setting and care team but can involve multiple sites of care or coordination with providers beyond a single setting. Given the historical separation between mental health and SUD settings, these programs incorporate staff training and ongoing quality improvement.

Drawing on SAMHSA's Treatment Improvement Protocol (TIP), which provides in-depth recommendations on the delivery of integrated treatment for people with CODs based on the evidence and an expert panel (SAMHSA 2020), here we summarize core components of the integrated treatment process in outpatient behavioral health settings and use key findings from informant interviews and case studies, where applicable, to illustrate these components and provide examples. ***Appendix B*** includes profiles of each case study clinic.

Client engagement. SAMHSA has outlined a 12-step assessment process for CODs (SAMHSA 2020), shown in ***Appendix Exhibit C.1***, that begins with client engagement. To engage the client, clinics should create a welcoming environment where staff greet clients with an open, non-judgmental attitude using a trauma-informed approach (SAMHSA 2020). For example, the case study clinic Samaritan Daytop Village's intake process involves creating a supportive atmosphere. They have a peer support specialist individually welcome clients to the clinic, introduce services, provide clients with food and a private area to rest, and facilitate a warm hand-off to intake staff, especially when referrals are required. CRF similarly reported an accessible intake process for clients, with walk-in hours. The five case study clinics used a mix of values-driven treatment philosophies; they variously used a harm reduction, person-centered, and trauma-informed approach toward engaging clients in care.

Screening and assessment. Although there are no gold-standard screening or assessment tools for CODs, clinics should implement holistic screening and assessment protocols for clients with CODs to determine their readiness for change and their motivations, diagnoses, disabilities, functional impairments, strengths, and supports--to guide the development of an individualized treatment plan (SAMHSA 2020). Although outpatient settings provide a majority of mental health and SUD treatment, some people with CODs might need a higher level of care. Clinicians often use instruments such as the Level of Care Utilization System (LOCUS) and the American Society of Addiction Medicine (ASAM) Levels of Care Model, described in ***Appendix Exhibit C.2***, to match clients' needs to level of care (Mee-Lee 2014; SAMHSA 2020). In addition to using instruments to determine level of care and whether an outpatient behavioral health setting is most appropriate for a client's needs, a variety of assessment tools can be used; common tools for each component of this assessment process are detailed in the TIP. A comprehensive assessment process guides the development of an individualized treatment plan and includes a series of appropriately matched interventions related to each problem or diagnosis, accounting for a client's stage of change and other contextual considerations (SAMHSA 2020).

In alignment with SAMHSA's guidelines, all case study clinics used standardized tools to conduct comprehensive screening and assessments to determine a client's level of care, and many had a designated intake team. For example, Samaritan Daytop Village reported peers help transition clients to intake staff, who

conduct comprehensive medical, criminal, mental health, and SUD screenings and assessments, as well as a psychiatric evaluation. During this process, they also gather information about the client's medical and psychiatric history from the referral source, family members, and the client's previous providers. After comprehensive screening and assessment, each case study clinic matches clients with a cross-trained primary clinician, who works with clients and consults with other members of the care team to develop a treatment plan.

Exhibit III.1. Example Interventions that Integrate Mental Health and SUD Treatment

Integrated Treatment Intervention	Description	Feature
Assertive Community Treatment (ACT)	Provides intensive in-person services multiple times a week. Tailored for clients with serious mental illnesses who are not engaged in traditional outpatient services and have complex social needs including homelessness.	Multi-disciplinary, team-based service model. Outreach, engagement, low-barrier service delivery. Direct provision of range of integrated services, access and linkage to services related to unmet social needs (e.g., housing, legal assistance).
Dual recovery mutual-support programs	Non-professional self-help recovery support groups that apply a spectrum of personal responsibility and peer support principles, such as the 12-step programs, for people with CODs to learn how to manage their SUD and mental disorders together.	Members remain anonymous and take turns facilitating meetings. Purpose of achieving and maintaining dual recovery, preventing relapse, and supporting recovery. No direct service provision.
Motivational enhancement or interviewing	Client-centered approach that enhances clients' internal motivation to change through ongoing counseling; often used in the context of other evidence-based models.	Delivery by counselor. Accepting client's level of motivation as the starting point. Asking open-ended questions, using reflective listening, summarizing statements from the client, and determining readiness to change.
Combined psychopharmacological interventions	Medications prescribed for both SUD and mental disorders.	Continued provision of necessary non-addictive medication for known mental illness, even for people who continue to use substances. Appropriately matched medications for mental illness that adults and adolescents respond to, even when they continue to use substances. Medications with indications for mental health but not "magic bullets" for any combination of comorbid conditions. Team of providers, including a primary care provider, psychiatrist, and behavioral health professional, working together to monitor the effects and side effects of the medication regimen.

Sources:
Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *TIP 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders*. HHS Publication No. (SMA) 13-4801. Rockville, MD: SAMHSA. https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004.

Minkoff, K., & Covell, N.H. (2019). *Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?* National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf.

Care delivery and continuing care. There is no single recommended treatment approach for people with CODs, but there are common principles to guide treatment. Integrated care for CODs involves delivering mental health and SUD treatments concurrently; using multiple interventions available to support clients in

different stages of treatment; pharmacotherapy, where appropriate and monitored; a stage-by-stage approach; and motivational techniques used in alignment with the client's readiness to engage in treatment (SAMHSA 2020). Several specific evidence-based treatment approaches can support the concurrent delivery of mental health and SUD treatment. They include ACT, integrated case management, dual recovery mutual-support programs, motivational interviewing, and combined psychopharmacological interventions (***Exhibit III.1***). Given that clients' needs and contexts can change over time, SAMHSA recommends measurement-based care that includes regular assessments to inform adjusting treatment over the course of care (SAMHSA 2020).

In alignment with these practice principles, case study clinics offered a range of integrated treatments, including pharmacotherapy and COD-specific individual and group services. At most case study clinics, a range of other services are also available to clients, including vocational services, case management, peer support, and connections to affordable housing. Following practice principles, case study matched treatment with the needs and preferences of clients and used motivational techniques while respecting their clients' stage of change.

Case study clinics offered a range of services to provide care for people at different stages of treatment; for example, Westchester Community Services has a continuing care program for clients to support their engagement in activities and routines to help them avoid the use of substances after stepping down from more intensive treatment. Case study clinics also had protocols for primary clinicians to facilitate warm hand-offs between different levels of care. They also tracked clients' treatment progress in weekly multi-disciplinary team meetings and holding regular check-ins between primary clinicians and supervisors. Case study clinics often used an integrated EHR system to facilitate information sharing and care continuity across different clinic services.

Quality improvement. Efforts to measure and improve treatment over time are an integral part of integrated treatment programs. Clinics often use technical assistance, learning collaboratives, and other supports to successfully adopt and implement integrated treatment (Anastas et al. 2019; Drake & Bond 2010; Minkoff & Covell 2022; Padwa et al. 2015). ***Exhibit III.2*** details how case study clinics sought to improve the quality of integrated treatment.

Exhibit III.2. Improving Quality of Integrated Treatment

All case study clinics reported tracking client progress in treatment and using quality measures to monitor overall clinic improvement. While most clinics reported receiving technical assistance to help them adopt integrated treatment, several sites were actively involved in ongoing learning and quality improvement efforts specific to integrated treatment for people with CODs. Following are two examples:

- Westchester Jewish Community Services participates in a county learning collaborative in which providers receive help: (1) writing charters that include co-occurring principles and evidence-based practices; (2) performing self-assessments to understand their organization's capability with CODs; and (3) accessing ongoing technical assistance through inter-organizational collaboration and discussion.
- CRF is a member of San Diego County's CADRE initiative, a county-driven effort that provides technical assistance, training, and funding to providers related to CODs.

Reducing barriers to integrated treatment services. Certain populations with CODs disproportionately experience treatment barriers and worse outcomes, such as homelessness and involvement in the criminal justice system. People with CODs are overrepresented among people with these circumstances (SAMHSA 2020). To address these barriers, SAMHSA recommends that providers are equipped to deliver treatment approaches and services that meet the unique needs of clients. ***Exhibit III.3*** illustrates strategies from case study clinics and key informants.

Exhibit III.3. Reducing Barriers to Care for Clients with CODs

In alignment with the recommended approaches, case study clinics reported a variety of strategies to promote equitable service delivery:

- AllHealth reported strategies of embedding harm reduction into their policies, avoiding discharging clients against their will, and offering flexible pathways back into treatment after discharge.
- Multiple clinics reported efforts related to inclusion and language access, including actively recruiting providers from underrepresented backgrounds, requiring cultural competency training for staff, and ensuring access to bilingual clinicians or interpretation services.
- Westchester Jewish Community Services and CRF have care teams and clinicians specialized in serving special populations (for example, LGBTQ+ clients and transition-age youth) using models such as the Encompass model and approaches, such as motivational interviewing, to improve client engagement.
- Samaritan Daytop Village has a client advocacy committee that allows clients to provide suggestions and recommendations for improving treatment.

Key informants discussed the value of clinics' hosting listening sessions to ensure that community members and people with CODs can voice their needs and share ideas that clinics can then incorporate into policies. Key informants also recommended that clinics engage with community partners, behavioral health agencies, and other systems--possibly probation or legal, primary health care, housing, and child protective services--to address health-related social needs and better support clients who are engaged with multiple systems.

Staff training. Given that many providers do not receive formal training related to CODs, clinical staff often need additional training and education to provide care for clients with CODs. Beginning with new staff orientation, SAMHSA recommends that integrated treatment for people with CODs is introduced as central to the organization's mission and values and that agencies provide staff with high-quality continuing education that addresses the practical concerns of treating clients with CODs. Specifically, they recommend at least basic-level cross-training (for example, counselors with primary expertise in mental health receive training in SUD) and ongoing support, supervision, and practice around delivering integrated care. Finally, SAMHSA recommends that clinics provide a positive work environment for staff such as by ensuring flexibility in workloads, adequate compensation, and financial incentives for clinicians' CODs expertise. ***Exhibit III.4*** describes how case study clinics supported staff training.

Exhibit III.4. Ensuring Staff Cross-Training and Support to Deliver Integrated Treatment

In alignment with the recommended approaches, case study clinics provide staff with access to continuing education resources and other support related to treating CODs:

- Gracepoint Wellness leadership provides clinicians with continued education courses on CODs through a dynamic feature of the EHR system and encourages staff to use their weekly administrative time for training or research to improve care for clients with CODs.
- AllHealth uses state funding to pay for fees and training to support clinicians in obtaining dual licensure.

B. Integrated Treatment in Outpatient Behavioral Health Clinics

Several frameworks exist to categorize the capacity of providers and systems to deliver integrated care for CODs. ASAM's three levels of service integration--co-occurring capable (COC), co-occurring enhanced, and complexity-capable--offer a framework for states, managed care entities, and facilities to categorize the capacity of clinics to deliver integrated care. At the lowest level of integration, COC facilities focus mainly on either SUDs or mental health conditions but can treat clients with the other condition; a COC facility might have an outpatient clinic that focuses mainly on SUD treatment but provides on-site services for clients with stable mental health conditions and has a mental health counselor on-site or available through referral (Mee-Lee 2014; SAMHSA 2020). At the second level of integration, co-occurring enhanced services train staff to recognize the symptoms of both disorders and provide concurrent integrated treatment; these services

integrate SUD and mental health treatment at a higher level than COC services do. At the highest level of integration, complexity-capable facilities offer a range of services to meet the needs of people and their families with complex conditions beyond CODs. For example, an outpatient clinic that is complexity-capable delivers comprehensive mental health and SUD treatments for CODs that address clients' physical health needs as well as intersecting issues, such as trauma and housing insecurity, with a team of cross-trained behavioral health specialists, social workers, and medical professionals.

The Four Quadrants Model is a longstanding framework that has been used by behavioral health agencies to conceptualize the treatment needs of clients as well as client populations (SAMHSA 2020). Behavioral health provider agencies also commonly use the Comprehensive Continuous Integrated System of Care (CCISC) framework to systematically assess and work toward their complexity capability through developing a system-level continuous quality improvement partnership, building on existing resources and best practices, and embedding an integrated treatment philosophy (Minkoff & Covell 2019).

Several tools that have been developed to measure providers' and systems' capacity to deliver integrated care for clients with CODs include COMPASS-EZ and COMPASS-EXEC for mental health and SUD services, Dual Diagnosis Capability in Addiction Treatment, and Dual Diagnosis Capability in Mental Health Treatment (McGovern et al. 2014).

IV. Barriers to Integrating Care for Co-Occurring Disorders

Several factors impede the implementation of integrated care for CODs. This section summarizes critical barriers identified in the environmental scan, key informant interviews, and case studies. Where applicable, we also describe strategies used in practice to address these barriers.

1. Limited data related to CODs and their treatment at the community and clinic levels to inform integrated treatment adoption and quality improvement. Key informants described gaps in systematic surveillance of CODs and their treatment across local and state systems. These data gaps impede community-level knowledge of the high prevalence of CODs, which in turn impedes advocacy related to advancing integrated treatment for people with CODs. At the clinic level, key informants noted that lack of routine, standardized screening for and reporting of CODs and gaps in the measurement of the delivery and outcomes of integrated treatment hinder the adoption and improvement of integrated treatment. At the community level, leadership is often not aware of the problem of CODs and therefore lacks motivation to promote integrated treatment.

Case study clinics noted broader data-sharing challenges between organizations that hinder clinical decision making for specific clients and monitoring the delivery of integrated care. Specifically, adhering to 42 CFR Part 2 rules to protect the confidentiality of patient records for the treatment of SUDs has made it more challenging for some clinics to coordinate a client's care across different sites (for example, coordination of a client's care between an outpatient behavioral health clinic and separate methadone clinic). They did not comment on whether recent changes to these rules have improved care coordination. Key informants also discussed how the lack of standard data elements in EHRs across providers impedes care coordination and clinical decision making. For instance, the inability to electronically exchange information about a client's behavioral health history and past service use in other settings could compromise the quality of care a client with COD receives.

2. Reimbursement rates and billing structures do not support integrated care. According to our key informants and case study sites, reimbursement rates and other billing and insurance restrictions impede the delivery of integrated care. Specific reimbursement and billing challenges include restrictions on services eligible for reimbursement, inadequate reimbursement for providing integrated care, limits on the amount of care covered by insurance, and challenging billing rules. Key informants described how insurers typically use diagnostic and billing criteria based on a single disorder (for example, mental health disorders and SUDs are accounted for separately rather than concurrently) and do not consider the added complexity of serving a client with CODs in reimbursement rates (Yule & Kelly 2019). Delivering high-quality integrated treatment can require more time to develop treatment plans and coordinate care across providers (Padwa et al. 2015), which is often not covered by insurance. Integrating care may also require higher levels of effort from higher-paid staff like psychiatrists and nurse practitioners, but the modest revenue of many clinics makes it challenging for them to provide competitive salaries to hire and retain such staff. Case study clinics also explained how clients sometimes reach billing limits before they can complete the recommended treatment for CODs.

To address barriers related to low reimbursement rates, key informants and case study clinics described the value of the CCBHC model. Clinics' higher bundled reimbursement rates from the CCBHC model accounted for the increased administrative and staffing costs of quality, team-based care. In addition, to address barriers related to billing, literature from the environmental scan highlighted actions by state and local systems to clarify billing instructions for integrated treatment (Minkoff & Covell 2019, 2022).

3. Siloed regulatory, licensure, and funding structures. Key informants and case study clinics described how siloed mental health and SUD agencies, particularly at the state level, may result in different rules for delivering mental health and SUD services. For example, mental health services often have separate licensure requirements, administrative processes, billing procedures, reimbursement rates, and available funding

streams. For example, when behavioral health agencies operate with separate mental health and SUD licenses for clinicians, a behavioral health provider with both licenses must navigate different policies (for example, mental health license requirements might require providers to update treatment plans more often than is required under a SUD license). Finally, key informants frequently described siloed funding between mental health and SUD services at the state and local levels as a barrier to delivering integrated treatment. For instance, key informants noted that federal block grants or state funds traditionally earmarked for mental health or SUDs often do not include integrated treatment programs.

4. Under-resourced behavioral health workforce. Formal and continuing education opportunities for the behavioral health workforce--including cross-training and specialized preparation for delivering integrated treatment for people with CODs--are limited (Hawkins 2009; Yule & Kelly 2019; SAMHSA 2020). A key informant specializing in technical assistance described how training staff in integrated treatment can feel particularly difficult considering the breadth of COD--no one specific model of care or approach is used to treat all clients with CODs, and many behavioral health clinicians are unaware of principles and recommended practices for treating CODs (Kelly et al. 2021; Padwa et al. 2015).

Case study clinics had difficulty recruiting staff with cross-training or experience treating CODs and needed to invest more in training clinicians to treat CODs. However, behavioral health providers have limited financial resources to invest in continuing education (Drake & Bond 2010; Brunette et al. 2008). Behavioral health clinics also have difficulty retaining providers who are skilled at delivering integrated care due to staff burnout and large caseloads for CODs (Drake & Bond 2010; Brunette et al. 2008).

Case study clinics reported a variety of strategies to provide on-the-job training in integrated care. Some clinics offered training on evidence-based practices, in-person and virtual learning opportunities, one-on-one consultation, and financial and supervisory support for clinicians pursuing dual licensure. To address staff turnover, some case study clinics increased staff pay, implemented caseload caps, and increased their investments in supportive supervision.

5. Significant initial financial investment and staff time required to adopt integrated treatment. Some evidence suggests that certain integrated treatment models like IDDT might be too complex for many behavioral health outpatient providers to learn and implement with fidelity in real-world settings (Drake & Bond 2010). Case study clinics and key informants described how implementing such complex models requires significant investment in staff training, obtaining licenses, and reorganizing care teams, which may not be possible at all clinics.

To address these barriers, case study clinics used existing resources and grant funding to hold multi-day trainings, comprehensive reviews of integrated treatment practices, and develop new collaboration processes. For example, some clinics customized or updated their EHRs to improve access to centralized clinical information among care team members or remind clinicians to write progress notes, collaborate on integrated treatment plans, input specific co-occurring diagnoses, and use specific billing codes for integrated treatment. Clinics also described streamlining communication, especially between clinicians and medical providers, and participating in learning communities and quality improvement efforts focused on integrated care led by state and local behavioral health agencies or provider networks. Case study clinics hired external consultants to lead or support these activities.

6. Lack of organizational awareness and commitment related to adopting integrated treatment. Adopting integrated treatment practices requires a high degree of organizational commitment from provider agencies and local and state governments (Padwa et al. 2015; Brunette et al. 2008; Chandler 2009; Barreira et al. 2000). For example, key informants described how clinic leadership is often motivated to improve the experience and outcomes of people who receive behavioral health services, but they frequently have limited understanding of

CODs within their communities and client populations, leading to limited organizational commitment to make the changes necessary to support integrated care.

To address these barriers, case study clinics and key informants offered strategies that clinics have implemented to increase organizational commitment to integrated treatment. To adopt integrated treatment once it is viewed as an organizational priority, clinics have sought funding to establish programs for people with CODs, established executive committees of leaders to guide the transition to integrated treatment, embedded integrated treatment into their organizational mission and values, and have initiated planning processes to redesign their integrated treatment processes. Clinics and states have also hosted listening sessions to gather input from clients and community advocates to shape the design of integrated treatment programs for CODs.

V. Opportunities to Advance the Integration of Care

Efforts to advance the integration of care to support people with CODs must address longstanding structural, regulatory, and reimbursement barriers to delivering concurrent mental health and SUD treatment (Minkoff & Covell 2019; Minkoff & Covell 2022). Here we briefly summarize opportunities to advance the integration of care informed by the literature and suggested by key informants and case study clinics.

A. Key Opportunities

Improve data collection and measurement of community-level COD prevalence and the delivery of integrated treatment. Key informants recommend that government agencies--particularly at the federal and state levels--play a key role in guiding measurement, data collection, and reporting of the prevalence of CODs and their treatment. Such data could go beyond existing national data sources to provide local information for behavioral health systems to motivate the adoption of integrated care and support planning, monitoring, and quality improvement. Key informants broadly suggested the need for standard and routine measurement. For example, federal and state agencies could identify, recommend, and provide technical assistance around standardized tools to: (1) identify people with CODs; (2) measure the degree of mental health and SUD treatment integration within organizations; and (3) assess the quality and outcomes of integrated care for people with CODs. Finally, key informants broadly described the need for data infrastructure to support routine and standard data collection, reporting, and performance measurement. With improved data infrastructure, meaningful data could be reported regularly to guide the work of behavioral health providers and funders to design, implement, and continuously improve integrated treatment services.

Streamline regulatory, licensing, and reimbursement processes. To reduce administrative barriers to providing integrated treatment for CODs, key informants urged state and local mental health and SUD agencies to further integrate their functions. These agencies can merge fully into one organization or work more closely to coordinate programming. For example, agencies can work together to develop unified instructions and processes for providers to follow to obtain dual licensure and bill for mental health and SUD services. These agencies could also collaborate to ensure that all policies and regulations processes anticipate and encourage integrated treatment for CODs in mental health and SUD outpatient settings. Additionally, these agencies could work to simplify the billing process for both mental health and SUD treatment provided during a single session (for example, when the service provided during the session addresses both disorders) and provide clear billing instructions to providers. Finally, state and local agencies can convene steering committees, interagency workgroups, and listening sessions to understand specific barriers faced by providers and develop tailored approaches for promoting integrated treatment.

Expand reimbursement, grant funding, and technical assistance to incentivize and support providers to offer integrated treatment. Government agencies, provider networks, and community partners could work with payors to identify strategies to align reimbursement and grant funding with high-quality integrated treatment for people with CODs. For example, payors could identify strategies to redesign reimbursement for services to encourage integrated treatment, including adequate reimbursement for the screening, treatment planning, and care coordination activities included in models of care for COD. State and local government agencies can also expand funding streams to support providers with the financial and technical assistance resources needed to adopt integrated treatment. For example, state and local government agencies can develop new funding opportunities that encourage adoption and quality improvement related to integrated treatment or embed technical assistance for integrated treatment implementation into provider contracts. The clinics in our case studies benefited from the support of a partner entity to guide the implementation of integrated care. These partnerships were structured somewhat differently in each community, but most were supported by a state or local government agency. In varied ways, partner organizations offered technical assistance to help clinics embed integrated treatment into their care delivery processes and organizational cultures. For example, in

addition to facilitating tailored planning and training activities with individual provider agencies, partner organizations brought together clinics through learning collaboratives, often with the support of external consultants. Such learning collaboratives help clinics at various stages of implementing integrated treatment to identify solutions to common implementation challenges and are also used to connect networks of participating providers with affected community members and other agencies that serve people with CODs.

Support and incentivize formal and on-the-job training to equip behavioral health providers with skills to deliver integrated care. Key informants and case study interviewees suggested several strategies. National accreditation entities could set standards that require academic institutions to provide additional training for CODs. Licensing boards could reduce financial and administrative barriers to obtaining dual licensure for providers licensed in either field. Academic training programs can update their curriculum to include comprehensive education about CODs and support cross-training in mental health and SUD. States can encourage more individuals to enter the integrated treatment workforce through investments such as expanded loan forgiveness programs, increased training opportunities in community college settings, and expanded peer certifications relevant to CODs. Finally, related to on-the-job training, states and provider networks can fund accessible training for staff and help to cover the costs of fees and training.

B. Conclusions

Behavioral health systems are making slow progress toward integrating mental health and SUD treatment for people with CODs, often driven by state and local initiatives (Minkoff & Covell 2019). The findings in this report illustrate how providers continue to encounter numerous obstacles to delivering integrated treatment for people with CODs and highlight various promising approaches and opportunities for state and federal agencies, providers, and other entities engaged in improving the quality of care for people with CODs. These opportunities build on decades of evidence and expert recommendations to systematically focus on addressing structural, educational, and financial barriers to delivering integrated treatment.

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Appendix A. Detailed Summary of Methods

A. Quantitative Data Analysis

We used data from two national surveys--the National Mental Health Services Survey (N-MHSS) and National Survey of Substance Abuse Treatment Services (N-SSATS)--to examine changes from 2014 to 2020 in the availability of integrated treatment for people with CODs within outpatient mental health and SUD facilities in the United States, including all states, territories, and jurisdictions. We also looked at whether any facility characteristics are associated with offering integrated care for CODs using variables that reflect the facility's organizational capacity, commitment to high-quality care, ownership, and client population. For the survey analysis, we defined integrated care as facility having a treatment program or group dedicated to or designed exclusively for clients with CODs, because that definition best captured the idea of integrated care and was similar across surveys and time points. Using data from 2014 and 2020, we first examined the proportion of facilities that offered integrated care and the characteristics of facilities overall and by integrated treatment status. We used Pearson's chi-squared test or the Wilcoxon rank sum test to examine the statistical significance of group differences. Initial analyses included the total sample of outpatient, inpatient, residential and multi-setting facilities. We then limited the analysis to outpatient facilities. We used logistic regression to estimate the adjusted odds that an outpatient facility in 2020 offered integrated treatment as a function of facility characteristics, fitting two separate regression models (one using N-MHSS and the other using N-SSATS) that included similar facility-level variables.

B. Environmental Scan

We conducted a high-level environmental scan to describe integrated mental health and SUD treatment for people with CODs in specialty behavioral health settings with the goal of improving understanding of the current landscape of integrated treatment and informing key informant interviews and case studies. We gathered information through searches of the English-language peer-reviewed and grey literature, focusing on the past 5 years (2018-2022). We also included formative articles and reports prior to 2018 identified in supplemental searches to provide a more comprehensive review of the literature. Based on this search strategy, we reviewed titles and abstracts of peer-reviewed and grey literature through systematic word searches of PubMed. We scanned supplemental resources found in website and bibliography searches, excluding resources focused primarily on the epidemiology of CODs or the integration of behavioral health services within primary care or inpatient settings. The scan drew heavily on several recent syntheses of integrated care for CODs commissioned by the National Association of State Mental Health Program Directors (Minkoff & Covell 2019), as well as SAMHSA's TIP series on CODs (SAMHSA 2020).

C. Key Informant Interviews

To conduct key informant interviews with six relevant interest holders from varied backgrounds, we first identified and proposed 10-12 interviewees using findings from the environmental scan and from consultation with ASPE and Mathematica's internal experts. Key informants included researcher and government agency experts; policy and family/consumer advocates; and persons who were clinicians, health care administrators, or implementation specialists (for example, technical assistance providers). We developed an interview protocol with general questions appropriate for all stakeholders, as well as separate sections with targeted questions relevant to specific key informant interviewee types. We recruited key informants through email outreach, then audio-recorded and took notes for each virtual interview.

D. Case Studies

In consultation with ASPE, we conducted five virtual case studies to gather more detailed information on integrating mental health and SUD in outpatient behavioral health settings, on barriers and opportunities, and

on promising approaches. In selecting 12 candidate case study clinics, we sought to ensure variation across candidate clinics in characteristics such as primary service provided (indicates whether the clinic initially offered mental health services and integrated SUD treatment or whether the clinic initially provided SUD treatment and integrated mental health services), treatment setting (outpatient, inpatient, or multi-setting), type (non-profit, private for-profit, or state-funded organization), stage of implementation (maturity of the clinic's provision of integrated services), and services provided (outpatient, residential, and crisis services provided). Sites were identified in accordance with suggestions from key informants, web searches, and email outreach. For several sites, we profiled more than one clinic that could be interviewed for that behavioral health agency, given potential outreach challenges. For each clinic site, we sought to identify a partner organization that provided funding, technical assistance, monitoring, or other support for the clinic or agency to gather information about how these activities supported the implementation of integrated care for CODs.

We included six clinics, one of which was a CCBHC, each operating within differing policy and community contexts and with varying experiences providing integrated treatment for people with CODs. To conduct case study interviews, we first requested a 30-minute orientation call with a point person at the clinic or at a partner organization, during which we gave an overview of the project aims, confirmed the clinic and system of care points of contact, confirmed the clinic's use of integrated treatment for people with CODs, identified interviewees, and discussed logistics related to the honorarium and interview scheduling.

We created two interview protocols to gather clinic and partner organization perspectives. Clinic-level protocols gathered information about integrated treatment delivery and workflows from frontline providers, including social workers, counselors, and peer support staff, as well as about organizational goals, challenges, and facilitators from clinic leadership and administrators. Partner organization protocols included questions about how agencies, funders, and technical assistance organizations provided billing, payment, monitoring, and other supports for clinics that deliver integrated treatment, with the aim of helping the clinics to overcome structural challenges to integrated treatment delivery for CODs. To encourage participation and in recognition of the clinics' time, each clinic was offered a $1,000 honorarium.

Appendix B. Clinic Spotlights

We developed a brief profile of each case study clinic, describing a unique feature of approach toward delivery of care for CODs. In each profile, we also expand upon each site's system-level support for integrated treatment and describe a partner organization that supports integrated treatment for the clinic and others in the communities through policy development, funding, and/or technical assistance.

AllHealth Network, Recovery Cooperative (multiple locations, Colorado)

Spotlight: Well-Supported Clinicians Advance Integrated Treatment

AllHealth Network's Recovery Cooperative clinicians specialize in serving underserved clients with CODs in outpatient and intensive outpatient settings across the organization's clinic locations. AllHealth's evolution into an integrated treatment setting was driven in part by the staff's strong interest in delivering both mental health and SUD treatment and adopting a trauma-informed approach to care, which they refer to as their "tri-occurring" approach to treatment. Beginning in 2017, an external consultant helped AllHealth review its integrated treatment practices, form a dually certified team specializing in CODs, and guide Recovery Cooperative clinicians to rewrite the curriculum and outline a tri-occurring approach to integrated treatment delivery.

Supervisors support clinicians' well-being first, then advise on clinicians' caseloads and encourage them to set their own schedules, use telehealth, and apply therapeutic approaches flexibly in accordance with clients' needs. Individual clinicians drive their own specialization to support clients from special backgrounds, for example, by seeking external training and advocating for internal policy changes to support transgender clients. All Recovery Cooperative clinicians are dually licensed by the state to provide both mental health and SUD treatment or are in the process of obtaining dual licensure, using state funding to pay for associated fees and training.

System-level support for integrated treatment

Signal, a managed services organization in Colorado, acts as an intermediary organization between the state behavioral health agency and provider organizations in 37 counties to provide funding, credentialing, training, technical assistance, and referrals. To support integrated treatment, Signal assigns AllHealth and other provider organizations a technical assistance point person who can provide support on topics such as reporting requirements, quality monitoring, and standardized screening instruments.

Community Research Foundation (Chula Vista, California)

Spotlight: Partnering with Community Systems to Support Integrated Treatment

Community Research Foundation (CRF) employs a specialized team of clinicians to serve clients with CODs using the CCISC model of dual diagnosis enhanced care. CCISC is a vision-driven process for redesigning behavioral health and other related service delivery systems to be organized at every level to focus on the needs of individuals and families, and to reflect welcoming, empowered, helpful partnerships throughout the system of care (Minkoff & Cline 2004). Centrally located in downtown Chula Vista, CRF has walk-in hours and is accessible by public transportation. The clinic collaborates with neighboring SUD treatment programs and provides warm hand-offs when client referrals are required. Staff reflect the diversity of the community where they provide services. Each client is assigned to a therapist who arranges ongoing treatment and connects clients to other services, including medication, employment support, case management, and connections to housing and other community resources.

System-level support for integrated treatment

San Diego County's Change Agents Developing Recovery Excellence (CADRE) initiative provides technical assistance, training, and funding to providers who serve clients with CODs. In 2000, San Diego County and providers collaborated with external consultants to establish the CADRE initiative and implement the CCISC model. The county contractually requires all programs to provide co-occurring capable or co-occurring enhanced treatment and employ CADRE-trained providers. To support these providers, CADRE offers access to the COMPASS-EZ self-assessment tool for co-occurring capability and annual trainings. It also seeks to support integrated care for people with CODs; for instance, the county includes funding for SUD counselors in contracts with their child mental health programs. As providers increase the sophistication of integrated treatment, the county has offered more advanced trainings on subjects such as how to combat stigma associated with pharmacotherapy for SUDs.

Gracepoint Wellness (Hillsborough County, Florida)

Spotlight: Leadership-Driven Approach Toward Integrated Treatment

Gracepoint Wellness provides short-term stabilization and integrated outpatient treatment. Gracepoint Wellness leadership has driven the organization's evolution from a focus on mental health services to providing integrated care for CODs. They began implementing integrated treatment about a decade ago after obtaining a license to treat SUDs to complement their existing mental health license. The management of Gracepoint Wellness has SUD treatment experience and provides individual support to clinicians through an open-door policy and same-day or next-day consultations, monthly clinician meetings, and chart reviews to ensure that clinicians meet clients' integrated treatment needs. Leadership links clinicians to resources on SUD and integrated treatment techniques and service delivery, provides clinicians access to continued education courses on CODs through a dynamic feature of the EHR system, and encourages them to use their weekly 10 hours of administrative time to complete trainings or do their own research on integrated treatment. Clinicians also receive higher pay once they earn additional licenses.

System-level support for integrated treatment

Central Florida Behavioral Health Network (CFBHN) supports the development of integrated care programs in Hillsborough County and surrounding areas. They engaged external consultants to develop a co-occurring capable system of care. CFBHN provides annual trainings on evidence-based practices and other trainings to meet providers' self-identified needs. CFBHN also helps providers navigate siloed mental health and SUD funding streams by diverting federal and state funding into integrated bundled service rates for providers.

Samaritan Daytop Village, Suffolk Outpatient Treatment Program (Huntington Station, New York)

Spotlight: Robust Staffing and Services Facilitated by CCBHC Model

Samaritan Daytop Village's Suffolk Outpatient Treatment Program is a CCBHC licensed to provide mental health and SUD treatment and is also licensed as a comprehensive opioid use disorder treatment program. The CCBHC model allows Suffolk to provide multiple services to clients on the same day and at one central location, including individual and group therapy, pharmacotherapy, peer services, creative art therapy, case management; the outpatient treatment program also features recovery centers, which deliver rehabilitation trainings and resources for clients free of charge--such as résumé writing and vocational support--and social activities like yoga, dance fitness, arts and crafts, movies, and outings.

Suffolk employs a wide range of professionals: credentialed SUD specialists, licensed clinical social workers, psychologists, medical prescribers (including psychiatric nurse practitioners and psychiatrists), targeted case managers, and peers. Both targeted case managers and peers connect clients to housing, community

resources, and primary care. Peers also play a role in engaging clients in care; peers welcome clients to the clinic, meet with clients within and outside of the clinic, and advocate on their behalf in staff meetings.

System-level support for integrated treatment

The Suffolk site began participating in the CCBHC Medicaid demonstration in 2017 and received a CCBHC-Expansion grant from SAMHSA in 2019. New York State's Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) collaborate to manage mental health and SUD regulations and policies across the state and oversee CCBHCs like Samaritan. Both OMH and OASAS interviewees emphasized the importance of the CCBHC model in advancing the adoption of evidence-based practices for integrated treatment and providing access to multiple services and levels of care within one location. The state agencies support CCBHCs through quarterly technical assistance calls, webinars and guidance related to integrated treatment and billing processes, on-site interviews, chart reviews to assess performance, and data monitoring. As one of the original CCBHC demonstration states, New York has continually invested in the adoption and expansion of the CCBHC model.

Westchester Jewish Community Services, Recovery Cooperative (Westchester County, New York)

Spotlight: Community-Motivated Model of Care for Youth and Young Adults

Westchester Jewish Community Services (WJCS) adopted the Encompass model of care to provide integrated treatment for youth and young adults in 2020. The Encompass model trains clinicians to provide integrated treatment to youth and young adults ages 12-28 using cognitive behavioral therapy and motivational enhancement therapy. The adoption of Encompass was motivated by client advocates, who saw a need for a model for integrated treatment that was designed for young people. Dr. Paula Riggs, who developed the Encompass model, continues to provide training and implementation support to WJCS clinicians monthly. WJCS provides all new hires with live or recorded trainings on the Encompass model, and new hires shadow more experienced clinicians before receiving their own caseloads.

System-level support for integrated treatment

The Westchester County Department of Community Mental Health (DCMH) provides technical assistance to providers as they apply for dual or integrated mental health and SUD licenses from the state; offers trainings to support providers in establishing a co-occurring capable workforce; and convenes awareness, education, and policy reform activities across provider organizations as a leader of a monthly co-occurring system of care committee. DCMH also promotes integrated treatment for people with CODs in the community by requiring workforce COD training and evidence-based practices in contracts with provider agencies, prioritizing co-occurring competency when scoring provider organizations that submit proposals for behavioral health contracts, and incentivizing co-occurring evidence-based practices in new contracts. To support integrated treatment, DCMH worked with external consultants to develop a learning collaborative for county-based integrated treatment providers. Participating providers engage with other organizations and receive help in writing charters and performing self-assessments on co-occurring capability.

Appendix C. Supplemental Exhibits

Exhibit C.1. Steps in the Assessment Process	
Step 1:	Engage the client.
Step 2:	Identify and contact collaterals (family, friends, other providers) to gather additional information.
Step 3:	Screen for and detect CODs.
Step 4:	Determine quadrant and locus of responsibility.
Step 5:	Determine level of care.
Step 6:	Determine diagnosis.
Step 7:	Determine disability and functional impairment.
Step 8:	Identify strengths and supports.
Step 9:	Identify cultural and linguistic needs and supports.
Step 10:	Identify problem domains.
Step 11:	Determine stage of change.
Step 12:	Plan treatment.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2007). *Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders*. COCE Overview Paper 3, DHHS Publication No. (SMA) 07-4165. Rockville, MD: SAMHSA. https://radarcart.boisestate.edu/library/files/2017/07/OverarchingPrinciplesOP3.pdf.

Exhibit C.2. Instruments Used to Determine Appropriate Care for CODs	
Instrument	**Categorization**
Level of Care Utilization System (LOCUS)	Six major domains of service levels for people with CODs: Recovery Maintenance/Health Management **Low Intensity Community-Based Services** **High Intensity Community-Based Services** **Medically Monitored Non-Residential Services** Medically Monitored Residential Services Medically Managed Residential Services
ASAM Levels of Care Model	The ASAM Criteria uses six dimensions, including ones related to SUD severity and mental illness severity, to assign an individual to a level of care: 0.5 Prevention/Early Intervention **1 Outpatient Services** **2.1 Intensive Outpatient Services** 2.5 Partial Hospitalization Services 3.1 Clinically Managed Low-Intensity Residential Services 3.3 Clinically Managed Population-Specific High-Intensity Residential Services 3.5 Clinically Managed High-Intensity Residential Services 3.7 Medically Monitored Intensive Inpatient Services 4 Medically Managed Intensive Inpatient Services

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2007). *Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders*. COCE Overview Paper 3, DHHS Publication No. (SMA) 07-4165. Rockville, MD: SAMHSA. https://radarcart.boisestate.edu/library/files/2017/07/OverarchingPrinciplesOP3.pdf.

Note: **Bolded categories** indicate outpatient behavioral health care settings.

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