Considerations for Reorganization

California's Departments of Mental Health and Alcohol and Drug Programs

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I. Executive Summary

As of August 2011, there are multiple discussions underway concerning how the California government should redesign the oversight of mental health (MH) and substance use disorder (SUD) services within the state. Preparations for the transfer of Medi-Cal functions from the Department of Mental Health (DMH) and the Department of Alcohol and Drug Programs (ADP) to the Department of Health Care Services (DHCS) are already underway and more such efforts to streamline, consolidate, and maximize state functions are expected.

The basic parameters under discussion involve whether the leadership and oversight of MH and SUD services should be consolidated into one administrative entity (they are currently each organized as departments in the Health and Human Services (HHS) Agency) and/or whether these functions should be merged into the Department of Health Care Services, as a sub-department entity, or remain at a departmental level in HHS. By providing a perspective on the considerations involved with consolidating DMH and ADP into a single entity and merging this entity into the larger DHCS, we hope that knowledgeable decisions can be made to support a more cost-efficient, higher quality health system.

In this report, we review the history of how ADP and DMH evolved, including a description of why these two fields developed distinct practices, workforces, service financing methods, and organizational cultures. We describe earlier discussion and debate about the consolidation of ADP and DMH, and we review the factors that do and do not support consolidation of these two departments (Section IV). Although there has not been as extensive a discussion in the past about whether ADP and DMH functions should be merged into a larger governmental department, we review some of the perceived pros and cons of this idea (Section V). To help us understand the potential consequences of these consolidation and merger

questions, we contacted experts from around the United States who had previously been involved in consolidation and merger activities in other states and we reviewed the professional literature on this topic (Section VI).

Based on our research with experts from other states and from the limited research literature, we frame the major considerations in conducting a reorganization of MH and SUD services, such as the one being considered in California (Section VII). We also review the current health care reform environment. It is our view that it is critically important to make the California ADP/DMH reorganization plans within the context of the changes anticipated by the implementation of the federal Affordable Care Act of 2010 and the Mental Health Parity and Addiction Equity Act of 2008 (Section VIII). We present possible configurations of a newly organized DMH/ADP entity, along with the pros and cons of each of the different organizational scenarios. Included in this section is a potential organizational model for developing a consolidated ADP/MH entity that has been merged into DHCS (See Section IX).

Regardless of the actual configuration chosen to administer/oversee SUD and MH services in California in the future, there are factors that will be crucial to maintaining a service system that meets the MH and SUD needs of California's citizens (Section X). We strongly feel that these considerations will be the core challenges for the future of SUD and MH services in California.

These factors include:

- effective leadership,
- creation and promotion of a shared vision and culture,
- support from the executive branch of the California government,
- a modernized benefit design to support evidence-based practices,

- integration of SUD and MH services into primary care,
- special consideration for prevention services,
- communication with and engagement of stakeholders,
- review of regulations, licensing, and certification,
- a plan for workforce development,
- health information technology, data systems, and performance and outcomes evaluation,
- a phased approach for implementing the new organizational structure.

Finally, we provide a set of recommendations that synthesize the information we have collected and how it could most effectively be used to reorganize California's ADP and DMH functions (Section XI).

Synopsis of Findings

There is a great deal of historical context that can explain how the California government created separate departmental level structures to oversee/administer SUD and MH services. Clearly there are arguments that can be made to support leaving ADP and DMH as departments in the Health and Human Services Agency. However, considering the 30 years of National Institutes of Health (NIH) research promoting SUD and MH service integration, the time is right to consolidate the oversight and administration of the nonintegrated, or "siloed," SUD and MH services in California. The barriers between the "cultures" of MH and SUD services are breaking down. The concept of peer-based "recovery," once exclusively a core SUD model, is now embraced by the MH system. Use of medications, long one of the foundations of MH care, is

now becoming much more widely accepted in the SUD service delivery world. While there are still many issues to address, it clearly appears to be time to consolidate the administration/oversight of California's SUD and MH services.

The merger of ADP and DMH functions into a larger government department (DHCS) has received less systematic study than has the topic of SUD and MH consolidation. There is very little research or professional literature on this topic, but we did spend much of our time with experts from other states, discussing this issue. Some states have merged SUD and MH services into larger health care departments or other umbrella agencies and have reported savings by decreasing duplication of effort and increased efficiency. Other states have found that mergers into larger departments resulted in problems with maintaining timely reimbursement to providers, resulting, in some cases, in severe provider hardships. In virtually all of the states where SUD and MH services have been merged into a larger agency, there was a considerable period of adjustment as the larger department learned about the unique services and service providers of the MH and SUD systems. The two universal recommendations we heard were to have a senior level director with substantial direct experience in the SUD and MH systems of care to lead the SUD/MH entity and to have a substantial transition period for absorbing the functions into the larger government department. Finally, there was considerable discussion about the fact that prevention services might be more effectively placed in a different government department (e.g., Public Health) than with treatment services.

The existence of a Department of Alcohol and Drug Programs and a separate Department of Mental Health within the California government was an important configuration during a period when these systems were being established and defined. Each of these fields has been able to develop a network of services, a set of provider organizations, and a workforce to deliver its

services. However, for some time, there has been mounting research evidence, as well as an awareness by leaders in California, that SUD and MH disorders could be more effectively treated if these systems were more integrated. Further, with the approach of 2014 and the implementation of the Affordable Care Act, there is a dramatically increasing awareness that SUD and MH services need to be integrated with the broader health care system. For these reasons, it is our recommendation that the functions of ADP and DMH, with the possible exception of prevention services, be consolidated and merged into DHCS.

In addition, we make the following recommendations:

- Create a Division of MH and SUD Services (DMHSUDS, or DSUDMHS) within DHCS, led by a Chief Deputy Director, who reports to the DHCS Director and is confirmed by the Senate. This person needs extensive experience in the administration of SUD and MH services, and needs to understand the MH and SUD specialty care service delivery systems and the forthcoming challenges in the implementation of the Affordable Care Act.

- Within the DMHSUDS, establish two Deputy Division Director positions. One Deputy Division Director will oversee SUD services and one will oversee MH services. These individuals should have extensive experience in program oversight within their specialty care system. In addition, as discussed in Section IX, a 3rd Deputy or Branch Chief should be considered who would oversee the integration of SUD and MH services and promote a future Division within DHCS with a fully integrated SUD and MH service system.

- Bring consultants to California who have been involved with the consolidation of SUD and MH services and the merger of these services into larger health care agencies in other states. Knowledge from these consultants will provide California with expertise from states that have completed such transitions and help California develop an optimal organizational structure to promote necessary health care innovations and full integration of these services into primary care.

- As Drug Medi-Cal and other ADP and DMH functions are merged into DHCS, it will be critical for DHCS to move into service a fully adequate cadre of ADP and DMH staff who are knowledgeable and skilled in the functions needed to ensure continuation of critical Medi-Cal claims payment functions, program quality, monitoring and auditing functions, data system and performance management functions, licensing and certification functions, research, evaluation and technical assistance functions.

- Immediately establish an “action workgroup” for analysis and implementation of recommendations coming from the DHCS ongoing stakeholder process convened / continued under AB 106 and the Plan, as well as providing coordination of Medicaid

services with other state and federal funding streams available for AOD/SUD services, treatment and recovery. This workgroup, which will provide leadership on a revised plan for the use of finances for SUD and MH services in California and report to the Division Chief Deputy Director, will address the following issues: Medi-Cal benefit revisions (including consideration of moving to the Medicaid Rehab option, the addition of Suboxone and Vivitrol as treatment medications, activating the SBIRT codes, and reimbursement of other evidence-based practices).

- A significant portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds should be used to support housing and other recovery support services that are not supportable with Medi-Cal funds.

- In preparation for implementation of the Affordable Care Act, establish a workgroup to develop a process of planning and technical assistance to maximize the successful "no wrong door" integration of SUD, MH, and primary care (i.e., patients entering the system for any one of these concerns will easily find care for concerns from the other two areas). This workgroup should be informed by current recognized national efforts (using documents developed by the Treatment Research Institute and by the Center for Integrated Health Services) and ongoing California integration efforts (currently being organized by UCLA and California Institute of Mental Health).

- It should not automatically be assumed that alcohol and drug prevention services should be placed together with SUD treatment services. Careful study, analysis, and public input should be solicited about where the administration of alcohol and drug prevention services should be located. Consideration should be given to moving the oversight of alcohol and drug prevention services (and the administration of $50 million of Block Grant Prevention money) to the Department of Public Health.

- Establish a work group to develop a plan for a unified data system for SUD and MH services that will contain the strengths of both of the data systems (i.e., DMH's data collection system captures units of service delivered at the client level, whereas ADP's data system complies with critical federal data requirements and provides data for outcomes and performance measurement). This data system should be integrated within the larger DHCS data system architecture.

- Establish a transition plan to create a counselor certification infrastructure in which there is a single counselor certification/license under the DMHSUDS. Ensure that this certification/license emphasizes evidence-based information and promotes skills that will be of use as SUD and MH services are integrated with primary care.

- Establish a plan to harmonize licensing and regulations for SUD and MH service delivery sites to promote the delivery of, and identify obstacles to, integrated SUD and MH services. Further, refine these licensing and regulations to ensure provision of MH and SUD services within primary care services.

- Hold an extensive set of community stakeholder meetings led by DHCS and DMHSUDS leaders to explain the new structure and solicit input for considerations about how to best promote success of the new organization. Conduct extensive outreach to bring together in the same meeting, stakeholders from SUD, MH, and primary care service provider systems as well as consumers from these systems.

Considerations for Reorganization

California's Departments of Mental Health and Alcohol and Drug Programs

II. Overview

Introduction

Faced with record deficits and a decreased public appetite for government spending, many states across the nation have undertaken or are considering broad government reorganization efforts to decrease spending while maintaining effectiveness. Within this broader context of reform, and in conjunction with the nationwide shift toward a more integrated health care delivery system, many states have or are in the process of restructuring their health services to create a more cost-efficient organizational structure.[1] States possess substantial autonomy in the way their health and human services programs are administered, which allows for varying strategies to manage budgets and allocate funds across programmatic entities.[2] With this autonomy, many states have chosen to consolidate their mental health (MH) and substance use disorder (SUD) functions under a centralized structure to reduce spending on administration, while dedicating

more dollars to direct services. These consolidations[a] have often been promoted as a means to improve operational efficiencies and improve treatment quantity and quality, particularly for treating individuals who have co-occurring MH and SU disorders.[1]

Since the late 1990s, there has been a movement in many states (and counties) to consolidate the entity[b] that oversees the delivery of MH services with the entity that oversees the delivery of SUD services. At the present time, there is very little quantitative evidence documenting the impact of such consolidations. However, consolidation is intuitively appealing in that the consolidating of entities responsible for MH services and SUD services may result in a more cost-effective and efficient structure. There also is evidence that integrated treatment for MH and SU disorders provides superior outcomes for some patient groups.[3,4] Several papers reviewing these consolidations and our discussions with policy makers who have examined the impact of these consolidations, have provided mixed reviews, specifically about the delivery of SUD services under a consolidated MH and SUD structure.

The aim of this paper is to review the considerations involved with consolidating California's Department of Mental Health (DMH) and Department of Alcohol and Drug

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[a] ***Consolidation* and *Merger* Defined:** For consistency throughout the paper, the term *consolidation* will be used to describe and discuss the proposed restructuring of the DMH and ADP. If the currently separated functions of DMH and ADP are combined, they will create a *consolidated* structure. While varying terms have been used in reference to the organizational shift at hand, by definition, *consolidation* is used when *a new organization is created and the consolidating entities are extinguished.*

When referring to the movement of DMH and ADP functions, either as consolidated entities or as still separated entities, into DHCS, this shift will be referred to as a *merger*. A *merger* is defined as *when one organization absorbs the other and remains in existence while the other is dissolved.* In the perspective of the larger department of DHCS, the functions of DMH and ADP would move into DHCS to be part of a *merged* department. This paper will use the term *merger* in reference to this change.

[b] **Entity Defined:** It is unclear as to whether SUD and MH services will be a department, a division, or some other designation after this period of transition. Due to the undetermined nature of the restructuring that will take place, we will use the term *entity* to refer to the new structure that will provide the current functions of ADP and DMH. *Entity* is defined as *a general term for any institution, company, corporation, partnership, government agency, university, or any other organization which is distinguished from individuals*. The universal classification of this term is appropriate for the currently unidentified scope, position, and configuration of the new structure.

Programs (ADP) into a single entity and merging this agency into the larger Department of Health Care Services (DHCS). The paper will review the rationales and arguments that have been used to support and oppose consolidation and the specific debate/discussion points that have been raised on earlier occasions when this issue was considered in California. Examples of other states that have consolidated these entities will be presented with a discussion of the benefits and challenges they faced. We also will review relevant issues regarding future priorities of the broader health care system that are likely to arise from the implementation of the federal Affordable Care Act.

We will present several possible organizational structures for a consolidated MH/SUD entity and key elements in the process of initiating and sustaining a culture of integration. Further, we will discuss some of the considerations for where a consolidated entity might fit most effectively within the executive branch of California State government. Finally, we will discuss some of the major implementation questions and challenges that will be faced in creating a consolidated MH and SUD government entity. As of the writing of this document (August 1, 2011), Gov. Jerry Brown's realignment proposal, if enacted, would be a major restructuring event that would impact the financing and delivery of MH and SUD services. Since the specific elements of this redesign are still in the planning stages, this paper will address the state DMH and ADP departments as they currently are configured. It is our hope that the material summarized in this report can inform policy makers in California as they consider the future configuration of these government entities.

Research Methodology

Multiple sources were utilized to collect data and information for this report. Interviews were conducted with stakeholders, including other states' government leaders who were either

directly involved in or oversaw the consolidation of their state's SUD and MH services. Their experiences, lessons learned, and advice to states initiating similar efforts has been incorporated into this report. Information and documents from governmental and other state websites, and the scientific literature pertaining to organizations, particularly the public sector, were reviewed.

III. Background of California's Departments of Mental Health and Alcohol and Drug Programs

California's Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (ADP) have been separately administered departments since their inception. Each department has the responsibility of providing a variety of oversight activities, and each department works with the 58 county governments to oversee fiscal and management responsibility for the host of MH and SUD services delivered in California. Each department has a director, appointed by the governor, who reports to the Secretary of the Health and Human Services Agency. The 2011–12 proposed budgets for the two departments (dollars for administration and services that are overseen by the agencies) are approximately $4 billion for DMH and $630 million for ADP. An overview of the two departments, taken from their public websites, is as follows:

> ***The California Department of Mental Health (DMH):***
> ***Mission***
> *The California Department of Mental Health (DMH), entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.*
>
> ***Responsibilities:***
> *The California Department of Mental Health, located in Sacramento, has oversight of a public mental health budget of more than $4 billion, including local assistance funding. Its responsibilities include:*
>
> - *providing leadership for local county mental health departments;*
> - *evaluation and monitoring of public mental health programs;*
> - *administration of federal funds for mental health programs and services;*
> - *the care and treatment of people with mental illness at the five state mental hospitals (Atascadero, Metropolitan, Napa, Coalinga and Patton State Hospitals) and at the Acute Psychiatric Programs located at the California Medical Facilities in Vacaville and Salinas Valley; and*
> - *implementation of the Mental Health Services Act (Proposition 63), which provides state tax dollars for specific county mental health programs and services.*

DMH employs more than 10,000 employees in nine locations throughout the state, including its headquarters in Sacramento, five hospital facilities, and three acute care facilities within the Department of Corrections and Rehabilitation. As a state public agency, DMH has worked hard to transform and improve the state's mental health systems of care by working with the mental health constituency to develop a system of partnerships and coordinated interagency efforts. These models have provided the framework for success in developing department programs and coordinating services in the treatment of children and adults who are mentally ill.

Department staff constantly strive to find the most effective use of resources and innovation at all levels - not just in treatment, but in prevention and intervention as well. All programs are designed with the recovery process in mind.

DMH's state hospital programs and staff are among the country's finest. The facilities have passed national rigorous accreditation reviews. Each hospital is staffed by professionally trained clinicians and an administrative support team who provide full-time inpatient care to the most serious mentally ill and those incapable of living in the community. These referrals come from county mental health departments, the courts, the Department of Corrections and Rehabilitation and the California Youth Authority. In recent years, the population of the state mental hospitals has shifted to a majority (approximately 90 percent) of forensic patients, and DMH has met this challenge by prioritizing and balancing state-of-the-art treatment and public safety.[5]

The California Department of Alcohol and Drug Programs:
Mission
To lead efforts to reduce alcoholism, drug addiction, and problem gambling in California by developing, administering, and supporting prevention, treatment and recovery programs.

Vision
To have Californians understand that alcoholism, drug addiction and problem gambling are chronic conditions that can be successfully prevented and treated.

Overview
The Department of Alcohol and Drug Programs (ADP) was established upon enactment of the Health and Safety Code, Division 10.5, Sections 11750, et seq., (Stats. 1979, Ch. 679). It is designated as the Single State Agency (SSA) responsible for administering and coordinating the state's efforts in alcohol and drug abuse prevention, treatment, and recovery services. ADP is also the primary state agency responsible for interagency coordination of these services.

In partnership with California's 58 county alcohol and drug program administrators and in cooperation with numerous private and public agencies, organizations and individuals, ADP provides leadership and coordination in the planning, development, implementation and evaluation of a comprehensive statewide alcohol and drug use prevention, intervention, detoxification and treatment and recovery system. The Department utilizes each of the 58

county alcohol and drug programs as the broker of service. The counties in turn are able to provide services to clients either directly or by contracting with local service providers. California enjoys a statewide treatment, recovery and prevention network consisting of over 850 public and private community-based service providers that serve approximately 300,000 clients annually.

Organization

The Department of Alcohol and Drug Programs is organized into four divisions and six offices. The Department does not have any boards or commissions.[6]

IV. Consolidation of DMH and ADP: Some Contrasts in Agency Backgrounds and "Cultures"

A Brief History of Mental Health and Substance Use Disorder Services in California

In California, as in the rest of the United States, the configuration of the service delivery system for the prevention and treatment of MH and SU disorders has its roots in the 1960s and 70s. During this period, at the federal level, there were many extended debates about the best way to organize services. In the 1960s, MH and SUD services were administered under a single federal entity. Extensive drug and alcohol use among the youth of America during the 1960s created increasing concerns that the methods and approaches being used to assist individuals with SUDs were not being effectively addressed under the umbrella of "psychiatric illnesses." During this period, psychiatric care was dominated by Freudian and other psychodynamic models of intensive psychotherapy and was under the leadership of the psychiatric community. Substance use problems, including severe addiction, were considered mere "symptoms" of underlying psychodynamic disturbance. Substance users were considered difficult to treat and efforts from the field of psychiatry produced little benefit to substance-using patients and their communities.

During this period, community efforts to address the problem of SUDs expanded rapidly. The self-help fellowships of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) became widely used by alcoholics and addicts, and methods adapted, in part, from these fellowships, became a part of residential models of care called "therapeutic communities" (TCs). An overarching theme for these efforts was a heavy emphasis on self-help, addicts and alcoholics helping each other, and a disdain for professional treatments. At the same time, in New York City, Drs. Vincent Dole and Marie Nyswander were conducting early studies of methadone as a replacement medication for heroin addiction. Dole, an endocrinologist, viewed heroin addiction as a metabolic disorder in which opiate-addicted individuals needed a substitute medication

(methadone), much the way diabetics need insulin. During the 1960s, there were significant debates about the relevance of psychiatry for the treatment of drug addiction and alcoholism.

A major event that contributed to the separation of MH and SUD services into separate entities at the federal level was the Vietnam War. In the early 1970s, there were tremendous concerns about the possibility that thousands of Vietnam veterans would return with heroin problems and that services for them needed to be rapidly developed and implemented. As a result, the Nixon administration supported development of three federal research and service entities, the National Institute of Mental Health (NIMH), the National Institute on Alcoholism and Alcohol Abuse (NIAAA), and the National Institute on Drug Abuse (NIDA). This framework of separate federal entities to oversee the creation of new knowledge, as well as to develop a prevention and treatment capacity in each area, created the institutional separation of alcohol, drug, and mental health services in the United States. This federal framework was replicated within states, including California, for the organization and delivery of services.

During the 1970s and 80s, there was a gradual merger of the service delivery for individuals with alcohol and illicit drug disorders (although at the federal level, the NIAAA and NIDA remain separate institutes in the National Institutes of Health [NIH]). In California, the establishment of the Department of Alcohol and Drug Programs in 1979 reflected the recognition of commonalities among individuals with all types of SUDs. However, despite the acknowledgment of the commonalities of service needs and treatment models for alcohol and drug users, the needs of and treatment models for individuals with psychiatric/mental health disorders continued to be viewed as being very dissimilar and as requiring a very different service delivery system. It was during this period that the divergent cultures, practices, and attitudes of the MH and SUD fields were established. Even in 2011, these distinct differences between the

MH and SUD fields are significant realities and should be recognized as California considers a consolidation of DMH and ADP.

Development of the Different "Cultures" of MH and SUD Services

The evolution of MH and SUD services described above was accompanied by distinctly different philosophies, practices, and attitudes. Central components of the MH service delivery system were the state mental hospitals, community mental health facilities, and professional, licensed service personnel (psychiatrists, nurses, psychologists, social workers). There was a rapidly increasing view that serious mental illness (e.g., schizophrenia, depression, bipolar illness) was a brain disease and that a primary component in the treatment plan of most seriously mentally ill individuals was the use of powerful psychiatric medications. During the past 40 years, dozens of medications have been developed, tested, and marketed for psychiatric disorders, and the role of psychopharmacology in the treatment of MH disorders has become essential. Practitioners in the MH field have extensive education on the role of medications and their use. This view of serious mental illness as a disorder to be managed over time, frequently for life, with medication and professional support, established MH treatment as a health service, with a professional cadre of licensed service providers. This professionalization and medicalization of MH care also facilitated its inclusion in payment structures, including private insurance and Medicaid. Mental health treatment in California evolved into a service in which licensed MDs, PhDs, and LCSWs delivered medications for diagnosable brain diseases, along with social supports and behavioral therapies. The National Alliance on Mental Illness (NAMI) has also been a very strong voice for consumers of MH services (and their families). Within the world of MH care, the consumer/family movement has become a major factor in shaping the nature of services and influencing decision-making on treatment services and funding.

The field of SUD services developed in a very different manner. Central components of SUD services were the involvement of individuals in the 12-step programs of AA and NA, long-term (6–24 month) residential Therapeutic Communities, and 28-day "rehab" programs that promoted involvement in AA and NA as a framework for life "in recovery." In addition, short-term medical detoxification programs were developed that addressed the acute withdrawal syndrome from alcohol, opiates, and depressants, as were outpatient programs primarily delivering an idiosyncratic set of group therapies, with a heavy emphasis on the 12-step philosophy. In a virtually different universe, a distinctly separate collection of outpatient narcotic treatment programs (NTPs; commonly referred to as methadone clinics) were established to deliver methadone for detoxification and, primarily, long-term methadone maintenance treatment.

Substance use disorders were viewed as biopsychosocial disorders that led to personal, family, and community damage. Throughout the SUD service system (except in NTPs and detox programs, where physicians and nurses were required), practitioners were primarily non-licensed individuals, many of whom were "in recovery" from alcohol and drug addiction. Very few licensed health care professionals played a role in SUD service delivery. Even the MDs and nurses who staffed "detox" programs and NTPs played very small roles, generally addressing medication-dosing issues and medical safety. In many treatment programs, there was no involvement of licensed health care professionals, and the staff of SUD treatment agencies often viewed licensed MDs, PhDs, etc., with skepticism and antagonism. Although the SUD service system was often identified as a health service, the identity of the SUD system was that of a mixture of a social service system, an extension of the criminal justice system, a housing system, and peer fellowship. Because of the non-licensed nature of most of the clinical staff, funding for services was primarily via grant funds from the federal or local governments to individual

treatment programs, not individual clinicians. Reimbursement by Medicaid was relatively modest.

During the past decade in California (and throughout the United States), substantial changes have occurred, with the MH system recognizing the value of the concept of "recovery" and peer support activities. In the SUD world, the increased recognition of the brain changes caused by alcohol and drug use has led to a great acceptance of SUDs as "brain diseases" and that treatments backed by scientific evidence have great benefit. In the SUD system, this awareness has led to application of evidence-based and promising practices, the increased use of pharmacotherapies, including Suboxone and naltrexone, and an increasing role for licensed professionals as part of the treatment team. Still the cultures of the MH and SUD service systems in 2011 are remarkably distinct. Even in California counties where the county management of MH and SUD treatment has been merged under a single entity (often called "Behavioral Health Agency"), the MH service organizations and SUD treatment programs remain very different environments. Over the past decade, UCLA's work for ADP has allowed for visits to many of the 58 California counties to meet and work with county-level Alcohol and Drug Program administrators. When the topic of MH and SUD service integration was raised in these discussions, it was openly stated that while there was a behavioral health entity in name, the services were still quite segregated into different provider systems and treatment modalities. Reasons for the failure to more effectively integrate the services included: (1) Funding sources for SUD and MH services were very different, different regulations governed the use of funds, and different reporting requirements existed; (2) At the state department level, there were still distinctly different oversight entities (ADP and DMH); and (3) The differing cultures of the SUD

and MH systems, and the fact that personnel who delivered treatment in the two systems were not well versed in their non-specialty areas.

During the past decade in California, the funding of the Substance Abuse and Crime Prevention Act (Proposition 36), the emergence and expansion of drug courts, and the growth of prison treatment, has strengthened the linkages between the SUD service and criminal justice systems. By 2010, almost 70% of the individuals in publicly funded SUD treatment in California had some degree of involvement in the criminal justice system, whereas fewer than 5% of individuals in treatment were referred into treatment by the health system. On the other hand, a major source of change in California's DMH was the passage of the Mental Health Services Act (Proposition 63) in 2004, a new source of funding to modernize the MH service delivery system. This new source of funding allowed for the hiring of professional staff and the implementation of new forms of services based upon current mental health research. Initiatives to integrate MH services into the primary care system also began during this period.

As noted above, the cultures of ADP and DMH are populated by groups of individuals with different treatment approaches, philosophies, beliefs, and attitudes. The MH system largely focuses on treatment for serious mental illnesses. Few of the individuals practicing in the MH system are versed in addiction and they have little knowledge or appreciation for the treatments delivered to individuals with SUDs. On the other hand, most of the clinical staff in SUD programs are not licensed and therefore not qualified to deliver care in the MH system. Their knowledge base about MH disorders is minimal and many do not understand or support the use of medications (NTP staff excepted). Any consolidation of ADP and DMH will have to systematically address these cultural and knowledge/expertise differences and address the workforce issues that will be encountered as clinicians attempt to work in a consolidated system.

Increasing Awareness of the Need for Integrated SUD and MH Services

During the past 15 years, there has been an increasing awareness that MH and SUD disorders need to be treated in an integrated manner to attain optimal clinical outcomes. Research efforts have found that in many samples of MH patients and in many samples of SUD clients, a very large proportion of individuals meet DSM IV criteria for both MH and SU disorders. Depending on the study and the sample involved, rates of co-morbidity between 20% and 50% are commonly reported. This recognition of the high rates of co-morbidity, along with the increasing scientific evidence that better treatment outcomes can be achieved by the concurrent treatment of both MH and SU disorders, has led to much greater acceptance of the importance of integrated MH and SUD treatment.

California began working toward better collaboration by the MH and SUD treatment systems by establishing the Dual Diagnosis Task Force (DDTF) in May 1995.[7] With representatives from both ADP and DMH, four demonstration projects were funded to facilitate the development and accessibility of integrated programs for clients with co-occurring disorders (COD). With the use of Mental Health Services Act (MHSA) dollars, the Co-Occurring Disorders Workgroup was formed in 2002 to establish better relationships and improve collaboration between systems designed to address the needs of individuals with CODs. Efforts to improve COD treatment continued through the Co-Occurring Joint Action Council (COJAC), established in 2004, through which public and private stakeholders advised the DMH and ADP directors. While the establishment of the COJAC group underscores the recognition of the need to integrate services between DMH and ADP and while the gatherings and products of COJAC have been useful, they have not substantially changed the fact that MH and SUD services are still

delivered in very different and separate "silos of care." The cultures of the MH and SUD treatment systems also still remain quite distinct and different.

Past Efforts to Consolidate Departments

A proposal to consolidate ADP and DMH in California was put forward in 2004, under then Gov. Arnold Schwarzenegger, based primarily on the belief that consolidating the two separate departments would enhance the coordination of county-administered services for those suffering with both mental illness and substance use disorders. There was also an interest in reducing the financial burden of maintaining two large administrative entities to administer and oversee MH and SUD services. To this end, the governor's reorganization committee, the Committee on Performance Review, proposed combining the administrative functions of the state's substance use disorders and mental health programs. The committee determined that, through staff reductions, a savings of $1.8 million would result from eliminating the identical functions between the two departments. Based on the argument that 25 other states had merged MH and SUD entities and 38 California counties had consolidated county entities, there was a belief that the consolidation was a feasible and more cost-effective way to oversee MH and SUD service systems. Over time, the committee contended that operational barriers could be overcome and that the functioning of both systems could be streamlined and improved as a single integrated collection of services.[8]

The proposition to consolidate ADP and DMH and reduce administrative services by 10% and 5%, respectively, in addition to eliminating a number of overarching senior administrative positions, received harsh criticisms from stakeholders in both the MH and SUD fields. Department of Mental Health stakeholder groups expressed concerns that the loss of administrative personnel and MH leadership positions would dilute the expertise and person

power to oversee the large and complex MH service delivery system. The response of ADP stakeholders was far more negative: ADP stakeholders expressed concern that because of greater funding available for MH services and because the MH system was led by MDs, PhDs, and other licensed professionals, it was likely that the MH system would "swallow" the ADP system and become the dominant influence in the consolidated entity. It was felt that the MH leadership did not understand or appreciate the SUD service system or its models of care. There were references to the rationale for decisions made in the early 1970s to separate the MH and SUD research and services into separate departments. Substance use disorder service providers reported that an ADP/DMH consolidation would actually "endanger the lives of citizens" due to the inability of a MH-dominated entity to provide appropriate SUD services.[9] Both ADP and DMH argued that the proposal posed serious policy and fiscal implications that would need to be addressed prior to consolidation efforts. Due to the lack of support for this initiative from the majority of the stakeholders involved, the proposal was rejected and ADP and DMH remained as separate, independent departments.[10]

Consolidation of MH and SUD Service Entities in the United States

Since 2003, 23 states have implemented substantial restructuring plans across their health entities. Although the goal of streamlining services to better utilize scarce resources was common across states with restructuring initiatives, the resulting organizational structures varied, and there was no metric by which to define the most cost-effective and efficient.[11] Despite the lack of consistency across restructuring efforts, the changes that emerged within the states that took on reorganizational processes provide useful lessons and insight for California as it considers a possible reform of ADP and DMH. Every state's organizational design is constrained by compromises resulting from competing constituencies and expectations, which make it difficult to

determine an ideal structure. The descriptions of the state efforts highlighted in this report do not go into extensive detail on the specifics of their organizational design, but emphasize important operational and functional changes considered beneficial in providing California with relevant recommendations.

V. Merger of DMH and ADP Functions into a Larger Governmental Department

In addition to the question of whether ADP and DMH should be consolidated, there is the question of where in the government these functions (consolidated or not) should be located. Should they remain at a departmental level within the Health and Human Services Agency, or should they be merged into a larger department in the California government, and if so, which department? As of the writing of this paper, activities are underway to transfer the Drug Medi-Cal functions of ADP and the Medi-Cal billing functions of DMH into the Department of Health Care Services (DHCS). The question is now under consideration about whether some or all of the rest of ADP and DMH functions should be merged into DHCS. While the Medi-Cal billing functions may be a reasonable fit in this larger DHCS government entity, do the other functions of ADP and DMH fit as well into the DHCS environment?

Unlike the discussion about the consolidation of MH and SUD services into a single entity, there has been very little discussion, until now, in California about the merger of MH and SUD services into a larger California Department. In addition, unlike the circumstances surrounding consolidation of ADP and DMH into a single entity, where there was a previous public debate and discussion during the Schwarzenegger administration, the present discussion about merging the functions of ADP and DMH into a larger department has not been brought to the public level in California. As illustrated in Section VI on other state examples, such mergers

have occurred in other states, with the administration of SUD and MH services being located in a variety of governmental departments.

It is not altogether clear why the idea of merging ADP and DMH functions into a larger department has not been considered earlier. However, one factor may be that the nature of the services and provider networks that have evolved to deliver MH and SUD services may have been considered so unique as to preclude their effective integration with any other single California department. For example, as described in Section IV, SUD services evolved from a combination of social services, criminal justice services, and peer-based services, with only a very modest involvement with medical care services. As recently as the early 2000s, with the passage of California's Proposition 36, the SUD treatment system had a far greater partnership and a far greater interagency relationship with the criminal justice system and the Department of Corrections than with the health system. During this period, if ADP was going to be merged with a larger California department, a very good case could have been made for moving ADP into the Department of Corrections.

However, as reviewed in greater detail in Section VII, the passage of the federal Affordable Care Act of 2010 and the Mental Health Parity and Addiction Equity Act of 2008, produced a substantial paradigm change in which SUD and MH treatment services (this is less clear with prevention services) are much more widely perceived as health care services. Efforts to integrate SUD and MH services into primary care have increased acceptance of the concept that SUD and MH services belong in the broader health care system in California and around the United States.[12,13] As a result, as efforts continue to move SUD and MH services into alignment with other health services, the idea that SUD and MH services may be appropriately placed within a larger California Department of Health (Health Care Services or Public Health) seems far more

reasonable than in the past. Therefore, although this discussion has not previously received the public debate that occurred regarding ADP and MH consolidation, the idea of these functions being absorbed into a larger department appears to be congruent with the future of SUD and MH services and their clear identification as health care services. A possible exception to this is that even though treatment services appear to have a better fit within the environment of the DHCS, it could be argued that the Department of Public Health (DPH) would be a more congruent environment for prevention services, considering the larger prevention and health promotion efforts of the DPH.

In summary, the consolidation of ADP and DMH has been considered on previous occasions and has been the subject of much public debate. There is research evidence that has relevance to the discussion and there is more than a 40-year history of system evolution that has long been the subject of vigorous discussion and controversy. The subject of merging ADP and DMH functions into a larger department in California does not have the same history. As SUD and MH services are being fully conceptualized as health care services that belong within the broader health care system, the idea that SUD and MH services may be merged into a larger California governmental health department appears to be a concept that is in line with the future of health care services in the United States.

VI. Specific State Examples*

The states included in this review are Florida, Maine, Washington, North Carolina, Oklahoma, Texas, and Louisiana. These states have undergone restructuring efforts that may provide practical insight into the possible consolidation of California's ADP and DMH. Many other states have undergone restructuring of MH and SUD entities and were considered for inclusion in this analysis, but in the opinion of experts on this topic, the selected states provide designs that appear the most appropriate for providing California with useful lessons learned.[14] The selected states desired to streamline programs and administrative services and improve their SUD and MH service-resource allocations. The attributes and methods gathered from the review of these state systems will, it is hoped, be instructive to decision makers in their efforts to improve the structure and operation of California's system.[15]

Florida

In 2003, Florida reorganized its separate Department of Substance Abuse and Department of Mental Health Services into a centralized Department of Substance Abuse and Mental Health Programs under the Department of Children and Families. Prior to this consolidation, each Department had a Deputy Secretary, reporting to the Secretary of the Department of Children and Families, with separate chains of command. The new organizational structure positioned a Deputy Secretary to administer all MH and SUD programs with a Program Director for Substance Abuse Services and a Program Director for Mental Health Services. Consolidated administrative services include Human Resources, Financial Management, Information Technology, General Services, and Purchasing under the Deputy Secretary. The consolidated department resulted in a

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* Gelber S, Rinaldo D. *State Substance Abuse Agencies and their Placement within Goverment: Impact on Organizational Performance and Collaboration in 12 States.* Berkeley, CA: Health Systems Research; November 2005, was a major resource for this section.

reduction in administrative staff. While the administrative structure is shared, the clinical service programs still have a separate director overseeing district program supervisors, separate budgets, and contracting functions. This separation reflects the federal structure that administers different federal and state funding streams and different MH and SUD service delivery regulations.

The centralized structure has produced a number of benefits. Program directors have direct access to those making the decisions, which has allowed for more immediate decision making and problem solving. The new structure has also improved accountability for treatment facilities, personnel, and community programs through a more systematic approach to oversight. With the increased standardization of policies and practices, the districts and the central office have forged stronger working relations. There also appears to be more cohesion between the SUD and MH programs. The new department cites increased use of performance data in decision making and improvements in contracting staff and procedures. Whether or not the two programs will consolidate completely across all program level functions is uncertain, but the consolidation of administrative responsibilities has proven to be feasible and advantageous.[16]

Several challenges emerged as a result of the revised organizational structure, in that the reduction in staff created a need to utilize temporary employees to carry out program functions. Over-extended staff had difficulties working with the department's new structure, and delays occurred in contract monitoring and communication. These delays led to serious hardships for providers and in some cases, provider organizations were closed due to funding interruptions.

Maine

As a means to allocate resources more effectively, the Department of Behavioral and Developmental Services and the Department of Human Services consolidated to form Maine's Department of Health and Human Services. Despite this merger at the departmental level, the

Office of Adult Mental Health Services (OAMHSA) and the Office of Substance Abuse Services (OSA) remain separate and are managed by their own director and staff. Among other offices, OAMHSA and OSA report to the same Deputy Commissioner for Programs who serves under the Chief Operating Officer within the Commissioner's Office. The consolidation at the departmental level streamlined the management of Administrative Hearings, Legislative and Public Relations, Communications, and Constituent and Legal Affairs. The inclusion of offices under a broader umbrella department facilitated efforts to integrate policy and programs between the separate offices.

Under the same Deputy Commissioner for Programs, OAMHSA and OSA are working toward building the state infrastructure to integrate the functioning of the two offices. Initiatives to identify standardized screening and assessment tools for both SU and MH disorders, complementary licensing and credentialing standards, data sharing, network building, and financial planning are underway. Maine is an example of how a single line of authority to a Deputy Commissioner for Programs reduces the need for administrative support staff and the need for multiple office system functions.[14,17,18]

Washington

With the purpose of creating a more efficient and integrated system of care within the Department of Social and Health Services in Washington, this agency was reorganized in 2005 to include Medical Assistance Programs, Mental Health Services, and Chemical Dependency Treatment in their scope of services. This initiative brought the Division of Alcohol and Substance Abuse (DASA) and the Division of Mental Health (DMH) under the Health and Rehabilitative Services Administration. Both divisions still retained their respective director but now report to the same Assistant Secretary of the Health and Recovery Services Administration

under the Secretary of the Department of Social and Health Services. The other divisions under the same administration include Communications, Disability Determination Services, Eligibility and Service Delivery, Rates and Finance, Legal Services, Legislative Policy, Healthcare Service, and Systems and Monitoring.

The restructured department continues to facilitate key programs and pilot projects that promote the integration of services to further improve care and streamline efficiencies. Although both divisions continue to function according to their respective budgets and practices with separate administration and financing, established cooperative agreements are taking form. The revised structure encourages collaboration across divisions to reach the shared agency goal for integration and synergy.[14,19] A key element in the increased efficiency and greater accountability for this new department is the implementation of a data system in which each individual who receives services in the health system in Washington has a single identification number. This data system allows tracking of patients across all components of the Health and Social Service Agency and promotes more integrated and accountable care. A single identifier is allowing Washington State to have an unprecedented capability to examine relationships of service utilization and cost offsets within the entire service system. This data system is a model that can assist other states, including California in understanding how to use data to get the maximum treatment effectiveness and efficiency across the entire spectrum of health services.

North Carolina

In North Carolina, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) operates under the North Carolina Department of Health and Human Services (DHHS), an umbrella agency that encompasses 30 health and social service divisions and offices. Under the Secretary of the DHHS, the Director of DMHDDSAS

oversees five functionally organized sections. This structure was created to eliminate the autonomous single disorder agency decision-making processes that frequently required local service providers to respond to divergent priorities, demands, and approaches. Within the reorganized structure, the Community Policy Management Section (CPM) is responsible for program development and supervision of the local management entities (LMEs) that deliver local services. The CPM is further divided into units that include Data Collection and Analysis, Planning and Transformation, the Employee Assistance Program, and Other Administrative Duties. Five program teams, The Prevention and Early Intervention team, The Best Practice team, The Local Management Entity Systems team, the Justice Systems team, and the Quality Management team, address SUD, MH, and dual diagnosis issues related to their focus. There are no separate state SUD functions. This has been done in the hopes that the consolidated division will promote integrated and collaborative service delivery. Efforts to develop structures and processes for consistent approaches and improved access to services are continuing across the LMEs.

Numerous local capacity development initiatives have taken place and continue to occur as a result of the organizational transformation. One of these initiatives has been the development of a new classification for a provider agency, a Critical Access Behavioral Health Agency (CABHA). With the designation of these comprehensive provider organizations, it is hoped that over time, a more coherent service delivery model will be put in place with an emphasis on competency and holistic care. These agencies are required to have a Medical Director and meet regulations and certification procedures set by both the Division of Medical Assistance (DMA) and DMHDDSAS. Additional accomplishments achieved by the merged division include work

related to data integration, capacity building for health care reform, and integration with primary care.

The process of realigning the division, however, was far from easy, and issues continue to be worked out. Workforce issues proved to be a major hurdle and are still being negotiated. Key leaders with expertise in all clinical and functional areas have been involved in the decision-making process. To date, the system has been able to support the extensive changes, and collaboration and cooperation have remained high. The DMHDDSAS continues to build upon their infrastructure, operate more efficiently, and move toward more integrated services.[14, 20]

Louisiana

Prior to consolidation, Louisiana maintained an Office of Mental Health and an Office for Addictive Disorders within its Department of Health and Hospitals (DHH). These offices, in addition to four others, the Office of Public Health, Office for Citizens with Developmental Disabilities, Office of Aging & Adult Services, and Louisiana Commission for the Deaf, reported to the Deputy Secretary in the Office of the Secretary of DHH. As a way to promote the efficiency and effectiveness of the services provided by the Office of Mental Health and the Office for Addictive Disorders, the Department created an Implementation Advisory Committee in 2009 to consolidate the two offices into one Office of Behavioral Health (OBH). Propelled by other states that went through a similar restructuring process and in pursuit of strategies to maximize funding, the consolidation was designed to follow best practices, create a more comprehensive health care system, and consolidate administrative and planning functions at the state. The Committee comprised an equal representation of recommended stakeholders from both offices to create the mission, vision, procedures, and timeline for implementation.

With efficiency and effectiveness in mind, the Committee set forth the imperative that the improvement of quality and quantity of services needed to occur for any sustained cost savings to be realized. The infrastructure of the new Office was formulated as a functional matrix where teams were established to support identified functional areas of the OBH. These areas included Planning, Research and Special Initiatives, Continuous Quality Improvement, Workforce Development, Partnerships and Linkages, Operations, Emergency Preparedness, and Region/District Coordination and other Direct Service Operations, where distinct and overlapping responsibilities were outlined with the goal of eventually transitioning from a regional office to local governing entities (LGEs) that would deliver direct services. Key recommendations regarding infrastructure and staffing; performance measures and outcomes; access to care; licensing, training and workforce development; funding strategies; and local, state and federal coordination were gathered from consultants, researchers, and other state entities to guide the successful implementation of the organizational change. An incremental, developmental approach has been employed, with constant input and feedback, to ease the transitioning of an evolving system. While the Office is still in its early stages since the consolidation, it is anticipated that the reorganization will generate cost savings, efficiencies, and improved quality of services.[10, 21]

Texas

In 2003, through House Bill (H.B) 2292, Texas implemented a consolidation of their health and human services (HHS) to streamline services and better meet their clients' needs with a more integrated system. Prior to this transformation, Texas governed 200 health and human services programs across 12 departments. The consolidation reduced their departments to five—the Health and Human Services Commission (HHSC), Department of Aging and Disability

Services (DADS), Department of Assistive Rehabilitative Services (DARS), Department of Family and Protective Services (DFPS), and Department of State Health Services (DSHS). On September 1, 2004, after a year of intense planning and preparation for consolidation, the new department commenced operations.

Under this new structure, Mental Health Services and Alcohol and Drug Abuse Services report to the Commissioner of the DSHS along with Health Services. One of the benefits of consolidation is the ability of the DSHS to address the frequent co-occurrence of MH disorders and SUDs among patients within the same department. DSHS has also made significant enhancements in multi-program collaboration to improve efficiency and services. With better coordination of resources and organizational alignment, there are greater opportunities to link behavioral and physical health services. The new organizational structure has also allowed for the adoption of more cost-effective business practices and the centralization and consolidation of support services. With consistent human resources policies and practices, additional functions are coordinated across the HHS system. The standardized procedures have produced cost savings in a number of areas. For example, the consolidation of document output across agencies has resulted in a 26% savings with no capital expenditures. The establishment of an Office of Inspector General, which oversees all agency fraud and abuse issues, has also recovered "$122 million through sanctions, penalties, and recoupments, $148 million in third-party payments, and recognized cost avoidances of $383 million." Texas HHS continues to move toward their vision of a service system that integrates and coordinates services, identifies and addresses client needs, emphasizes accountability and continuous improvement, rewards innovation and results, and seeks and responds to public input and involvement.[22]

Oklahoma

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), which was established in 1953, has a long-standing history of operating a single department for the provision of mental health and substance abuse services. With the mission of providing the highest quality care to its citizens, ODMHSAS provides psychiatric hospital services, community mental health centers, crisis intervention centers, and alcohol and drug treatment programs. The Deputy Commissioner for Substance Abuse Services manages all community-based programs, prison-based programs, and state alcohol/drug treatment centers, with a Deputy Commissioner for Mental Health Services managing Community Based Services, Consumer Affairs, Children and Family Services, Crisis Centers, Hospitals, State CMHC Facilities, and Residency Training. A Deputy Commissioner for Communications and Prevention and a Director of Financial Services, Director of Human Resources, and Chief Information Officer also have oversight over their respective functions and report to the Chief Operating Officer under the Commissioner of the Governing Board for the overall department.

Due to the origination of the department as the provider of both MH and SUD treatment under a single governing board, it is considered exemplary in terms of treatment for people with co-occurring disorders and a leader in several areas of community-based services. ODMHSAS provides cross-training among the program divisions and facilitates collaboration through regular meetings for program planning and development. With the use of performance indicators and evaluation tools in decision-making and implementation of services, the department emphasizes the importance of evidence-based practices and data-based performance improvement. As a result, ODMHSAS continues to implement service and workplace improvements to achieve their overall vision of providing comprehensive, high-quality care for their consumers.[23]

Cross-State Analysis

The co-location of the state entities that oversee MH and SUD services under the same umbrella structure has received considerable attention during the past decade.[11,14,8,24-28] In general, the consolidation models that have been employed have maintained separation between the functions that manage clinical oversight and financing, while promoting inter-service coordination. Past efforts to merge MH and SUD services were rejected in California due to a number of arguments, including that the consolidation of the two disciplines at the organizational level would degrade each system's specialty clinical care.[9,10]

While most of the state consolidation efforts reviewed above have moved toward a shared administrative oversight body, with a single line of authority to the secretary of the primary health agency for the state, the states acknowledge the importance of maintaining each system's specialty line of service and do not allow one system to subsume the authority or scope of service over the other. As seen in the states described, two distinct entities, one for SUD and one for MH are in place within most of the consolidated systems. Due to differences in funding streams, licensing and regulatory requirements, technical assistance needs, and community stakeholder input, these responsibilities are still directed by a separate lead deputy. While there is a belief among experts that it may be possible to consolidate all of the MH and SUD functions into a truly integrated entity, to date, it appears that maintaining separation, while establishing some combined oversight functions, has been viewed as necessary in managing the complexities of MH and SUD funding.

An example of a state that has not consolidated MH and SUD services into a single entity, but is felt by experts to have made major progress in promoting substantially improved coordination of care for individuals with co-occurring disorders, is Ohio. Ohio's Department of

Alcohol and Drug Addiction Services (ODADAS) is an autonomous cabinet-level entity that is noted for working in close collaboration with its Department of Mental Health (ODMH) and initiating major initiatives to improve efficiencies, achieve cost savings, and improve clinical care. Instead of consolidating under a single entity, ODMH and ODADAS recently released a joint community plan to streamline statutory requirements and reduce administrative burden. Whether this effort will produce the intended system improvements is unknown at this time.[29] However, experts believe that Ohio's example is noteworthy in how they developed a cooperative and collaborative process to make system changes. Experts emphasized that the process for promoting integration and synergies, with or without a consolidation of SUD and MH systems, is highly dependent upon an implementation process that provides for equal input and influence from the MH and SUD leadership, involves stakeholders, and works to promote frequent communication and collaboration.

Connecticut, New York, Ohio, and South Carolina have cabinet-level SUD structures, and the experts for this report strongly agreed that this positioning in the state government resulted in those entities having more influence in making system modifications due to their ability to exercise greater authority.[30] Experts felt that the placement of the entity within the state governmental hierarchy was of great importance in determining the effectiveness of the head of the merged entity in making changes to promote an integrated and efficient system.

An overarching theme in all discussions was the key role of leadership. There was a universal recommendation that any reorganization plan would only be as successful as its leadership. Further, a commonly voiced theme was the view that the successful MH and SUD consolidations resulted from the combination of two equal disciplines. In cases where MH subordinated SUD care, there was a significant degradation of SUD care and loss of clinical

capacity in the state. There were strong recommendations that the leader of a successfully consolidated SUD and MH entity would need to have extensive direct experience in the oversight and management of both services. In those states where consolidations appeared to have the most difficulty, the director was a person with only MH experience and minimal knowledge of the SUD system. Finally, successful mergers have had directors over the MH/SUD agency, with different deputies who had detailed knowledge of the SUD and MH service systems. While some states reported that the domain-specific deputy would be a transitional position for 3–5 years, other states apparently intended to sustain those separate deputies long term.

VII. Considerations for MH and SUD Reorganization in California

As of August 2011, there are two significant and related components to the MH and SUD reorganization being considered in California. These are: (1) Consolidation of the functions of DMH and ADP into a single entity; and (2) Merger of the consolidated entity into the Department of Health Care Services (DHCS).

Considerations for Creating a Consolidated DMH and ADP

For the purposes of this paper, the consolidation of ADP and DMH refers to the integration of financial, legal, logistical, and managerial processes required to provide leadership and regulatory oversight of the MH and SUD services delivered in the State of California. While myriad specific details are involved, there are primarily three reasons to consider consolidation of DMH and ADP: (1) By consolidating the two departments, cost savings will potentially be realized through integrating the departments' parallel functions and reducing the number of personnel needed to administer the consolidated entity; (2) By consolidating the departments, a better integration of MH and SUD services will result, producing better clinical care, especially for those individuals with co-occurring MH and SU disorders; (3) A consolidated entity, encompassing the responsibilities and financial resources for both the MH and SUD systems, would have a larger combined constituency, a larger combined budget and, consequently, could play a larger role and have a greater voice within California government. In short, a consolidated MH and SUD entity could empower California to better align MH and SUD system goals and procedures for cost savings, more clinical effectiveness and efficiency in services, and a stronger voice in policy decisions.[31]

Although numerous studies document the need for better coordination to successfully treat the high rate of patients with co-occurring disorders, integrated services are not necessarily

achievable through a merged state entity.[31] The few studies evaluating whether costs savings and better care for clients are achieved from consolidating public service organizations show few, if any, advantages to such reorganization.[32] There is substantial agreement among those who have been involved in the process of MH/SUD consolidation that the successful implementation of the effort is less dependent upon the specific structure of the reconstituted entity than it is on the methods used to implement the consolidation and on the leader selected to lead the consolidated entity. The experiences of individuals who have gone through a MH and SUD consolidation in other states show that the resulting entity can realize the hoped-for benefits listed above, but there are myriad ways that a consolidation can weaken services, destroy service capacity, and result in reduced quantity and poorer quality of patient care services (especially SUD services).

Considerations for Merging a Consolidated MH/SUD Entity into DHCS

If SUD and MH oversight is consolidated into a single entity, where should this new consolidated entity be located within the California government? Currently ADP and DMH are departments in the Health and Human Services Agency. Each has a director, appointed by the governor (as of August 1, 2011, each has an acting director) and these directors report to the Secretary of the Health and Human Services Agency. At the present time, ADP and DMH are at the same organizational level in the California governmental structure as is the much larger Department of Health Care Services (DHCS), which oversees health care expenditures of over $40 billion (DMH oversees expenditures of about $4 billion and ADP oversees about $630 million). Having a department of government at a high level, with a director appointed by the governor, is generally considered to give the department and its constituents political influence and access to decision makers. A decision to maintain the consolidated SUD and MH entity at

the level of a department directly under the HHS Agency Secretary is thought to be important to maintain its effective influence and priority within the California government.

Governor Brown's June budget message proposed to move the consolidated entity to an entity within the DHCS. The proposal is backed by the argument that by merging the consolidated MH/SUD entity into DHCS, there could be potential savings from reducing redundant personnel, developing integrated billing and fiscal services, and better integrating SUD and MH services into the larger health care system. As discussed above, the potential for government consolidations to save money has often been unrealized when actually attempted. It is well established that while the "cultures" of the SUD and MH systems are different from each other, their differences are modest in comparison to the differences in the cultures of the MH or SUD systems and the larger health care system. It has been reported in other state reorganizations that the incorporation of SUD and MH services into a larger health care system can result in substantial disruptions in quantity and quality of MH and SUD services. This is due to the inability of the larger health care entity to understand and accommodate the unique patient population, service providers, and service modalities used within SUD and MH systems.

Experts we consulted in the preparation of this report suggested that a merger of SUD and MH services into a larger health services department could have some tremendous potential benefits, if the head of the consolidated entity is at a high level in the department structure (at a salary adequate to attract candidates of excellence) and if this person had substantial experience in the administration of SUD and MH services. As we understand the organization of the DHCS, it appears that to get a person with the necessary knowledge and skills to institute and then lead a consolidated SUD/MH entity within DHCS and for that person to have adequate access to the DHCS Director, he/she would need to be offered a Chief Deputy Director position. Under this

person, individual Deputy Directors of SUD and MH would then be needed to manage the ongoing functions. This discussion will be expanded in Section IX.

Are Considerations for Prevention Services the same as for Treatment Services?

The focus of the discussion of this paper and of much of the discussion and debate concerning the reorganization of ADP and DMH has been on the treatment services provided by these two departments. Substance use disorder treatment providers receive approximately 90% of the service dollars that are spent in California on alcohol and drug related services. However, California receives over $50 million per year that is specifically dedicated for prevention services, and within ADP there is a prevention branch and a statewide set of drug and alcohol prevention activities. However, there is not a significant degree of integration between treatment and prevention services. In fact, within ADP, each of these areas operates within its own "silo" of sorts. As a result of its status as the much smaller "junior partner" relative to the treatment system, the system of drug and alcohol prevention is often given less attention, and certainly in the recent discussions of ADP and DMH reorganization, there has been far less consideration concerning how prevention services would be effected by a consolidation or merger. While the current zeitgeist of SUD and MH treatments is that they are becoming far more compatible and incorporated into the broader health care delivery system, it is not clear if this is the case with prevention services.

It is important to consider that the conceptual framework, the goals and objectives, and target populations for prevention and treatment services are very different. Among the differences are:

- Treatment services are designed for individuals ("clients" or "patients") with a specific range of defined objectives as measured by drug and alcohol abstinence, reduced use, or decreases in problems related to use. While treatment services include a diversity of methods and settings, the clear objective of treatment services is to assist the individual in

reducing or eliminating their drug and alcohol use and associated health and other negative consequences. Prevention services are not limited to individuals. They address communities and large populations at risk including: K-12 schools, colleges, workplaces, health settings, and the public at large.

- The target population for treatment services is individuals who meet diagnostic criteria for substance abuse or dependence. Targets for prevention include populations who do not use drugs and alcohol (to delay or prevent their first use); those who use alcohol and drugs at a non-abuse or dependent level but are "at risk" for more serious use; and those who have become dependent, received treatment, and are now at risk for re-addiction.

- The setting for treatment services is in SUD licensed and certified treatment programs. The settings for prevention services are far more varied, including various media, and in educational, health and workplace settings.

- The measurement strategies and data requirements for treatment services address the impact of specific services on the behavior of individuals. The measurement strategies and data requirements for prevention services are far more diverse and require measurement at the community and population level.

- Prevention services involve far more interaction with the public policy arena. Issues such as liquor store density, availability of products such as "alcopops" and other products to promote drug and alcohol initiation, and the impact of initiatives such as medical marijuana and many others are all considerations in the prevention arena.

At present, the discussion concerning the merger of the functions of ADP and DMH into a larger department have primarily addressed treatment and which department would be most compatible with ADP and DMH treatment services. As a starting point, ADP Drug Medi-Cal billing functions are being merged into the DHCS, as they have responsibility for the huge Medi-Cal billing apparatus for health services. As a result, as of the time of this manuscript preparation (August 2011) there is a growing perception that all functions of ADP and DMH will be merged into DHCS. While this may, in fact, be the best fit for treatment services, it may not be the best fit for prevention services. There is an already existing partnership between the drug and alcohol prevention activities of ADP and of the highly touted tobacco prevention activities in DPH. The alcohol and drug prevention services may have more in common and have more areas of

compatibility with the prevention activities that are under the direction of the DPH than with the treatment activities for SUDs. This is an issue that deserves careful consideration and analysis.

VIII. The Health Care Context in 2011: Changing Expectations for SUD and MH Services in the Future

The National Response to Health Care Reform

The passage of the federal Affordable Care Act (ACA) has set the stage to transform the delivery of health care toward a whole-person approach where services are comprehensive and patient-centered. After years of separate and isolated services, federal legislation has emphasized the need to improve the quality, availability, and affordability of health care for all Americans through integration and collaborative processes. In order to move this agenda forward, the Secretary of the U.S. Department of Health and Human Services (HHS) has established a National Strategy for Quality Improvement in Health Care (the National Quality Strategy).[33] A central principle in this system change is the need to move toward a collaborative and patient-centered approach to health care through the integration and coordination of health services. At the national level, the Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized the need for the SUD and MH arena to restructure, develop new services, and use new technology. In line with the National Quality Strategy, SAMHSA released the National Behavioral Health Quality Framework to realize similar goals and priorities for improving the delivery of behavioral health services.[34] This imperative is an indication that at the federal level, there is an expectation that the SUD and MH fields will be part of the transition toward integrated care.

Rationale for Integrated Care

The health reform initiatives to improve care coordination and adopt integrated disease management programs are longstanding and proven needs for enhancing the U.S. health care system.[35] Research continues to show that integrated care, where multiple specialized providers

are involved in treating a chronic condition and are aware of all care activities, results in the most cost-efficient health outcomes.[36] As individuals with multiple chronic conditions increasingly become the greatest users of health care, the shift from a system designed to treat an acute illness event to a system that can treat people in need of care across a span of multiple providers is underway.[37,38] A growing number of integration models have been implemented to reduce inefficiency and maximize the potential of the consumer.[37,39, 40] While progress to include mental health and SUD treatment has been limited,[40-43] a growing number of studies and initiatives are bringing greater attention to the need to include these conditions in the move toward integrated care.

Studies show that psychosocial issues are a substantial factor in 70% of all health care visits.[44] When mental health services are integrated into primary care settings, studies also show an overall reduction in health costs as well as improvement in patient access, prevention, and early intervention.[45,46] Randomized clinical trials that have examined outcomes after patients received SUD services in primary care settings and those assessing the use of screening, brief intervention, and referral to treatment (SBIRT) in primary care settings show similar results in better health outcomes and cost savings.[47-49] Providing MH and SUD services in health care settings is feasible,[47,48, 50, 51] can reach many more individuals than reliance on community-based specialty MH and/or SUD treatment alone, promises better outcomes for patients,[52-54] and can result in reduced overall health care utilization costs.[48,55,56] The promising evidence for better outcomes with integrated care and the need to improve the quality of health care in the United States supports the need for the integration of the MH/SUD fields with the primary care field. While preserving their specialty areas of expertise, they can maximize the impact of these services by working with other providers to bridge the knowledge and communication gap that so

often diminishes the quality of the U.S. health system. The trends in national health care policy and practice are already moving to adopt more strategies to initiate coordinated, clinically integrated behavioral and primary health care during this period of reform.[34]

As SUD and MH integration efforts roll out in California, it is clear that the workforce will require a broad and diverse set of skills—which very few individuals in the current workforce have. There will also need to be close coordination of MH and SUD services within the broader health care service system for effective and efficient integration efforts.[57] Primary care settings are very busy environments that value personnel who have a wide range of flexible skills to address multiple problems.[58,59] Primary care settings are not conducive to personnel who "only do one thing." In fact, according to experts in behavioral health integration, one of the most common contributors to failed behavioral health integration efforts is the employment of individuals who do not have a broad range of MH and SUD skills.[60] They emphatically contend that moving the "specialty silos" of SUD services and MH services into primary care settings is a sure formula for poor acceptance of these services by primary care staff and suboptimal care to patients and their families.[61,62] For the future success of integrating SUD and MH services into primary care, the traditional segregation of these services using personnel with a single set of specialty skills (i.e., SUD or MH) will impair integration efforts.[63]

Independent efforts to integrate SUD and MH services with primary care (PC) result in gaps in competencies and increase misconceptions about both MH and SUD services.[64] The administrative and cultural divisions between the two systems impede integration efforts shown to be more effective in providing better care.[57] A review of research studies investigating integrated models of care for people with co-occurring MH and SUD problems generally found that integrated treatment results in higher retention and engagement.[65] A number of studies also found

higher treatment compliance across clients receiving integrated care.[66-69] Other optimal outcomes include increased attendance rate,[70] stronger intentions to stay sober,[67] lower relapse rates,[66] and overall reduction in drug and alcohol use.[71] Some studies, however, found no effect or difference between integrated and separated treatment[72,73] and one even found that the integrated treatment group fared worse than the non-integrated treatment group.[74]

The bulk of evidence provides substantial evidence for improved outcomes through integrated care and that key elements of successful models require support at all levels of the organization. As efforts to integrate SUD and MH services into PC continue,[75] the continuation of segregated SUD and MH care will result in suboptimal practice standards, protocols, and tools used to identify and treat SU and/or MH problems. Poorly coordinated SUD and MH services will reduce the willingness of PC providers to incorporate SUD and MH services. The absence of collaboration between SUD and MH service providers puts both fields at risk for exclusion from integration efforts with the PC service system. These are only some of the various issues that support the need for the MH and SUD fields to align efforts in their attempts to work with a much larger, often resistant, and better funded PC system of care.

IX. Frameworks for Reorganization of California's DMH and ADP

Based upon the information collected and our understanding of the responsibilities that ADP and DMH have within the California governmental structure, we present a number of frameworks for oversight and administration of SUD and MH services in California. Our discussion is intended to present several models that are being considered to structure the functions currently under ADP and DMH. The following analysis will be presented with the perspective of how the choice of configurations will impact the future of SUD services. We begin

with a discussion of the current manner in which ADP and DMH are organized and located within the structure of California's government.

Question 1: Should ADP and DMH remain as Separate Administrative Entities or should they be Consolidated?

<u>Option 1:</u> The Status Quo: ADP and DMH Remain as Independent Departments under the Secretary of HHS Agency

Current Model of ADP and DMH as Separate Departments within HHS

Chart 1

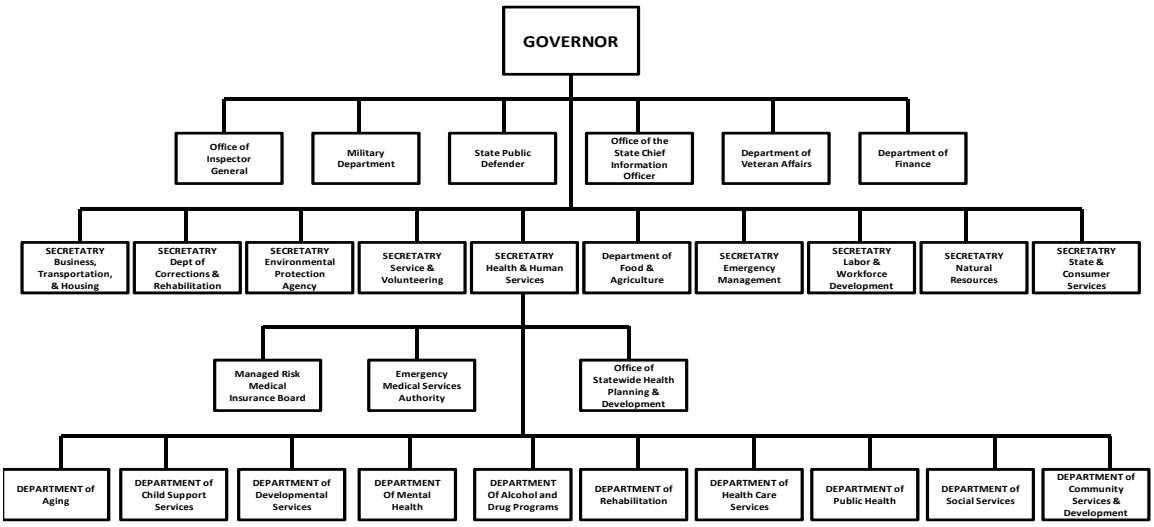


Chart 1 is an organizational schematic of the California Executive Branch of government, showing the current location of ADP and DMH as separate departments in the Health and Human Services Agency. Each department has a director appointed by the governor, who reports directly to the Secretary of the Health and Human Services Agency. The following is an articulation of

some of the perceived advantages and disadvantages of the current ADP and DMH departmental structure:

Advantages: As reviewed in Section IV, ADP and DMH were established as independent departments over 30 years ago to build the capability of effectively preventing and treating MH and SU disorders. The model of independent departments allowed the State of California in combination with its 58 counties to develop programs of prevention and systems of care for individuals with MH (DMH) and SU (ADP) disorders. Provider networks were established, cadres of prevention and treatment professionals were developed, funding mechanisms were put into place, and relationships with the federal government evolved— Health Resources and Services Administration Center for Mental Health Services with the California Department of Mental Health (DMH), and the U.S. Center for Substance Abuse Prevention (CSAP) and the U.S. Center for Substance Abuse Treatment (CSAT) with the California Department of Alcohol and Drug Programs (ADP). The current ADP/DMH configuration is well suited to sustaining all of these functions. Other strengths include:

- Mental health and substance use disorder issues are represented at the highest level of California government. This visibility and representation at the Agency is considered by many to be indicative of the administration's level of interest in, and commitment to, MH and SUD issues.
- The financing of MH and SUD services in California is complex, with multiple funding sources and very different reporting and regulatory requirements. Each department has spent many years developing systems to maximize access to prevention and treatment dollars and each has extensive in-house expertise in maintaining maximum funding levels.

For example, California is required by federal block grant requirements to have a Single State Agency to provide leadership and accountability for the Substance Abuse Block Grant. The ADP currently fills that role.

- The MH and SUD service delivery systems are very different. The current configuration allows DMH and ADP to maintain an awareness and promotion of provider entities that meet the unique needs of California's diverse population. Specialty providers who meet the cultural/racial/ethnic/gender/sexual identity needs of patients can be maintained and nurtured. Further, as new knowledge is developed concerning the prevention and treatment of MH and SU disorders, ADP's and DMH's extensive knowledge and expertise about the current service systems promotes their capacity to implement those advancements effectively.
- The personnel who deliver services in the SUD and MH service delivery systems have very different backgrounds, training, licensing/certification, and skill sets. The current configuration provides the focus and understanding of each personnel group to ensure that the workforce in each area will be sufficiently trained and certified to deliver effective and ethical SUD and MH specialty care into the future.
- Due to the unique nature of how MH patients and SUD patients interact with other systems within California government, the separate DMH and ADP departments can optimally build governmental relationships. For example, California Proposition 36, or the Substance Abuse and Crime Prevention Act (SACPA), led to a very important partnership between the SUD service delivery and criminal justice systems. The creation of this extensive endeavor is believed to have been facilitated by the independence of ADP to rapidly take the needed steps to build this complex collaboration.

- There is “institutional memory” within ADP and DMH staff members regarding the existing SUD and MH service systems. The individuals with this knowledge understand the unique challenges to SUD and MH service delivery in California. Any change reducing this resource could result in less effective service systems.

Disadvantages: The DMH and ADP departments were established in a very different health care environment. MH treatment in California was delivered from the large network of state mental hospitals, and SUD treatment primarily consisted of therapeutic communities developed by recovering individuals. There was minimal overlap in the services being delivered to the individuals in SUD and MH treatment and very little common ground between the workforce delivering and overseeing the services. The science that underpins our understanding of SU and MH disorders has greatly advanced. MH and SU disorders are both recognized as brain diseases and have many common factors (including genetics and early childhood experiences) that increase vulnerability to the development of serious mental illness, addiction, and alcoholism. Extensive research has documented high rates (30–50%) of SUD disorders in MH treatment populations and similarly high rates of MH disorders in SUD treatment populations. Disadvantages of the current DMH and ADP configurations include:

- Budgets (ADP = $670 million; DMH = $4 billion) are dwarfed by other parallel departments (e.g., DHCS = $40 billion). It is difficult to know if having a position at the “table” is meaningful when representing a budget that equals a tiny fraction of the other departments’ budgets.
- The overlap in the patient population is extremely high. Segregation of SUD treatment and MH treatment into silos of care results in suboptimal clinical care for many patients.

- Segregation of SUD and MH treatment services and funding may have resulted in the exclusion of SUD services from the recent 1115 Waiver. If SUD and MH services were presented as an integrated service system, it is likely that there would be less support to include one (MH) and exclude the other (SUD). Their combined budgets would represent a more substantial segment of the health care budget.
- The science of treatment for SUDs is moving in a direction in which medications are much more important, which increases its common ground with MH treatment. Similarly, for over a decade, the role of "recovery services," with a long foundation in SUD services, has become a more important component in MH treatment. With the two fields remaining segregated, the knowledge and expertise of both have not been synergistic and the strengths of each system have not optimally benefitted the other.
- Data and billing systems for ADP and DMH are very different. The ADP has the California Outcomes Measurement Service (CalOMS), which has capability as a treatment performance/outcomes measurement system. The DMH has a billing system with extensive data on services delivered. Together, these data systems would provide an excellent integrated system, but segregated, as they are now, neither the ADP nor the DMH data systems are adequate to support data-based decision making.
- Many of the administrative and support services in ADP and DMH appear to be redundant, and a segregated system increases administrative costs.
- The future of integrated health care services as envisioned in the Affordable Care Act will promote service integration at all levels of the health system. The segregation of SUD and MH services makes their integration into primary care inefficient and in some cases competitive and in conflict.

Any substantial system change will create anxiety as "things are not going to be the same as they have always been." In times of change, there are always advocates for the status quo. Many of the employees of DMH and ADP and providers of SUD and MH services have spent their careers building the service system and delivering care within the existing service configuration. Most have strong, genuine beliefs that the existing service systems provide essential services to their communities and that any merger and/or change in control of these systems will result in substantial service degradation. Efforts to consolidate ADP and DMH will be met with resistance by some portions of the field. Further, if changes wrought by a consolidation require substantial changes in the types of services required or standards of care for their delivery, a segment of the existing service delivery system will not successfully survive the transition. This point is presented not as an advantage, nor disadvantage, to the impact of a consolidation.

<u>Option 2</u>: ADP and DMH are Merged as a Single SUD/MH Entity under the Secretary of HHS Agency

Chart 2

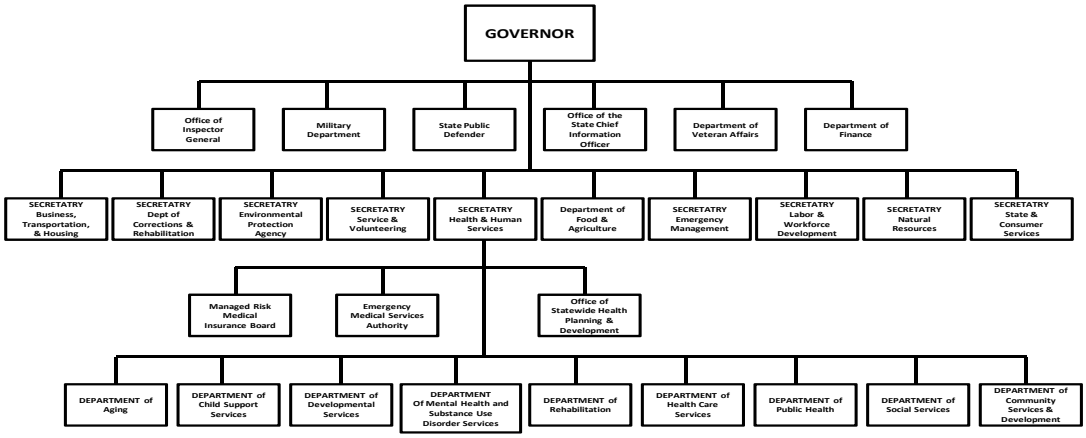


Chart 2 is an overview of the California Executive Branch of government, showing where a new consolidated entity would be merged. This model positions a consolidated SUD/MH Department with a reporting line to the Secretary of the HHS Agency. The Director of the SUD/MH Department would be appointed by the governor.

The following is an articulation of some of the perceived advantages and disadvantages of the consolidated SUD/MH Departmental structure:

Advantages: As described in the background above, consolidation of ADP and DMH has been under consideration for a long time, and in 2004, Gov. Schwarzenegger's Committee on Performance Review recommended that ADP and DMH should be consolidated. Essentially, the view of the committee was that by consolidating the two departments, the California State government would reduce duplication of roles and functions, and improve application of best practices. Further, a consolidation would provide an improvement in administrative efficiency and provide cost savings. In creating a consolidated SUD/MH entity, California would align with the majority of other states in the United States and the majority of counties in California. Other advantages include:

- High rates of co-morbidity between SU and MH disorders make segregated SUD and MH service delivery less than optimal. There is considerable empirical evidence that integrated care for SU and MH disorders provides better clinical and cost/benefit outcomes. It is anticipated that consolidating the administration of SUD and MH services should result in better integration of clinical services.

- ADP and DMH have very different systems with varying strengths and weaknesses. A consolidation of SUD and MH services should promote a better, more coordinated data system that could draw on the strengths of each system.
- In the recent 1115 Waiver process, SUD services were not included as a mandatory benefit. By merging SUD services with MH and viewing them as a unified set of services, the marginalization of SUD services in health care decision-making would be unlikely.
- In the 2004 consolidation discussions, there were expectations of administrative efficiencies and consequent cost-savings from reducing duplicative services and roles.
- The consolidation of licensing, regulatory, and legal functions of ADP and DMH into a single entity would likely be more effective in reducing regulatory barriers and changing legal obstructions to the delivery of SUD and MH care from the same facilities.
- The SUD system has a long and robust history of providing recovery-oriented services using peer mentors and self-help groups. Such experience in the MH system is more recent and less well-developed. Conversely, the MH system is staffed with MDs and nurses and makes extensive use of medications. In the SUD field, with the exception of methadone, this is not the case. By consolidating the administration of SUD and MH services, each specialty could benefit from the strengths, experiences, and resources of the other.
- At the federal level, there is a priority effort to integrate SUD and MH activities and services throughout SAMHSA and, via federal influence, across the United States. In the current year, it has become possible for states to submit applications to SAMHSA for unified (MH and SUD integrated) block grants, which will become required in future

years. The consolidation of SUD and MH in California will facilitate the alignment of the state system with the future federal block-grant funding model.

Disadvantages: In the 2004 report of the Committee on Performance Review, it was noted that the recommendation to consolidate DMH and ADP generated 328 public comments as part of the feedback process. Of the 328, eight were in favor of the consolidation and 320 were opposed.

The themes of the opposing public comments were:

- Alcohol and drug treatment programs need a distinct identity and should be separate to be most effective.
- If consolidated, mental health programs will dominate to the detriment of alcohol and drug treatment programs.
- Consolidating the administration of the state's substance use disorder and mental health programs does nothing to increase funding for either of the programs.
- Substance abuse is so critical in California that it needs a stand-alone department to assure that treatment is most effective.

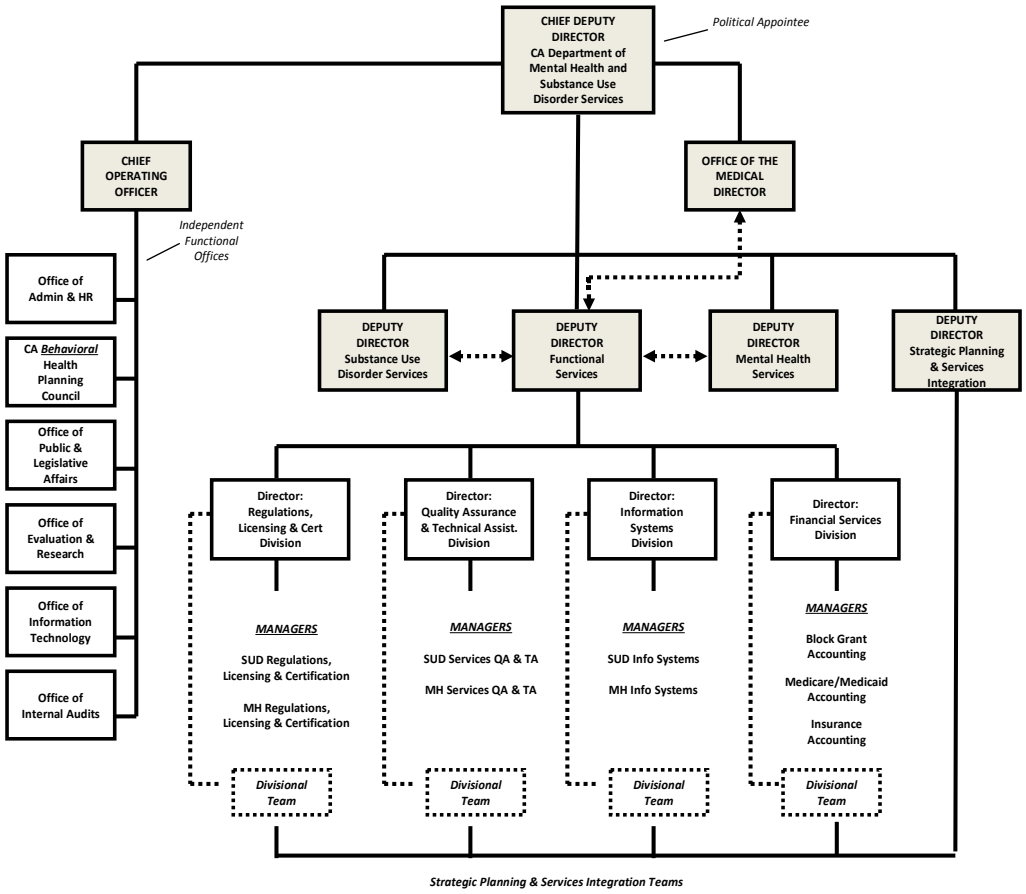
Other states and some California counties have consolidated SUD and MH administrative organizations under a department, which is frequently called "Behavioral Health Agency." There has been a tendency for the influence of the MH system/leader to outweigh the influence of the SUD system and its leaders within these agencies. In some states/counties, the result has been perceived as a degradation to the SUD system with a loss of SUD providers and loss of expertise in the SUD area. The opposite situation has rarely been reported (i.e., excessive influence of the

SUD system/leaders). From multiple reports, if the person appointed to lead a consolidated MH/SUD entity does not have adequate SUD expertise and experience, the result is a downgrading in the quality and quantity of SUD services.

One Possible Model for Organizing the Functions of the Consolidated Entity

Chart 3 shows how a consolidated SUD/MH Department might be organized.

Chart 3



Structure of a Consolidated Department

To both recognize and emphasize the continued importance of both MH and SUD services, we propose naming the new entity the "Department of Mental Health and Substance Use Disorder Services" (DMHSUDS) or "Department of Substance Use Disorder and Mental Health Services" (DSUDMHS). If retained at the departmental level, the Director of the DMHSUDS will be a governor appointee who reports to the Director of the Health and Human Services Agency. Reporting to the appointed Director will be Deputy Directors. The recommended initial organizational hierarchy envisions four Deputy Directors: (1) Mental Health; (2) Substance Use Disorders; (3) Functional Services; and (4) Strategic Planning and Services Integration. These Deputy Directors should have requisite experience in the designated disciplinary fields (i.e., "disciplinary experience"). Thus, the Deputy Director of Mental Health Services would be someone with a strong MH background. The Deputy Director of Substance Use Disorder Services would be someone with a strong SUD background. The Deputy Director of Strategic Planning and Services Integration would likely be someone with an equal level of experience/background in both MH and SUD, or he/she may be someone with less (but equal) experience in those areas but with a strong background in organizational sciences—someone who would bring a strong level of objectivity to the position and its mission. Like the Deputy Director of Strategic Planning and Services Integration, the Deputy Director of Functional Services should be someone with experience/background in both MH and SUD. This person will oversee the functional divisions, which each contain "silo" departments related to MH and SUD functions, will report directly to the Director, but also will have reciprocal reporting responsibilities to the Deputy Directors for MH and SUD.

Also reporting directly to the Director of DMHSUDS will be a Chief Operating Officer who is responsible for overseeing "Independent Functional Offices." These independent functional offices are responsible for functions that are or can be considered more or less independent of the MH and SUD disciplines. Examples include Administration and Human Resources, Information Technology (IT), Public Relations, Legislative Affairs, and Internal Audits. Finally, reporting to the Director of DMHSUDS will be a Medical Director who oversees MH and SUD services relating to the delivery of medical care, psychiatric care, and prescription medications.

Reporting to the Deputy Director of Functional Services will be the "Core Functional" divisions. Core Functional divisions will be responsible for functions that directly relate to the delivery of MH and SUD services. Examples of core functional areas encompassed by these divisions are finance and billing, licensing and regulatory oversight, information systems, quality assurance, and technical assistance. Within each of the core functional divisions, there should remain, in the beginning, a separation of functions—a distinction between those functions directly related to the delivery of MH services and to SUD services. Each of these core functional divisions should be managed by an individual with experience in that functional area who is also supportive of and committed to the longer-term goal of fully consolidating the core MH- and SUD-related functions.

Within each functional division, "Divisional Teams" should be formed. These Divisional Teams should be made up of an equal number of people from the separate functional departments (MH and SUD) within each division and chaired by the Division Manager. The teams will be charged with meeting regularly and developing and recommending action plans and strategies for merging the separate core functions within their respective divisions. These teams should have

direct reporting lines to the Deputy Director of Strategic Planning and Services Integration. These Divisional Teams also should be considered a tangible and defined part of the DMHSUDS organization—synonymous with organizational "departments or offices." The structure and objectives of the Divisional Teams should be clearly defined and documented, and the teams should appear on all published organizational charts of the DMHSUDS. The Deputy Director of Strategic Planning and Services Integration will be responsible for developing and overseeing a plan to gradually achieve a phased-in fully consolidated organizational structure over a period of 3–5 years.

Question 2: Should the Administration of SUD and MH Services be maintained at a Departmental Level or become a subunit "Division" within the Department of Health Care Services?

Charts 4 and 5 illustrate how the administration of SUD and MH services could be moved into DHCS, either as two separate entities or as a single consolidated entity ("Division").

Chart 4

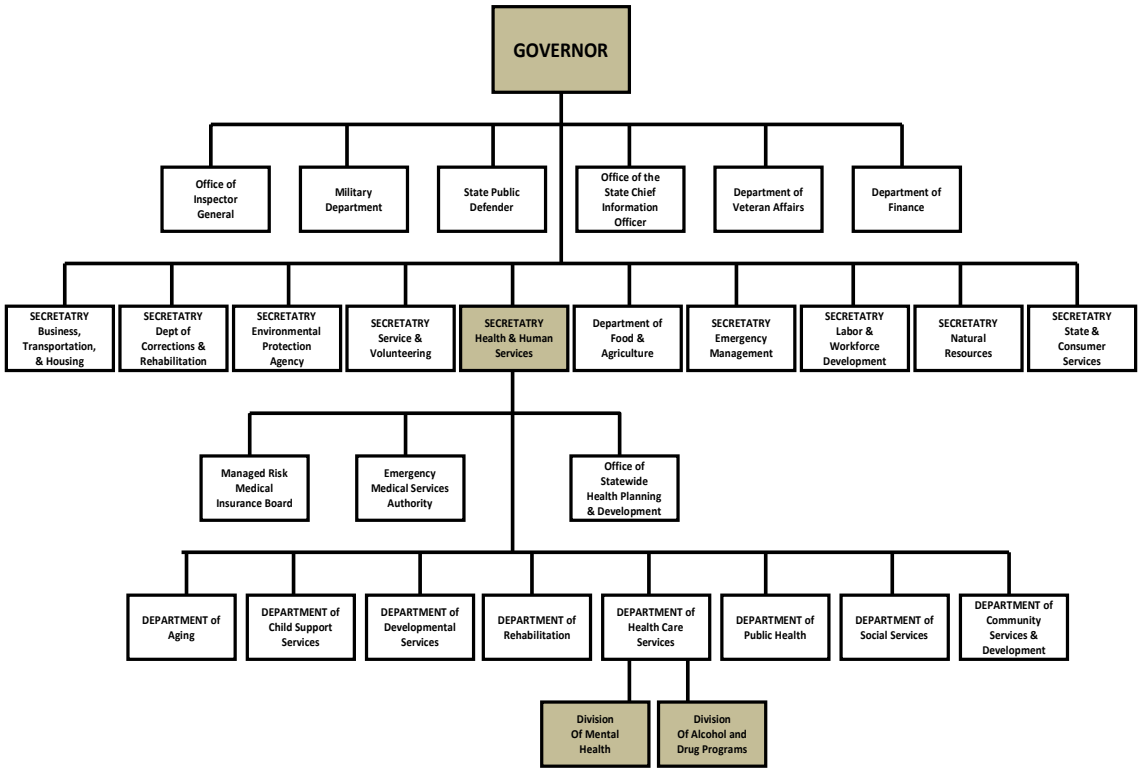
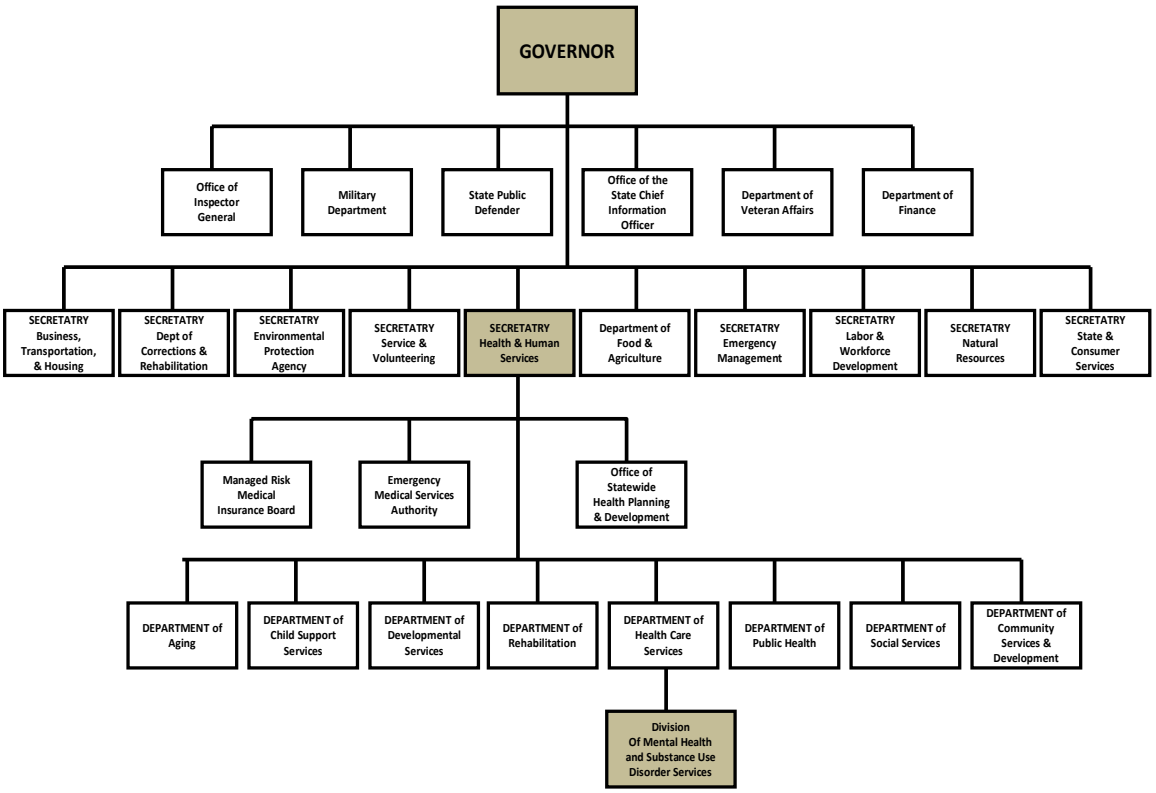


Chart 5



With either of these configurations, the Division(s) would have a Chief Deputy Director who reports to the Director of DHCS. If transferred into DHCS as a Division(s), the considerations about whether this should be a single consolidated Division or two separate Divisions are essentially the same considerations as described above under Question 1. In the following discussion of Question 2, we will assume they will be in a single Division.

Considerations that Support Maintaining the SUD and MH Administrative Entity at the Departmental Level

The primary consideration that supports maintaining the SUD and MH administrative entity at the departmental level is that MH and SUD services consist of a set of services for a largely disenfranchised group of people (consumers/clients) who suffer from severely stigmatized disorders and are treated in a highly specialized service system by a very specialized work force. The nature of MH and SU disorders is not well understood by the larger health care system, and the treatments used and the workforce who deliver the services are unfamiliar and poorly appreciated/recognized within the larger health care system. While the treatment of SU and MH disorders are clearly health care services, the MH and SUD service systems have unique relationships with the criminal justice, employment, educational, and social service systems. Issues that impinge on the delivery of care for SUD and MH services involve unique legal issues concerning patient confidentiality, responsibility/competence in decision-making, and the illegal nature of illicit drug use. For these and other reasons, it is argued that the MH and SUD consumers/clients and the systems that provide care for these consumers/clients require robust representation within the political structure. Without representation at the departmental level and a direct line of communication with the governor and the Secretary of HHS, the unique issues that influence the needs of the consumers/clients and the specialty care service system that has developed to meet their needs will lose support, resources, and necessary political advocacy.

Another benefit to maintaining the SUD/MH entity at a departmental level is the speed with which the organization can undertake initiatives to respond to funding opportunities and promote changes in the service delivery system. A report for NIDA found that when the administration of SUD services was located in a government agency that was many layers distant from the governor, it was far more difficult for the head of that entity to respond quickly to

funding opportunities and, consequently, there were many missed opportunities in these states. In the same report, it was also documented that evidence-based practices are being employed to a far greater extent in states where the entity is at a higher level in the government structure.[14]

Finally, there is a concern about moving a relatively smaller entity (the SUD/MH entity) into a much larger entity, a concern that is best conceptualized by the economics concept called "crowding out." This phenomenon comes into play when one structure that is small and idiosyncratic is merged with another structure that is much larger and has a different mission. When this occurs, the mission of the larger organization literally “crowds out” the concerns and particular needs and priorities of the smaller organization. In a number of the states in which the SUD and MH service administration has been merged into a larger administrative structure, the larger entity has failed to recognize the needs of the SUD or MH service systems and those systems have been negatively impacted. In Florida and Texas, when the SUD service administration was merged into a larger government entity, the unique reimbursement systems in place for SUD services were not maintained, resulting in long delays in provider reimbursement and ultimately in the loss of important and valuable service provider organizations.

In short, maintaining SUD and MH administrative leadership at a departmental level is viewed by many as necessary to maintain political influence and visibility in representing the interests of the people who suffer from SU and MH disorders and their families. By maintaining these functions at a departmental level, the specific service needs and challenges of providing care for individuals with SU and MH disorders and the providers who care for them can be most effectively addressed.

Considerations that Support Merging the SUD and MH Administrative Entity into the Department of Health Care Services

The considerations that support integration of the SUD and MH services into the Department of Health Care Services fall into essentially two categories: (1) those that can potentially increase efficiency, reduce duplication of effort, and harmonize practices of the SUD and MH entity within the larger DHCS system, and (2) those that promote the integration of SUD/MH services into the broader health system.

The transfer of ADP and DMH administrative functions into DHCS has the potential for many of the idiosyncratic systems and practices in DMH and ADP (e.g., billing, reimbursement, licensing, data, etc.) to be integrated into the larger health care delivery-system frameworks in California. While the potential for savings and increased efficiencies is attractive, the challenge will be to accomplish this integration in a manner that does not create hardship and cost to the SUD and MH service providers. For example, the establishment of a single data system across all aspects of the California health service system could be a major advancement in promoting a health care system that can operate with fully informed data-based decision-making. As seen in the State of Washington, there is a wealth of data that can be used for policymaking and priority setting when a single data system is used across state entities. This is currently not the case in California due to its separate and incompatible discipline-specific data systems. However, the development of a single integrated data system has to be done with an awareness that the data needed for purposes of federal reporting, epidemiology, performance measurement, etc., are different across disciplines. Therefore, although a common data platform can offer tremendous benefits, it has to be done with each discipline having the capability to collect the specific data needed to meet federal data obligations and effectively measure the impact of services delivered.

As preparations for the implementation of the Affordable Care Act in 2014 move forward, there is a major push to integrate SUD and MH services into primary care. As discussed in Section IV of this report, it is evident that the segregation of SUD and MH services has contributed to a minimal connection between the SUD/MH service systems and the broader health care system. In many parts of California, SUD and MH providers are only now starting to familiarize themselves with the broader world of Federally Qualified Health Centers (FQHCs), health care homes, accountable care organizations, etc. As a result of being separated by departments, with little contact with DHCS, SUD and MH priorities have not developed collaboratively with the broader health care system. For example, data from the ADP CalOMS system indicate that only 3% of the individuals who were admitted into SUD care in 2009 were referred into SUD care by a health care professional. The world of primary medical care has had little contact with and little knowledge of the MH and SUD systems. In many parts of the broader health care delivery system, there is very little awareness and appreciation of the value and benefits of SUD and MH care in reducing overall health care costs. During the recent 1115 Waiver process, the fact that SUD services were excluded from the covered benefit is an indication of the lack of recognition and awareness of how SUD services can benefit overall health. It is possible that moving the functions of ADP and DMH into DHCS will facilitate a greater integration of SUD and MH services into the broader health care system.

In summary, ADP and DMH have developed policies and practices over the past 3 decades that have resulted in service systems that deliver a diverse set of specialty SUD and MH services to millions of Californians. As independent departments, their access to the highest levels of California government has allowed them to effectively educate policy makers about SUD and MH issues and advocate for their consumers and service providers. They have

developed unique and important relationships with other California governmental departments to implement complex major initiatives (e.g., Prop 36 and Prop 63). They have developed department systems to license, monitor, fund, and implement evidence-based practices, and they have been able to rapidly take advantage of SUD and MH funding opportunities because of their independence. They have both developed institutional expertise in these specialty areas, and their knowledge of their services systems is comprehensive. By remaining as independent departments or as a single consolidated entity, many of these strengths will be retained.

However, the segregation of ADP and DMH has led to the development of many idiosyncratic and suboptimal systems and circumstances. The fact that it is not possible to look into a single data system and see the full array of health services received by an individual (including SUD and MH services) is an impediment to effective and efficient health care.[57] The fact that most primary care heath service settings and professionals do not have the knowledge or capacity to detect or treat individuals with SU or MH disorders, or appropriately refer them for specialty care, is one consequence of the separation of SUD and MH services into different departments. As California re-engineers its health care system for 2014 and develops health care practices that promote patient-centered care, the placement of SUD and MH services within DHCS could have substantial benefits for promoting service and system integration efforts.

X. Considerations for Reorganization

As of the writing of this manuscript (August 1, 2011), the circumstances in Sacramento and Washington DC, suggest that over the next 12 months there will be significant changes in how SUD and MH services are funded and administered. For a variety of reasons, it appears that for the immediate future, it is unlikely that it will be "business as usual" at ADP and DMH. As discussed above, there are a number of ways that the oversight of SUD and MH services can be configured and located. Regardless of which of these options are selected, there are a number of factors that will be critical to sustaining a viable service system in California for SUD and MH services and for meeting the anticipated challenges of the changing health care environment. These include:

Effective Leadership

The quality of leadership is particularly crucial during periods of major change. Effective leadership legitimizes, reinforces, and communicates the urgency for change and recognizes the benefits and opportunities inherent in the current and emerging environmental realities. Regardless of whether DMH and ADP are consolidated, merged with DHCS, or both, it is clear that the financing of SUD and MH services, the services provided, the venues of service provision, and the types of personnel providing services is likely to change over the next several years. It will be imperative that the future leadership for SUD and MH services in California promote these changes and be proactive in preparing for change. The leader(s) of SUD and MH entities (consolidated or not) will need to be a senior level, very experienced individual(s), who, if not a Department Director, should be at the Chief Deputy Director level within a merged department. It is imperative that the leadership position for these functions have excellent access to decision making and that a salary is provided that will attract candidates with the necessary

experience and skills. It will be essential that this individual, or these individuals, develops a vision and mission that are congruent with the larger changes in the "big picture," and that this vision and mission are effectively communicated to his/her department/office. It will be critical for the leader(s) to solicit stakeholder input on planning and implementing organizational change,[76] take stakeholder participation seriously, and commit the requisite time and effort to manage change effectively. Further, it will be important to recognize that the "stakeholders" in the future of SUD and MH services will not be limited to only the traditional SUD and MH stakeholder groups. As the future of SUD and MH services will involve a far greater integration with the broader health care system, including primary care, it will be important for the future leadership to effectively engage decision makers in the health care system in shaping the future of SUD and MH service delivery. As a result of these realities, the future leadership of SUD and MH services will need an appreciation of the role of SUD and MH services within the health care system and how to effectively navigate the complex and evolving fiscal, administrative, and regulatory health care systems, and develop positive, collaborative relationships within this vast new health care landscape.

Leadership within a Consolidated Entity: If there is a consolidation of the functions of ADP and DMH into a single entity, the lessons from other states should be carefully considered. A repeated theme in our interviews with other state leaders and with experts on this topic is that in a consolidated SUD/MH entity (aka "Behavioral Health") it is essential that the director of this entity has an understanding of the distinctive needs of the SUD and the MH areas. We repeatedly were told that if SUD services were subordinated to MH services (i.e., SUD disorders are simply one form of the larger category of MH disorders), there would be serious negative consequences to the state's SUD service capacity.

The most common problematic scenario for a leadership choice in a consolidated SUD and MH entity is when a person with experience and expertise in the treatment of MH disorders is placed in the leadership position and they have no awareness of the nature of the SUD service system, the evidence-based practices developed via the science funded by NIDA and NIAAA, the methods used to evaluate services, the elements of the continuum of care and how the concept of "addiction as a chronic illness" has changed service delivery, etc. It is critical that the leader in a consolidated MH/SUD entity understands the field of SUD services, is aware of the empirical evidence base that has been created to guide the development of the service system, and respects the service system that has evolved to meet the needs of individuals with SUD. From all of our research, it was universally recommended that the director for the consolidated entity have experience in the worlds of SUD and MH services and a firm commitment to building a service system that will meet the needs of Californians who have SUD and MH disorders and/or complex combinations of these disorders.

Leadership in an Entity Merged into DHCS: As the fields of SUD and MH services both become increasingly aware of the importance of integrating services into primary care, there is a rapidly growing appreciation for becoming part of the larger health care system and moving out of the small "silos of care" developed for SUD and MH service delivery. The merger of ADP and DMH functions into DHCS potentially could facilitate this integration effort. However, within this very large and very complex health care environment, the leadership of a consolidated SUD/MH entity within DHCS will require some additional skills and perspectives.

As we understand the organization of DHCS, it appears that the leader of a consolidated SUD/MH entity within DHCS, should be at the level of a Chief Deputy Director, with individual Deputy Directors over the SUD and MH functions as described above in Section IX. A Chief

Deputy Director-level position will be needed to ensure that an experienced, senior level individual can be attracted into this position and that he/she will have adequate access to the Director of DHCS. The person leading the new entity will face challenges to create a new culture, ensure maintenance of the existing service system, and address the many barriers and opportunities forthcoming in health care reform implementation activities.

It will be essential that the Chief Deputy Director of a consolidated entity, merged into DHCS, has a thorough understanding of the world of Medi-Cal, insurance reimbursement, managed care, and the larger world of health care services. Because of the timing vis-à-vis the Affordable Care Act, the new Chief Deputy Director will have to understand the cultures and service systems of MH and SUD, but he/she will also have the responsibility of aligning SUD and MH services with the broader health care system. Further, he/she will need to be able to effectively communicate to the DHCS leadership the tremendous benefits that SUD and MH services have in improving the overall health of consumers and reducing the overall cost of health care. The director will have to allay the anxieties of building collaboration and trust between the SUD and MH service stakeholders, while at the same time, equipping the new entity with the tools to move these services into greater integration with the primary health care system.

Creation and Promotion of a Shared Culture and Vision

If an ADP/DMH consolidation and/or merger into DHCS occurs, the leadership of the new entity will need to articulate a vision that promotes the potential synergistic effects of (or the value added by) the consolidation/merger. To that end, the development and dissemination of a compelling vision statement relating to what can be accomplished within the new entity will provide staff throughout the entity with direction, facilitate the development of specific goals and strategies for overcoming identified obstacles to achieving the vision, and strategically position

the newly formed entity to meet future challenges and take full advantage of opportunities for innovation. From the establishment of this new entity, there should be clear acknowledgment that MH and SUD services are an integral part of the overall service mission of California's Health and Human Services Agency. They are not to be viewed as isolated "silos of care" that only deliver specialized services from a narrow specialty care system. Rather, the services overseen by the new entity should be viewed as being integrated into California's broad health care system, and therefore beneficial to the health and well being of the citizens of California (not just those with severe drug and alcohol problems).

Experts were very emphatic that the development of a new collaborative and synergistic culture requires effort and planning. Bringing thought leaders from within the existing ADP and DMH will be critical in transferring institutional memory into the new entity. DMH and ADP leadership is needed to prioritize specific components of the change process and develop integrated teams to begin building new integrated methods of functioning. Having clear metrics, agreed upon by the integrated teams for measuring progress toward accomplishment of specific components of system integration, will be important to show progress toward the creation of a new integrated culture and procedures. Public acknowledgment of the successes of integration by the entity leadership will be instrumental in promoting positive change.

Support

An important characteristic of a successful consolidation of the functions of DMH and ADP and/or merger into DHCS will be the sustained support from governmental leaders (e.g., governor, legislature) and key external stakeholders for the newly formed entity, especially those stakeholders who can impose statutory changes and control the flow of vital resources. It will be essential that funding for MH and SUD services under the new entity is truly at "parity" with

other health services. It will be important that future contractual agreements between the State of California and the federal government and between the State of California and fiscal intermediaries fund SUD and MH services at levels that are equivalent to other mainstream health care services. The exclusion of SUD or MH service coverage from any form of health care coverage agreement should be avoided. We reiterate our suggestion that leadership at a high level (i.e., Department Director or Chief Deputy Director) for the SUD and MH functions will be needed to ensure that effective strategies are developed to maximize service financing opportunities.

Financing and Benefit Design for SUD and MH Services

Historically, the funding for SUD services in California has primarily come from federal block grants, with Medi-Cal (a specialty benefit referred to as "Drug Medi-Cal), CalWorks and county funds serving as other sources of funding. Plans for the implementation of the Affordable Care Act include an expectation that Medi-Cal will play a much larger role in the funding of SUD care in California and that use of block grant funds will need to be restructured to fund non-medical services ineligible for Medi-Cal reimbursement. There are many considerations involved with this paradigm shift. What will be the basic federal benefit for SUD services under Medicaid? Will "Drug Medi-Cal" continue to exist as a specialty program? How will plans for managed care interface with these benefits? Will California consider a rehab option for its SUD benefit? How will the funding of non-medical services using block grant funds be done and how will the interface between block grant and Medi-Cal funds be structured and monitored?

The new leader(s) of the SUD and MH entity in California will need to be familiar with the historical funding mechanisms and state and federal regulations, and have working relationships with funding leaders at SAMHSA and the counties. There are opportunities for

obtaining funding for services in California that will require creativity and an awareness of new federal programs and practices. As the oversight of SUD and MH services in California are reorganized, it will be essential for the leader(s) to have a thorough grounding in these specialty topics and a recognition of his/her responsibility to optimize funding for SUD and MH services in California.

Integration of SUD and MH Services with Primary Care

As described in Section IV above, the service agencies in California for individuals with severe mental health and substance use disorders each developed its own idiosyncratic "silo" of care, with its own treatments, service providers, and financing mechanisms. There was relatively little interaction between the MH and SUD silos of care and almost no interaction with the larger health care system. With the passage of the Affordable Care Act and the recognition that integrated health care services provide better and more efficient health care, there has been a very dramatic increase in efforts to integrate SUD and MH services into primary care and a wide range of other health care settings. Many county SUD treatment providers have already begun integration initiatives in their respective communities. There are various examples of SUD providers working with local community health centers, including FQHCs and other primary care providers, to integrate SUD screening, intervention, referral, and/or treatment into primary care settings, and to integrate primary care into SUD specialty care settings.

The most commonly cited barrier to SUD/PC integration in California is inadequate funding. Twenty-three of the 25 county systems that have begun to integrate SUD and PC services reported that financing integrated care was a major barrier. There are a variety of regulatory issues that obstruct integration efforts, including Medicaid regulations that do not allow FQHCs to bill for physical health and behavioral health services provided to one individual

on the same day and special confidentiality regulations around SUD and MH patient records. Clearly, the leader(s) of the entity for SUD and MH functions in California will play a major role in creating a major paradigm shift for the future of SUD and MH services in California. This will require an awareness of the tremendous opportunities for SUD and MH services to contribute to reducing the overall health care burden in California by moving into new settings and addressing new patient needs, while at the same time maintaining the system of essential specialty care of individuals with severe MH and SUD disorders.

Prevention Services

Another area that requires consideration is the appropriateness of placing alcohol and other drug (AOD) prevention services within the consolidated and/or merged ADP/DMH entity. The administration of AOD prevention services in California is currently a function of ADP, with the primary source of funding being the approximately $50 million of federal block grant funds. Currently, prevention activities are delivered either directly by the counties' alcohol and drug program offices or via contracts with community agencies. Despite efforts to bridge services and programs between prevention and treatment, there has been considerable difficulty in creating linkages and synergies between the two fields. Treatment services for individuals in need of serious medical/psychosocial treatments and prevention activities have very substantial differences in approaches, funding mechanisms, priority populations, workforce requirements, etc. As a result, in many counties there is very little overlap between treatment and prevention providers and activities, creating a fragmented and suboptimal effort.

There is a rapidly developing science of disease prevention and health promotion, with the hub of this work being led by the federal Centers for Disease Control (CDC). There is an increasingly accepted view that to produce maximal impact with the greatest efficiency, disease

prevention efforts are best viewed from the broad public health perspective employing approaches that cut across disease categories. We interviewed a representative of the Office of Community Health and Prevention within the Illinois Department of Human Services, who described the model used in Illinois in which all aspects of health promotion and disease prevention activities were coordinated though this government agency. It was the strong impression of this individual that it was far easier to create synergies across these public health activities than it had been to bridge the gap between alcohol and drug treatment and prevention efforts. Other experts we consulted also strongly supported the idea that the placement of AOD prevention services within the same organization that conducts tobacco use prevention activities should be considered. In California, tobacco control and prevention activities are located within the Department of Public Health.

Currently there are some existing constructive partnerships between ADP and the Department of Public Health that have created a foundation of positive working relationships and organizational collaborations. The AOD prevention arena has a culture and promotes a set of activities that may more closely align with the public health field than the health care delivery field. As has been successfully done by a number of other states, consideration of merging AOD prevention services into the Department of Public Health (DPH) may offer a more appropriate and effective home than the treatment-focused DHCS. Due to the complexity of this consideration, it is mentioned within this discussion as another area that requires more study and discussion.

Communication with and Engagement of Stakeholders

A communications and information dissemination strategy regarding the consolidation/merger is essential. Frequent, consistent, and regularly scheduled communications via multiple dissemination channels and with all those involved in or affected by the consolidation/merger is of paramount importance, both at the beginning and throughout the planned implementation of the new entity. This can be accomplished via regularly scheduled meetings or forums for stakeholders to raise concerns and receive answers to frequently asked questions. Departmental newsletters and webinars that provide updates and reinforce the new entity's vision and mission, and annual conferences featuring respected leaders from both the MH and SUD fields who focus on themes reflecting the new entity's overall mission and objectives can also be effective.

Regulations, Licensing, and Certification

The regulations instituted for a system of specialty SUD treatment will not be appropriate for a SUD and MH system oriented to coordinated and integrated care with the primary care system. If ADP and DMH functions are consolidated and/or merged into DHCS, the regulations governing these once independent systems will provide many obstacles to achieving the vision of consolidated services that are integrated with primary care. Titles 9 and 22 in the California Code of Regulations govern the facilities that deliver SUD treatment. Some provisions in these regulations are major obstacles to the delivery of evidence-based practices and integrated care. As part of the reorganization of SUD and MH services, revision of these regulations will be an important element to the success of a newly reorganized entity within DHCS.

There is tremendous overlap, duplication, and inefficiency in the processes to license and certify the facilities that deliver SUD and MH services. State and federal agencies license and

certify facilities to ensure that safe, reliable, and approved services are delivered to the public in an appropriate and equitable manner. The current processes by which facilities delivering SUD and MH services are licensed, certified, and monitored need to be reexamined to establish procedures that are more efficient and consistent with national standards. One example is the licensing of narcotic treatment programs (NTPs). Currently, there is a national accreditation process that provides federal oversight of these specialized facilities. At present, the California ADP is required to conduct costly and redundant state audit visits, which add nothing to assuring the quality of services. The streamlining of these processes will reduce the workload and cost to service providers and lessen the workload and cost to California taxpayers for oversight responsibilities. Currently, DMH licenses Mental Health Rehabilitation Centers (MHRC) and Psychiatric Health Facilities while certifying Community Residential Treatment Systems (CRTS), Community Treatment Facilities (CTFs), and Special Treatment Programs (STPs). CRTS and CTFs are licensed by the Department of Social Services (DSS) and STPs are licensed by the California Department of Public Health. ADP has the sole authority to license any facility providing 24-hour residential nonmedical services and Narcotic Treatment Programs and provides voluntary facility certification to both residential and nonresidential programs. As a result of these overlapping and often conflicting regulations, providers of SUD and MH services must manage reporting responsibilities to demonstrate compliance to diverse and frequently contradictory standards and requirements. As the movement toward service integration moves forward, it will be critical to better align regulations and remove duplication and redundancy while maintaining high standards of quality services.

Plan for Workforce Development

The services provided for the treatment of SU and MH disorders require a very specialized workforce, unique in the health care system. The MH workforce has long struggled to find an adequate number of licensed and trained clinicians with the skills needed to work within California's publicly funded MH service delivery system. Although these challenges are substantial, for the SUD service system, the workforce situation is far more problematic. The process to become a certified SUD counselor is markedly different from the requirements needed to be a certified MH clinician, and the standards to be a working professional in the SUD field are not at par with the MH field.

California's current "system" for certifying "counselors" is one of only two state systems that do not have a requirement for licensed SUD counselors (Mississippi is the other). There are nine organizations responsible for registering and certifying SUD counselors, all using a different set of standards, many of which are seriously out of date and not reflective of evidence-based practices. At a recent meeting on the SUD workforce needs for the future, California was singled out as the state with the most dysfunctional counselor certification/licensing process. The current reorganization discussion presents an opportune time for the SUD system to modernize its workforce licensing process to ensure that the SUD workforce is qualified to work in a 21st Century health care system.

Health Information Technology/Data Systems/Performance and Outcome Evaluation

The move toward electronic health records and integrated data systems is clearly part of the near future for all health care services. At present, the data systems used by DMH and ADP are very different, each having strengths and weaknesses. Currently the MH system has data that provides detailed documentation of the services received by the patients who receive treatment.

The SUD treatment system has an excellent data system for tracking substance use trends in the community to guide service development and for measuring the performance of treatment organizations and outcomes resulting from treatment services. If SUD and MH functions are consolidated, this is an excellent opportunity to standardize data requirements drawing on the strengths of both data systems. Further, if ADP and DMH functions are merged into DHCS, it will be an opportunity to integrate the data systems with the larger health care data system in California.

At present, the SUD field has federal data requirements that are part of the federal block grant requirements. ADP has used these data to develop performance algorithms that allow for qualitative assessment of service providers and assessment of county service systems. Further, these data provide a foundation for measuring patient/client outcomes, allowing providers to improve services. As empirical data becomes more important for demonstrating effective and quality services, both the MH and SUD fields will need data systems that provide accurate and timely information.

Phased Approach

A common theme that emerged from our interviews with individuals from other states was the importance of adopting a phased-in or gradual approach to consolidating the core functions and policies common to both MH and SUD entities (e.g., licensing, regulatory oversight, services reporting, finance/billing) and merging these into a larger health care system. At least at the beginning, these core functions should retain a sufficient level of autonomy within the newly formed entity to ensure uninterrupted services, sustained focus on priorities, purpose, and mission, and the retention of experienced staff.[14] A plan, including a timeline with specific expectations and benchmarks, should be developed to guide the integration of the core MH and

SUD functions into a single system, with staff cross-trained to be able to function within the context of the SUD or MH system. With cross-trained staff and proper technical assistance, the end-goal of this process would be to have an integrated set of core functions.

Summary

The successful consolidation of ADP and DMH and/or the merger of their functions into DHCS (if undertaken) will require substantial time and an active planning process with strong leadership and clear vision. Effective leadership and management of the process will be crucial to promoting "psychological ownership," reducing and overcoming obstacles to organizational change, and facilitating the communication of a vision for a new entity with a new mission and goals. Considerable attention will be needed to revise current regulations and licensing and certification requirements that impede an integration of services. The development and alignment of standards within the SUD/MH workforce will also be essential to producing a qualified cadre of professionals to deliver SUD and MH services. The unification of data systems that currently manage performance and outcomes data in existing systems will also reduce the segregated delivery of services. A phased approach to all of these processes will avoid a disruption and delay in services that could result from abrupt and impulsive change. All of these considerations will be instrumental in determining whether reorganization results in more efficient and effective leadership and oversight of SUD and MH services in California.

XI. Recommendations

The following recommendations are based on a synthesis of the information collected for this report.

- Create a Division of MH and SUD Services (DMHSUDS, or DSUDMHS) within DHCS, led by a Chief Deputy Director, who reports to the DHCS Director and is confirmed by the Senate. This person needs extensive experience in the administration of SUD and MH services, and needs to understand the MH and SUD specialty care service delivery systems and the forthcoming challenges in the implementation of the Affordable Care Act.

- Within the DMHSUDS, establish two Deputy Division Director positions. One Deputy Division Director will oversee SUD services and one will oversee MH services. These individuals should have extensive experience in program oversight within their specialty care system. In addition, as discussed in Section IX, a 3rd Deputy or Branch Chief should be considered who would oversee the integration of SUD and MH services and promote a future Division within DHCS with a fully integrated SUD and MH service system.

- Bring consultants to California who have been involved with the consolidation of SUD and MH services and the merger of these services into larger health care agencies in other states. Knowledge from these consultants will provide California with expertise from states that have completed such transitions and help California develop an optimal organizational structure to promote necessary health care innovations and full integration of these services into primary care.

- As Drug Medi-Cal and other ADP and DMH functions are merged into DHCS, it will be critical for DHCS to move into service a fully adequate cadre of ADP and DMH staff who are knowledgeable and skilled in the functions needed to ensure continuation of critical Medi-Cal claims payment functions, program quality, monitoring and auditing functions, data system and performance management functions, licensing and certification functions, research, evaluation and technical assistance functions.

- Immediately establish an "action workgroup" for analysis and implementation of recommendations coming from the DHCS ongoing stakeholder process convened / continued under AB 106 and the Plan, as well as providing coordination of Medicaid services with other state and federal funding streams available for AOD/SUD services, treatment and recovery. This workgroup, which will provide leadership on a revised plan for the use of finances for SUD and MH services in California and report to the Division Chief Deputy Director, will address the following issues: Medi-Cal benefit revisions (including consideration of moving to the Medicaid Rehab option, the addition of Suboxone and Vivitrol as treatment medications, activating the SBIRT codes, and reimbursement of other evidence-based practices).

- A significant portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds should be used to support housing and other recovery support services that are not supportable with Medi-Cal funds.

- In preparation for implementation of the Affordable Care Act, establish a workgroup to develop a process of planning and technical assistance to maximize the successful "no wrong door" integration of SUD, MH, and primary care (i.e., patients entering the system for any one of these concerns will easily find care for concerns from the other two areas). This workgroup should be informed by current recognized national efforts (using documents developed by the Treatment Research Institute and by the Center for Integrated Health Services) and ongoing California integration efforts (currently being organized by UCLA and California Institute of Mental Health).

- It should not automatically be assumed that alcohol and drug prevention services should be placed together with SUD treatment services. Careful study, analysis, and public input should be solicited about where the administration of alcohol and drug prevention services should be located. Consideration should be given to moving the oversight of alcohol and drug prevention services (and the administration of $50 million of Block Grant Prevention money) to the Department of Public Health.

- Establish a work group to develop a plan for a unified data system for SUD and MH services that will contain the strengths of both of the data systems (i.e., DMH's data collection system captures units of service delivered at the client level, whereas ADP's data system complies with critical federal data requirements and provides data for outcomes and performance measurement). This data system should be integrated within the larger DHCS data system architecture.

- Establish a transition plan to create a counselor certification infrastructure in which there is a single counselor certification/license under the DMHSUDS. Ensure that this certification/license emphasizes evidence-based information and promotes skills that will be of use as SUD and MH services are integrated with primary care.

- Establish a plan to harmonize licensing and regulations for SUD and MH service delivery sites to promote the delivery of, and identify obstacles to, integrated SUD and MH services. Further, refine these licensing and regulations to ensure provision of MH and SUD services within primary care services.

- Hold an extensive set of community stakeholder meetings led by DHCS and DMHSUDS leaders to explain the new structure and solicit input for considerations about how to best promote success of the new organization. Conduct extensive outreach to bring together in the same meeting, stakeholders from SUD, MH, and primary care service provider systems as well as consumers from these systems.

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