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Coordination of Alcohol, Drug Abuse, and Mental Health Services

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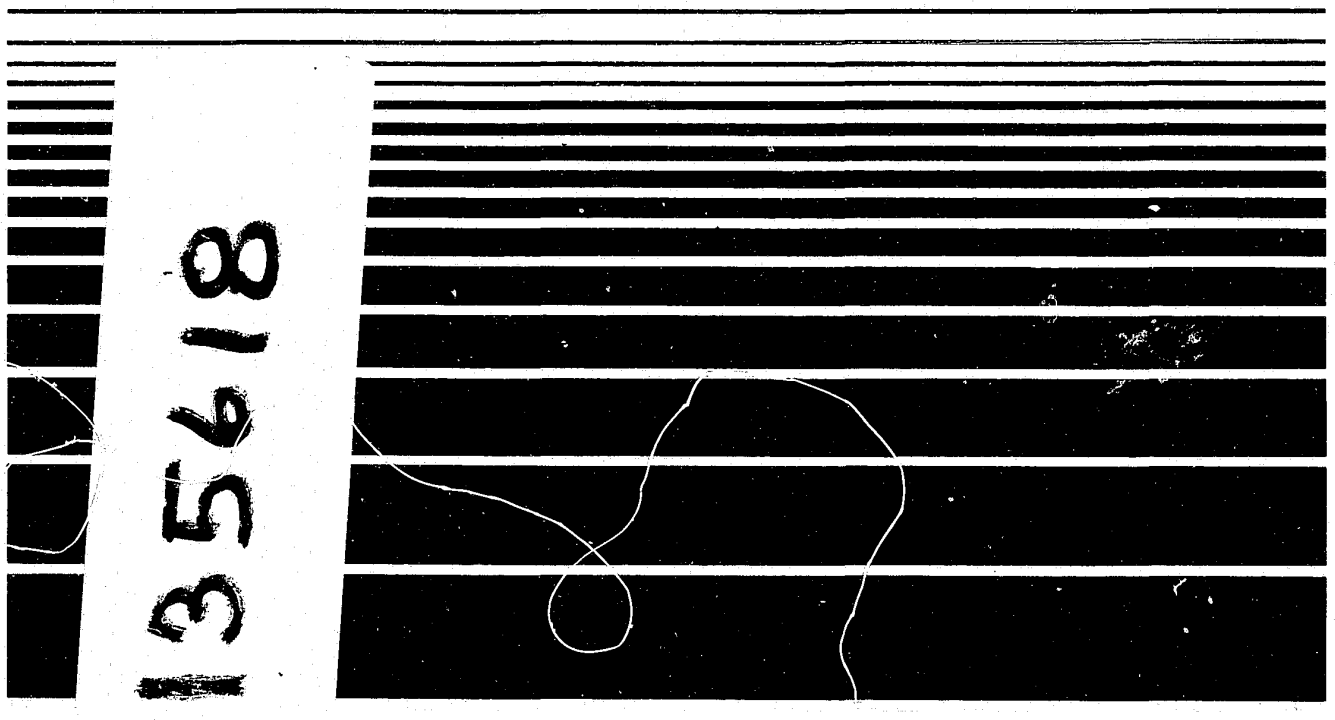

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Frank Baker, Ph.D.

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Foreword

The treatment philosophy of the Office for Treatment Improvement (OTI) is based on the observation that there are a host of environmental, physiological, and psychological factors that contribute to the onset and maintenance of addiction. The incidence of physical disease and infection, including tuberculosis, bacterial pneumonia, the human immunodeficiency virus (HIV/AIDS), gonorrhea, syphilis, and other sexually transmitted diseases is extremely high among the addicted, especially among racial and ethnic minorities.

Mental and emotional disorders, such as schizophrenia, depression, antisocial behavior, and cognitive disorders, to one degree or another, are clinically indicated in a large proportion of patients who seek treatment for chemical dependency through public channels in the United States. Anecdotal evidence points to the fact that as many as 60 percent of patients diagnosed with an addictive disorder also suffer from some form of mental illness.

Moreover, addicted individuals tend to experience high rates of social and economic dislocation, such as homelessness, poverty, unemployment, child abuse, abandonment, divorce, and poor academic performance.

The research literature points again and again to the fact that an individual's addiction cannot be treated in isolation from addressing his or her physical, mental, emotional, and practical needs. Just as importantly, there is a vast amount of research knowledge which points to the chronicity of the complex bio-psycho-social disease phenomenon known as addiction. OTI therefore asserts that patients should be provided with a broad array of primary health, mental health, economic, vocational, and educational services, as needed over a sustained continuum, in order to ensure recovery.

OTI advocates that a patient's bio-psycho-social needs be concisely assessed at admission to treatment and at intervals during the course of treatment, and a treatment protocol designed that will properly address each and every patient need.

The components of the nation's health and social service delivery systems are often constrained by autonomous facilities, resources, and support policies that create obstacles to the successful coordination of services to those in need of comprehensive, integrated care. States and service providers therefore have a need to understand these operational and practical constraints in order to effect coordinated, comprehensive services for individuals affected with multiple disorders.

The Office for Treatment Improvement requested the development by Dr. Frank Baker of this report on the coordination of ADM services, in order to provide an overview of this topic to the field. This report contains a historical perspective, discusses the multiple needs of individuals with co-occurring mental health and addictive disorders, presents specific coordination mechanisms, and makes recommendations for future directions in this area.

I hope you find this report to be a valuable resource in your efforts to provide effective, comprehensive treatment to persons suffering from addiction to alcohol and other drugs.

Beny J. Primm, M.D.
Associate Administrator for
Treatment Improvement

Executive Summary

The primary purposes of this report are to review current knowledge about coordination of alcohol, drug and mental health (ADM) services, to describe the major models and mechanisms available for this purpose, and to make recommendations regarding the process of developing coordinated ADM services. The sources of information drawn upon for this document are the published literature, discussions with ADAMHA staff, telephone interviews with people knowledgeable about coordination, and meetings with State ADM representatives.

The report is organized in six chapters. Chapter 1 is a brief introduction, followed by chapter 2, a historical overview of previous attempts to coordinate services. Chapter 3 discusses the multiple needs of patients with ADM disorders that make it necessary to coordinate services for them. Incorporating the suggestions of the members of the April conference, the characteristics of the dual diagnosed are used to illustrate the complexity of serving individuals whose needs cross the boundaries of categorical programs. Chapter 4 defines coordination and provides some related concepts and some working principles of services coordination. The core chapter of the report is chapter 5, which presents specific mechanisms and models of coordination and offers case examples to illustrate them. Chapter 6 presents recommendations for the future.

There are a number of reasons for attempting to develop coordinated services. Early attempts to coordinate services in the United States can be traced back at least 100 years. During the 1960's and 1970's, the rapid expansion of human service programs in general, the deinstitutionalization of the mentally ill, the increase in substance abuse, the funding of programs through many different public and private sources, and a variety of other professional, community, and social factors resulted in a set of highly complex, fragmented, duplicative, and uncoordinated services. Many separate programs provide specialized services to narrowly defined target groups. While this fragmentation of services interferes with accessibility for all potential users, it is particularly burdensome for those who require help from multiple programs. Individuals and families who have alcohol, drug, or mental health problems often require a wide range of services (e.g., health, mental health, public welfare, corrections, employment, housing). Persons with mental disorders that co-occur with alcohol and/or drug abuse disorders, the so-called dual diagnosed, illustrate the need for coordinated services for populations whose problems cut across the existing categorical service structure.

In defining coordination, it is helpful to begin by defining two related concepts: continuity of care and integration of services. Continuity of care is focused on the patient level and refers to maintaining a chain of professional responsibility as a patient moves from one program to another to receive needed services. Continuity of care has been identified as having two kinds of dimensions and goals: cross-sectional, so that the services provided to an individual at any given time are comprehensive and coordinated; and longitudinal, so that the system provides comprehensive, integrated services over time and is responsive to changes in the person's needs. The longitudinal dimension is particularly critical when case management systems serve populations whose disabilities are both significant and lifelong.

By contrast, services integration focuses on the organizational level and refers to the attempt to bring agencies and programs into a single system. Coordination is also concerned with the attempt to bring together the agencies and programs that deliver human services in the community, but it differs in that it implies recognition of the integrity and autonomy of separate organizations that are attempting to find ways to work together without giving up any more of their individual autonomy and control than necessary.

Operationally, coordination is defined by certain assumptions:

- Coordination is one form of interorganizational relations.
- Organizations are motivated by the need to obtain resources

(money, personnel, support, recognition, patients, information) necessary to achieve their goals, and engaging in interorganizational relations is often viewed as a means to obtain these resources; however, it can also be seen as a means to fragment them, through loss of control over existing resources.
- Organizations need to control their environment, and coordination is a way of achieving control over uncertain environmental conditions.
- Two or more organizations engage in efforts at coordination when the organizations perceive mutual benefits or gains from interacting, or when at least one is motivated to establish a relationship and powerful enough to force the others to interact.

The following working principles seem consistent with the experience of those attempting to coordinate ADM services:

1. Services coordination is usually a slow, evolutionary process.
2. Services coordination is primarily a consensus-building process.
3. Organizational changes do not necessarily lead to services coordination.
4. Successful service coordination depends on the leadership and talents of responsible individuals.
5. Service coordination may reduce short-term costs, but other funding incentives are crucial.
6. Perception of benefit by service providers from services coordination is crucial.
7. At the delivery level, effective coordination requires shared information systems.
8. A common services strategy for State and local governments facilitates services coordination.
9. Formal interorganizational agreements facilitate the coordination process.
10. Being responsible to a common superordinate authority facilitates coordination.
11. Linkages may be likely to be adopted outside major urban areas, but comprehensiveness is difficult to achieve.
12. Travel times that exceed 45 minutes seem to interfere with coordination between agencies.
13. Efforts to develop the sharing of an ideology that supports coordination appear worthwhile.
14. Relevant training and continuing education are necessary for staff dealing with patients, as well as for their supervisors, in a newly coordinated system of services.

A number of specific mechanisms and models for coordination are available, each with its own particular advantages and disadvantages. These are listed in table 5-1, and case examples of each are presented in the text of chapter 5. These different ways of coordinating services are as follows:

1. Colocation—placement of the deliverers of services from a number of different agencies in the same physical setting.
2. Information and referral—a system for directing people needing assistance to agencies that meet their needs.
3. Centralized intake and referral—provision of a single point for access to a full range of services.
4. Interagency networks—a specific set of linkages among a defined set of service agencies. There are three types:
   - multidisciplinary team—provision of multiple linked services through the inclusion of different service professionals on a team;
   - bilateral coordination—two agencies working together; and
   - multilateral coordination—multiple agencies developing agreements to work together.
5. Case management—a method or process for ensuring that patients are provided needed services in a coordinated, effective, and efficient manner through the use of a case manager and core service agency.
6. Sharing staff—an arrangement through which two or more agencies share the services of the same staff.
7. Financing models—use of funding arrangements to encourage coordination such as incentive programs, strengthening local entities to manage funding of services, and capitation of funds.
8. Education and training—conferences, seminars, educational forums, professional training programs, and other types of instructional approaches offer a means of teaching the value of coordination.

A number of recommendations can be made for how to choose coordination mechanisms, including matching the approach chosen to the specific goals for coordination, to the specific environmental context, to the resources available, to the developmental stage that has been achieved, and to the results of evaluative feedback. In developing coordination, six steps are recommended:

1. Assess the current environment.
2. Build support for coordination.
3. Design a coordination program.
4. Implement the program.
5. Evaluate the program.
6. Adjust the program and build sustainability.

Coordination is not automatically good and lack of coordination bad; coordination has a price and should be assessed in a cost-benefit context. However, if the choice is made to attempt to meet the comprehensive needs of patients with ADM disorders, then services coordination should be strongly advocated, if not mandated. In any case, effective coordination of services requires leadership at all levels—State, local, and Federal.

Chapter 1—Introduction

Purposes of This Report

The primary purposes of this report are to

- review current knowledge about coordination of alcohol, drug abuse, and mental health (ADM) services,
- briefly review previous attempts to coordinate services,
- define coordination,
- identify some of the characteristics and needs of ADM patients that affect efforts to coordinate services for patients with multiple needs,
- describe the major mechanisms available for coordinating services, and
- to make recommendations about the process of developing coordination of ADM services.

Over the years, considerable knowledge and experience regarding health and human services coordination have been developed, but in general, this information has not been brought together in an accessible form. This report is intended to begin to remedy this deficiency.

Sources of Information

Four major sources of information have been used in developing this report: First, an extensive review of the literature was conducted. This review covered the ADM literatures as well as the human services literature on coordination and integration of services, and the social science literature on interorganizational behavior. The library research included using various computerized abstract systems including WELMED, WELCORK, Psychology Abstracts (Silver Platter), and Sociology Abstracts (Silver Platter). In addition, several libraries, including The Johns Hopkins University library, the University of Maryland library, and the National Library of Medicine, were searched for relevant books. The tables of contents of particularly relevant journals on alcohol, drug abuse, mental health, and organizational behavior were reviewed as well.

Discussions with Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) staff led to a series of telephone interviews with State alcohol and drug abuse administrators around the country. On April 19, 1990, a conference of more than 20 persons, including State alcohol, drug, and mental disorders staff, representatives from the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD), and ADAMHA staff, was held in Washington, DC, to review a summary and outline of this report (see appendix A for the list of attendees' names). The discussion at this meeting was particularly helpful in providing case examples of different approaches to coordination of services for individuals with ADM disorders. The group emphasized the importance of considering the multiple needs of patients in anchoring a discussion of coordinating services. In particular, discussion focused on "dual-diagnosed" patients and the challenge of coordinating services for this difficult group. Following the meeting, additional telephone interviews were conducted with persons who had attended, as well as with others who were suggested by the attendees.

A draft of this report was circulated to attendees and to representatives of various ADAMHA agencies. Subsequent revisions were made on the basis of comments and suggestions received by the author.

Organization of the Report

Chapter 2 offers a brief historical overview of previous attempts to coordinate services. Chapter 2 is intended not to provide a detailed, comprehensive view of the history of treatment services coordination but to place current coordination efforts in a historical context and to introduce some of the models and mechanisms that have previously been employed. Chapter 3 discusses the characteristics of patients with ADM disorders that make it necessary to develop coordination of services. Following the suggestion of the April

conference attendees, the characteristics of the dual diagnosed are emphasized to illustrate the complexity of serving patients whose needs cross the boundaries of categorical programs. Chapter 4 defines coordination and related concepts and offers some working principles of services coordination. Chapter 5, the core section of the report, presents specific mechanisms and models of coordination and offers illustrative case examples. Chapter 6 presents recommendations for the future.

Chapter 2—Historical Overview of Attempts To Coordinate Services

The coordination of human services in the United States is not a new issue. Attempts to organize fragmented services go back at least 100 years (Morris & Lescohier 1978).

Reasons for Coordination

There are a number of reasons for continuing to attempt to develop coordinated services. The rapid expansion of health and human service programs in general during the 1960's and 1970's, the deinstitutionalization of the mentally ill, the increase in substance abuse in the 1980's and 1990's, the funding of programs through many different public and private sources, and a variety of other professional, community, and social factors have resulted in a set of highly complex, fragmented, duplicative, and uncoordinated services. A great number of separate programs provide specialized services to narrowly defined target groups. Although this fragmentation of services interferes with accessibility for all potential users, it is particularly burdensome for those who require help from multiple programs.

Fragmentation

Agencies delivering ADM and other treatment services operate according to different goals and objectives. They are separated by different sponsorship, geography, and operating principles. They employ different eligibility criteria and deal only with parts of the needs of individuals and families. Categorical approaches perpetuate the existing patterns of specialist and single-function agencies dealing with even smaller aspects of larger problems. The result of this fragmentation is that accessing services is particularly difficult for persons with multiple needs. The insulation, separation, and limited focus of most human service agencies place a particular burden on persons who need multiple services. It is not unusual for patients to have to seek the help of a dozen or more agencies. Furthermore, those persons with the greatest need are also the least likely to have the resources (knowledge, money, and social support) required to obtain needed help.

Duplication

Not only are services fragmented, they tend to overlap and duplicate one another. For example, it is common in some urban communities to find several agencies concerned with essentially the same problem area—such as drug abuse among teenagers—and offering essentially similar services. Also, city, county, and State agencies may have overlapping mandates for providing various elements of the services required for this population.

A problem related to duplication in the functioning of service agencies is the expense and inefficiency of requiring separate management, support services, and other overhead items for each organization. Thus, needless duplication of human services results in less efficiency and increased costs for patients and taxpayers.

No Provision for Multiple Needs

Typically, agencies do not provide a wide range of services to respond to the complex needs of some individuals. The person who goes to an agency for one type of service and needs other assistance as well may or may not get to an agency that provides that service. Often, agencies are not adequately aware of one another, and often the most that an individual can expect is to be told about the other agency and its location. The referral process may not result in persons getting to the right place or receiving what they need if they do get there. A related problem is that many agencies do not respond adequately to patients with chronic problems. The individual who needs a continuing program of care over a long period may find it difficult to receive attention in a convenient way that preserves personal dignity and rights in a noninstitutional environment.

No Accountability

Once a service is begun, as long as funding is available, it tends to continue regardless of whether it is producing any demonstrable

positive effect. In general, fiscal accountability is reasonably maintained, but professional programs tend to be trusted as self-policing, and relatively little is done to check on the quality of care for many patients.

As funds for ADM services are increasingly challenged by limitations in Federal and local funding and changes in the priorities of State legislatures, it becomes particularly important to make sure that public agencies are held accountable. Particular problems are encountered in ensuring accountability for individuals treated by several agencies.

Early Attempts at Coordination

Settlement houses

Among the earliest efforts to provide comprehensive coordinated services for a needy population was the settlement house movement. The first settlement house in the United States was established in 1886 in New York on the lower east side. The settlements were located in the neighborhoods close to the poor, who needed varied social services, and they were particularly helpful to the numerous immigrants entering this country at that time. By 1910, there were more than 400 settlement houses located principally in the industrialized cities of the East and Midwest (Bolan 1977).

Voluntary Agencies

The United Way and many foundations provide funds for a number of nongovernmental human services programs. Contemporary efforts to coordinate public services originated in the activities of these organizations:

> The earliest attempts at coordination date back to the nineteenth century central case registries and service inventories performed by the charitable organization societies in major cities. In the twentieth century, local health and welfare councils established in many cities were responsible for producing the first plan in the United States outlining broad human needs and developing strategies for fulfilling those needs. Unified fund agencies, such as the United Way and United Fund organizations were also established to centralize funding, establish program priorities and disperse priority-determined resources (Agranoff 1977, p. 527).

These unified funding agencies still exist in many American cities and consist of representatives of various individual programs and agencies. The purposes of the united funding agencies include not only the joint raising of funds but also planning, sharing information, identifying unmet needs, and working together in other ways as well. A major emphasis in the attempts to bring together private and voluntary agencies was a concern for coordination.

Public Sector Growth

In recent decades, the voluntary sector has been overshadowed by growth in the public sector, as Federal and State governments have enacted legislation funding a panoply of programs to be delivered at the local level. As the number and variety of agencies have grown, coordination has become a major concern.

New Organizational Structures

A major strategy for facilitating access to a comprehensive range of services has been to change the organizational structure through which services are performed. Community mental health centers (CMHC's), health maintenance organizations, neighborhood service centers, multiservice centers, neighborhood health centers, and youth opportunity centers are all examples of organizations that were designed to integrate services. In 1971, Secretary Elliott Richardson of the Department of Health, Education, and Welfare (HEW) indicated that there were more than 2,000 such organizational units in the United States with the major goal of providing comprehensive integrated services (Demone 1973). In general, these organizations sought to provide improved assistance to individuals to meet their mental health and other human service needs by incorporating the following features:

- Comprehensiveness of services.
- Decentralization of services in areas of high need.
- Concerting of resources from different programs.
- Colocation of service components.
- Operational integration of services in proper sequence, thereby eliminating present duplication and wasted time for patients and employees (March 1968).

Community Mental Health Centers

The CMHC's colocated a variety of services in one organizational entity. More than 500 CMHC's were funded by the National Institute of Mental Health (NIMH). As of 1969, three-fourths of the CMHC's then in existence had been formed by the affiliation of two or more separate agencies (Levenson 1969). By 1972, 85 percent of all the federally funded CMHC's comprised "several different organizations working together under written agreements to

provide a coordinated program" (Feldman 1972, p. 6). One CMHC was actually composed of 18 different organizations (Ozarin et al. 1971).

This organizational model can be considered an example of a multiorganization, that is, a union of parts of a number of organizations that come together to perform a common task (Stringer 1967). In a highly differentiated multiorganization such as this type of CMHC, developing effective mechanisms for coordination becomes increasingly important.

Many of the initial applications for CMHC grants were indeed the result of bringing together bits and pieces of existing organizations and colocating them under one roof. To some extent, the centers also began to cooperate with parts of existing separate systems. However, one of the major deficiencies during the era of CMHC's was the failure to coordinate the services of the centers with public mental hospitals, and CMHC's lost Federal funding and general support because of their lack of attention to the chronic[1] mentally ill.

Multiservice Centers

Another organizational structure that colocated a number of service elements with the goal of providing comprehensive and locally responsive services was the multiservice neighborhood center. Initial efforts centered on creating new neighborhood centers that would coordinate the social services and human resource program funded under the Juvenile Delinquency-Youth Offenses Control Act of 1961. Because it was recognized that delinquency stems from a complex set of interrelated causes, Federal demonstration grants were made to a number of cities to develop comprehensive programs, including neighborhood centers. The broader efforts of the "war on poverty" overtook these programs and gave neighborhood centers further impetus for comprehensive expansion (March 1968). The Economic Opportunity Act of 1964 provided authority to the Office of Economic Opportunity (OEO) to fund hundreds of neighborhood centers as part of a broad spectrum of programs attempting to deal with problems of poverty.

Neighborhood service centers were developed, among other goals, to coordinate previously fragmented services. The multiservice centers usually included a community organization component and were frequently committed to social action. Studies of neighborhood service centers generally agreed that the presence of the centers made more services available to the local community (Kirschner Associates 1966; O'Donnell and Sullivan 1969; Perlman and Jones 1967); however, "data about effectiveness, efficiency, and innovation were missed." The limitations of the centers studied were traceable to a "conflict as to whether the centers housing local programs were to be judged in terms of service output, development of local leadership, or employment of poor people" (Kahn 1969, p. 40).

Model Cities

Model cities was another program that attempted to coordinate planning and service delivery. The model cities program attempted to rebuild deteriorated neighborhoods in selected cities by coordinating Federal, State, local, and private approaches in housing, education, health, and transportation. Model cities had some success but revealed the problem of categorical programs at the State and local levels, and in the number of constituencies that Federal agencies attempt to satisfy (National League of Cities/U.S. Conference of Mayors 1972).

Services Integration Targets of Opportunity (SITO)

Throughout the 1960's, as the Federal Government funded various new programs, it became increasingly apparent that something more had to be done to pull together existing programs. In the early 1970's, HEW recognized the need to coordinate its own programs better at State and local levels and proposed a legislative initiative, the Allied Services Act, to facilitate integration of services. The department also began a series of demonstration projects—the SITO grants—to test various services integration techniques in States and localities.

Under SITO grants, numerous service integration techniques were developed and demonstrated, including patient tracking systems, information and referral (I&R) mechanisms, one-stop service centers, specialized management information systems, interagency planning and service delivery agreements, computerized resource inventories, management reorganization projects, and case management (Mittenthal 1976; Morrill 1976). Although the SITO grants covered many different types of human service programs, they had little impact on programs for mentally ill persons and substance abusers.

Services for the Severely Mentally Ill

With regard to the history of the care of the mentally ill in the United States, there have been four major reform movements with related new organizational structures (Tessler and Goldman 1982): The first cycle of reform introduced moral treatment and the asylum (Caplan 1969; Grob 1966, 1973). The second cycle generated the mental hygiene movement and the psychopathic hospital (Rothman

1980). The third reform created the community mental health movement and the CMHC concept (Joint Commission 1961; Levinson and Brown 1967).

A fourth reform associated with psychosocial rehabilitation and community support developed within the community mental health movement and spawned several programs at State and local levels. The NIMH Community Support Program (CSP) "pilot approach" came out of the movement's failure to address adequately the needs of adults with serious and persistent mental disorders (Turner and TenHoor 1978). The NIMH CSP sought to create a "community support system" (CSS) and gave case management and a core service organization basic roles in coordinating separate services into a system for providing comprehensive continuity of care for the psychiatrically disabled. Rather than attempt to locate all the major services for the mentally ill under one roof, CSP used a different approach. It recognized that the needs of people with chronic mental illness extended well beyond the boundaries of mental health and that meeting the comprehensive needs of this population would require collaborating with a broad array of health and social welfare agencies.

Services for Alcohol and Drug Abuse Patients

Like services for the retarded before them, alcohol and drug abuse services had separated from mental health. Beginning in the late 1960's and flourishing in the late 1970's, alcohol and drug abuse services moved toward distinct community-based services. For various professional and ideological reasons, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse separated from NIMH and abandoned the NIMH CMHC model. Until recently, services have remained relatively separated and specialized.

During the 1980's and into the 1990's, the problems of widespread alcohol and drug abuse gained increased attention, especially when they co-occurred with other problems, including mental illness, homelessness, and criminal behaviors.

Recently, an appropriately named Institute of Medicine report (1990), "Broadening the Base of Treatment for Alcohol Problems," noted that the treatment of alcohol problems is no longer viewed as the exclusive province of a specialized treatment sector. The report posits the need for community treatment and an effort to assure continuity of care and provide whatever services a patient needs in a coordinated manner.

Although numerous articles published in past years have discussed the organizational and administrative arrangements that function best for social and mental health services, there is only scant literature of this type in the substance abuse field. Some of this lack may reflect the earlier integration of mental health with Federal, State, and local administrative offices for alcohol and drug abuse, but a different approach to problems is also undoubtedly reflected. Recently, discussion of the dual diagnosed (which tends to appear primarily in mental health journals) has highlighted the need for coordinated services for those who have both mental and substance abuse disorders. These patient characteristics and multiple needs in relation to pressure for coordinated services are discussed in chapter 3.

Endnotes

[1] The term "chronic" is used here in a historical sense, because that term was more widely used by mental health professionals until recently, when consumers objected to it as being offensive and negative. A number of different phrases are in current usage, including "psychiatrically disabled," "adults with serious and persistent mental disorders,"

Chapter 3—Service Needs of Patients with ADM Disorders

A primary reason for concern about coordinating programs is that patients have a variety of needs that extend beyond the services usually offered by disability-segregated programs. Despite the variety and complexity of patients' needs, most service programs are organized, and most service workers are trained, to meet the needs of a single disability group.

Multiple Patient Needs

Growing literature documents the occurrence of multiple disorders among patients and the population at large. Recent reviews report that multiple disorders are frequently found among individuals seeking ADM treatment (Galanter et al. 1988; Ridgely et al. 1986). For example, a number of studies have examined the rates of substance abuse among admissions to psychiatric hospitals. Crowley and others (1974) found that nearly half of the adults admitted to the psychiatric unit of a university hospital had psychoactive drugs in their urine. However, only a third of the sample had reported drug abuse problems. Fisher and others (1975), in a similar study, found that a third of their sample of persons admitted to psychiatric hospitals reported previous drug use. Of the admitted drug users, about half were currently abusing illegal drugs. Further, mental disorders have been found co-occurring with alcohol and drug abuse disorders quite commonly among the general population in the Epidemiologic Catchment Area studies of community prevalence of these disorders (Boyd et al. 1984).

The seriously mentally ill and substance-abusing patients also have other severe problems, including homelessness, unemployment, legal difficulties, and illness. For example, Gelberg and others (1988) conducted a community-based survey of 529 homeless adults and analyzed factors associated with their use of mental health services. They found that homeless persons who had previously been hospitalized for a psychiatric disorder had been homeless for nearly twice as long as the rest of the sample. They also had the worst mental health status, used alcohol and drugs the most, and were involved the most in criminal activities. In discussing how to meet the multiple needs of homeless adults, Gelberg and others suggested combining mental health, drug and alcohol abuse, housing, and social service programs, and providing them in a single coordinated setting.

Another group with multiple problems are the so-called new chronic patients, composed of the never-institutionalized, severely disturbed young patients who were generally given less attention by the NIMH CSP effort to promote comprehensive community systems of care (Pepper et al. 1981; Bachrach 1982; Tessler and Goldman 1982). Substance abuse is a major problem in the community care of such young adults with serious mental illness (Bachrach 1982; Bergman and Harris 1985; Pepper and Ryglewicz 1984; Ridgely et al. 1986; Schwartz and Goldfinger 1981). For example, a study by Test and others (1989) found that 58 percent of young adult patients with schizophrenic disorders in a long-term community treatment study were rated by staff or themselves as using alcohol, cannabis, or other street drugs several times a week or more.

Of course, there are other important combinations of needs in addition to mental illness and substance abuse. Some of them have received attention for some time, such as mental illness and mental retardation. Other combinations of needs are just beginning to be recognized and little has yet been accomplished in coordinating services to meet these needs, such as the case of mentally ill patients who are also suffering from acquired immunodeficiency syndrome (AIDS). Additional needs result from the extremely high incidence of physical health problems among those with addictive disorders, including bacterial pneumonias, tuberculosis, syphilis, herpes, and other sexually transmitted diseases, especially human immunodeficiency virus (HIV), AIDS, and AIDS-related complex (ARC).

Problems in Caring for the Dual Diagnosed

Seriously mentally ill and substance-abusing persons are often referred to as "dual diagnosed." According to Wallen and Weiner (1988), the term "dual diagnosed" is used for patients who meet the diagnostic criteria for an addictive disorder and also meet the diagnostic criteria for

- an organic mental or developmental disorder,
- a major psychiatric disorder with minimal or no residual psychiatric symptoms,
- a major psychiatric disorder with ongoing psychiatric symptoms,
- a personality disorder, or
- an additional compulsive disorder such as pathological gambling or an eating disorder (Wallen and Weiner 1988).

Dual-diagnosed patients are often rejected in addiction settings because they are difficult to manage or because they require pharmacological intervention. Because mental health facilities may not deal with dependency issues and chemical dependence treatment programs may not work with psychiatric issues, people who need services from both systems may fall between the cracks. Because of their multiple problems, these patients are likely to require services not only from ADM programs, but also from other health and human services agencies. However, such patients tend to be treated for their multiple disorders sequentially at different agencies rather than simultaneously (Wallen and Weiner 1988).

Patients become confused and frustrated as they are passed back and forth between the two service delivery systems, and they may drop out of treatment. The common shortage of required service elements—such as detoxification services and specialized residential and outpatient services—produces gaps in service.

Individuals usually come to the attention of alcohol and drug abuse or mental health systems in a crisis (e.g., psychiatric or medical emergency, acute intoxication, or contact with the criminal justice system). Although the immediate problem may be dealt with, a comprehensive coordinated approach of continuous care is missing and, as a result, these patients constitute a large part of the recidivist population of mental health systems.

Differences in knowledge, attitudes, and philosophy among providers of alcohol, drug abuse, and mental health services interfere with continuity of care of the dual diagnosed. For example, the abuser of cocaine and alcohol poses special problems for a traditional alcohol recovery program because staff typically are inadequately informed on how to deal with such patients. In addition, they may have ambivalent attitudes toward multiple drug addiction, which can further interfere with treatment.

Another problem is related to the important role played by self-help groups in substance abuse aftercare. The difference in ideologies and treatment philosophies between mental health professionals and these groups make adequate use of these self-help groups difficult for individuals (Wallen and Weiner 1988).

The CSP Model

In conceptualizing the services components to be coordinated to provide for the special needs of people with ADM disorders, it is helpful to look at the NIMH CSP model. CSP developed from an NIMH work group that was convened in 1974 to develop a community-based system of care for mentally disabled adults (Turner and Shiffren 1979). Promoted by NIMH in response to criticisms in the 1977 General Accounting Office report, *Returning the Mentally Disabled to the Community: Government Needs to Do More,* CSP became NIMH's pilot approach to addressing the needs of the adults with serious and persistent mental disorders that had not been adequately met by the community mental health movement.

A major theme of CSP was the concept of CSS, defined by NIMH (1977, appendix A) as a "network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potential without being unnecessarily isolated or excluded from the community." Although the NIMH CSS guidelines and the CSP focused on "severely mentally disabled adults whose primary disability is emotional and for whom long-term, 24-hour nursing care is appropriate" (NIMH, 1977), it was recognized from the beginning that "this general concept could be adapted to numerous vulnerable populations" (Turner and Shiffren 1979, p. 2).

However a particular state or community arranged its services, CSP guidelines specified that a comprehensive support system must assure that the following 10 functions are performed (Turner and Shiffren 1979: Turner and TenHoor 1978):

1. Case identification and outreach to offer appropriate services to those willing to participate.
2. Assistance in applying for income, medical, and other entitlements.
3. Twenty-four-hour crisis stabilization services in the least restrictive setting possible.
4. Provision of psychosocial rehabilitation services.
5. Provision of supportive services of indefinite duration.
6. Provision of adequate medical and mental health care.

7. Provision of backup support to families, friends, and community members.
8. Recognition of natural support systems.
9. Protection of patients rights, both in hospitals and in the community.
10. Provision of case management services.

Assuming that all these service components and opportunities are available in a community, four conditions were also specified in the NIMH CSP request for proposals (1977):

- Assessment of the comprehensive needs of the population at risk.
- Legislative, administrative, and financial arrangements to guarantee the availability of appropriate forms of assistance to meet needs of the population.
- A core services agency in the community committed to helping severely mentally disabled people improve their lives.
- An individual or team responsible at the patient level for staying in contact with patients on a continuing basis, regardless of the number of agencies that become involved (Tessler and Goldman 1982).

NIMH provided funds to operationalize the CSS concept through a request-for-proposal mechanism, which awarded contracts to States on a competitive basis. NIMH transferred funds to State mental health agencies through these contracts, and then many of the States subcontracted with local community programs. During the first year of the CSP, NIMH awarded contract funds directly to 19 State authorities (and the District of Columbia) to encourage the development of model programs as part of statewide strategies for implementing community support systems (Turner and TenHoor 1978). The program used a comparatively small amount of Federal funds to stimulate development of a comprehensive program of services at the State and local levels. Many States actually began to develop community support models before the CSP was started at the Federal level in 1977, and some States budgeted funds at a much higher level for these programs than the $3.5 million that CSP awarded in contracts the first year (Tessler and Goldman 1982; Turner and TenHoor 1978).

Supplementing the CSP Model

While the CSP model identifies 10 components as essential for comprehensive care, the substance-abusing patient has special needs and characteristics that are not adequately taken into account in the basic CSP model. In applying this model to patients in need of alcohol and drug abuse services in addition to mental health care, each of the 10 CSP components is considered in the following discussion below, and then supplementary service components are identified.

1. *Case identification and outreach.* CSP incorporated one of the basic tenets of the community mental health ideology in this first essential component, that is, the concept of a "population focus." Baker and Schulberg (1967) identified this public health notion as one of the basic beliefs of the community mental health movement, namely, that a service agency assumes responsibility for the entire population "at risk" in a defined planning area. The CSP model also incorporates the principle of active reaching out to patients to make sure that they receive appropriate attention and are informed of the availability of services.

   Mentally ill substance abusers who are most in need of help are least likely to make use of services and may require "aggressive outreach" (Test and Stein 1976). Outreach is likely to continue to be important for addicted patients because they are typically ambivalent about stopping their drug use. Drugs produce pleasant, as well as some extremely unpleasant, effects. Motivation changes from day to day or even hour to hour, as the balance of positive and negative valences changes (Kleber 1989).
2. *Assistance in applying for entitlements.* Mentally ill and substance-abusing patients also may need help in meeting basic needs for food, clothing, medical care, housing, transportation, employment, and money. However, some addicts come to treatment with existing vocational skills and may be employed more easily than lower functioning chronically mentally ill patients. When substance abuse ceases and necessary lifestyle changes are made, the functioning of some of these addicted patients may improve dramatically (Kleber 1989).
3. *Provision of 24-hour, quick-response crisis assistance in the least restrictive setting possible.* Crisis intervention is needed on a 24-hour basis for individuals who experience a psychiatric crisis, or an alcohol- or drug abuse-related crisis or both. Alcohol and drug abuse patients may need to be separated from their usual community environments, because these settings tend to support substance-abusing behaviors (Kleber 1989). Staff doing crisis intervention are likely to need special training to intervene effectively with mentally ill substance-abusing patients. Crisis intervention teams, including staff from both mental health services and alcohol and drug abuse services, may be needed.

4. *Provision of comprehensive psychosocial rehabilitation services.* Because some addicts entering treatment have social skills, vocational skills, or both, as well as other community living skills, they may not need the same psychosocial services that typical CSS patients need. However, they may profit from specialized rehabilitation services. Vocational, transitional, and supportive employment programs and specialized vocational training may be essential to some patients.
5. *Provision of supportive services.* In the 1980 revision of the 10 essential CSS services, this component of the CSP model was changed to "provision of a range of rehabilitation and supportive housing options." Included are psychosocial clubs and other special living arrangements for those who need them.

   For those seeking to recover from alcohol and drug addiction, the self-run, self-supported recovery house is an important source of supportive help. Patterned after the self-help recovery programs of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), these group-supported recovery homes such as Oxford House help to prevent relapse by providing support from living with other individuals coping with the same problems, and threatening that use of alcohol or drugs in any amount will immediately result in expulsion from the house (Primm 1989).

   The Anti-Drug Abuse Act of 1988 (Public Law 100-690) includes a provision that requires each State to establish "a revolving fund for the purpose of making small loans to individuals recovering from alcoholism or other drug addiction to start self-run, self-supported recovery houses" (Primm 1989). The group recovery home provision of Public Law 100-690 is based on the experience of Oxford House. A technical assistance manual describing the Oxford House model was published by the ADAMHA OTI to facilitate the implementation of the group recovery homes provision of the act (Molloy 1989).
6. *Provision of adequate medical and mental health care.* Mental health services are particularly important for dual-diagnosed patients. Coexisting mental health problems may affect response to treatment for drug dependence, and the presence and severity of psychological problems may affect success of treatment for alcohol and drug abuse. For example, research has demonstrated that patients with low or mid-levels of severity of psychiatric problems showed substantial improvement in either methadone maintenance or therapeutic community treatment; high-severity patients were more affected by what treatment they were receiving (McLellan et al. 1983). Medical services are also particularly important for these patients. Pharmacologic therapy for psychiatric problems may interact with illicit drugs that patients are taking. The metabolic changes that may result from long-term drug addiction may change the psychotropic effects of therapeutic medication for patients with coexisting mental health problems. Even when psychiatric problems are successfully treated, either chemotherapeutically or nonpharmacologically, the substance abuse disorders may continue as an independent problem. Additional needs result from the extremely high incidence of physical health problems among those with addictive disorders, including bacterial pneumonias, tuberculosis, syphilis, herpes, and other sexually transmitted diseases, especially HIV, AIDS, and ARC.
7. *Provision of backup support to families, friends, and community members.* Families may play important roles in helping to either resolve or continue drug dependence problems. Likewise, friends can play either a helpful or a harmful role in the patient's attempt to remain drug free. Lifestyle changes may be required. Social contacts and activities associated with drug use may need to be changed; if they cannot be changed, then the patient will need help with coping with them. The patient's associates may also be in need of services for their own addiction problems, whether the patient maintains contact with them or is forced to discontinue it.
8. *Recognition of natural support systems.* Natural support systems include churches, community organizations, and self-help groups. AA and NA have been particularly effective with substance abusers. Traditionally, these groups recommended abstinence from all drugs, including psychopharmacologic drugs necessary to treatment of the mental disorders of the dual diagnosed, but this attitude has changed (Minkoff 1989).
9. *Protection of patients' rights in and out of services.* This component of the CSS guiding principles is also important for the dual diagnosed both in and out of treatment programs or residential facilities. The use of illicit drugs by patients complicates the issues of patients rights because of the legal problems involved. Also,

the restrictive nature of some drug treatments raises difficult issues regarding grievance procedures and mechanisms to protect patients rights.

10. *Provision of case management services.* In CSS, case management combined with a core services agency provided the principal means of coordinating otherwise fragmented services into a system to meet the particular needs of patients. Although case management has not been used as frequently with alcohol and drug abuse patients as with the severely mentally ill and other disability groups, it nevertheless has *great* potential for coordinating services for these patients as well.

Additional Components Needed for Substance Abuse Patients

As relevant as the components listed in the CSS model are for substance abuse patients who may also have mental disorders, some components are missing; one is individualized treatment.

Individualized Treatment

The principle of individually tailored treatment regimens was not specifically included in the guiding principles of the CSP, although as Tessler and Goldman (1982) point out in their evaluation of CSP, individualized treatment plans were expected in local CSP projects. Bachrach (1980) defined individualized treatment as a necessary element for model programs for the chronically mentally ill.

The principle that treatment should be individualized is particularly important for drug-dependent patients. Kleber (1989) asserted that in developing programs of treatment for individuals with drug dependence, two basic principles should be considered. First, at different stages in an individual's addiction cycle or career, he or she needs different kinds of treatment. And second, even though a group of drug-dependent individuals may seem similar in a number of characteristics such as type and length of drug use, they may require very different treatment approaches. Treatment must be matched to the needs of the individual; the right treatment and the right individual must be brought together at the right time.

Detoxification Services

Linkage to medical care for detoxification of substance abuse patients is another essential service component not considered in the CSS model, but it is particularly important for this population. Hospitalization was not included in the CSP (Tessler and Goldman 1982), but it is an important component for those who need hospital-based services. The mentally ill substance abuser may have complicated medical symptoms as a result of the effects of alcohol or other drugs in combination with pharmacological interventions or chemotherapeutic interventions.

Programs may have more than one drug to deal with because of polydrug use. Addicts commonly abuse multiple drugs today. It is not uncommon to find addicts using heroin or cocaine or both, plus alcohol, diazepam, or marijuana, alone or in combination.

Linkage with Self-Help Groups

A basic principle of CSP is to develop linkages with community resources. However, the self-help groups of AA and NA are particularly important for alcohol and drug abuse patients. It has been noted that self-run group houses like Oxford House, which are modeled on some of the ideological principles of AA and NA, have been recognized as particularly salient living arrangements for drug-dependent patients. Some mentally ill substance-abusing patients may not be accepted by traditional self-help groups.

Special Training for Staff

Staff from the mental health and the alcohol and drug abuse systems require cross-training in dealing with the multiplicity of their patients' problems. Training in the treatment and clinical management of the mentally ill substance abuser will probably also be required, because the combination of disabilities presents special problems. This training should be made available both to staff offering direct services as well as to administrative personnel. This training should include the ideology and philosophy that underlie services integration and coordination. Continuous education and inservice training of public and private agency staff are required and should be sponsored by State agencies, universities, and professional organizations. Evaluation of such training programs is also vital.

Consideration of Environmental Context

Bachrach (1980), in reviewing criteria for evaluating model programs, noted the importance of being sensitive to the unique qualities of the communities in which they were located. In the definition of essential services in the CMHC model and the 10 components of a CSS, there is a failure to recognize the variation in the availability of resources in different communities. A function necessary for a particular target population may be scarce or unavailable in some communities but overabundant in others. The local environmental context has to be considered in developing

networks or systems of services. Resource development is required, as well as linkage and coordination among components of services, in some environmental contexts.

Linking the Components

The functions of resource development and administrative linkage were assigned to the core service agency in the CSS model. Coordinating service components at the patient level was made the responsibility of the case manager. However, other mechanisms for coordinating services have been developed over the years (chap. 2). These other approaches to coordination of ADM services are discussed in chapter 5, but first a definition of coordination is presented in chapter 4.

Chapter 4—Definition of Coordination

In defining coordination, it is helpful to begin by defining three related concepts: comprehensiveness, continuity of care, and integration of services.

Comprehensiveness

A concept that is closely related to coordination is comprehensiveness, which deals with whether a set of services is complete, that is, whether all the necessary resources and types of help are present and available to patients to meet all their needs. So closely allied is comprehensiveness with the concept of coordination that some theorists have argued that one cannot speak of coordinated services for a target group of patients unless all the necessary programs are present. For example, Aiken and others (1975) argue that "the first concern of attempts at coordination must be whether the system has all the resources and programs necessary to service clients" (p. 6).

Others have found it more appropriate to separate these two concepts and allow the "coordination" to describe the extent of collaboration and exchange among those program elements that are available, even though further effort is necessary to develop and/or connect missing components.

Continuity of Care

Continuity of care is focused on the patient level and refers to maintaining a chain of professional responsibility as a patient moves from one program to another to receive needed services. Test (1979) suggested that continuity of care has two kinds of dimensions and goals: (1) cross-sectional, so that the services provided to an individual at any given time are comprehensive and coordinated; and (2) longitudinal, so that the system provides comprehensive, integrated services over time and is responsive to changes in the person's needs. This longitudinal dimension is particularly critical when populations whose disabilities are both significant and lifelong are served. Continuity of care holds special significance for ADM patients because of the chronic, relapsing nature of many ADM disorders, which often require a lifetime of interventions.

Services Integration

By contrast, services integration focuses on the organizational level and refers to the attempt to bring agencies and programs into a single system. Coordination is also concerned with the attempt to bring together the agencies and programs that deliver human services in the community, but it differs in that it implies recognition of the integrity and autonomy of separate organizations that are attempting to find ways to work together without giving up any more of their individual autonomy and control than necessary.

Definition of Coordination

Having defined the related terms of comprehensiveness, continuity of care, and services integration, let us consider the implication of coordination for organizing services. In the context of service delivery, coordination may be defined as the degree to which collaboration and exchange exist among an aggregation of service providers so that services may be provided in a meaningful, appropriate sequence. Aiken and others (1975) identified four elements that require coordination in a service delivery system:

1. Programs, including all the needed services necessary to provide a continuum of care.
2. Resources, including all the needed funds and degree of autonomy.
3. Patients, including the treatment of all the needs of all eligible patients.
4. Information, including centralized patient record keeping, directories of service programs, knowledge about availability of resources, and continuous feedback about patients, resources, and programs.

Operationally, coordination is defined by certain assumptions: (1) coordination is one form of interorganizational relations; (2) organizations are motivated by the need to obtain resources (money, personnel, support, recognition, patients, and information) required to achieve their goals, and engaging in interorganizational relations is often viewed as a means to obtain these resources; (3) organizations need to control their environment, and coordination is a way of achieving control over uncertain environmental conditions; (4) two or more organizations try to coordinate when they perceive mutual benefits or gains from interacting, or when at least one is motivated to establish a relationship and powerful enough to force the others to interact (Blostein 1983).

As Grusky and others (1985) have observed, three major units of analysis in organizational studies have been used:

1. "Organization sets," consisting of all interorganizational interactions established by a focal organization (Evan 1966).
2. Interorganizational networks, consisting of all interactions among organizations in a community or a population of organizations.
3. Entire systems of organizations, consisting of organizations interacting interdependently within a defined boundary (Baker 1973; Baker and O'Brien 1971).

The CSP initiated by NIMH in 1977 to assist States in planning and implementing comprehensive community-based services for psychiatrically disabled adults was in essence an experiment in creating interorganizational networks (Tessler and Goldman 1982). Grusky summarizes the overall goal of this program:

> CSP was instituted to encourage the development of community resources that could reinforce, complement, and even substitute natural systems of social support. CSPs were designed to stimulate provision of a range of needed services and encourage continuity of care by increasing coordination among agencies serving the target population (Grusky et al. 1985, p. 688).

Types of Interorganizational Interaction

Conceptualization of coordination as a form of interorganizational interaction dates back to the work of Levine and White (1961), who formulated the concept of coordination as organizational exchange. They saw organizations as voluntarily exchanging patients, services, information, staff, and elements of economic value to maximize goal attainment. They argued that domain consensus—that is, agreement about what each organization should be doing—facilitates coordination. Once domain consensus develops, Levine and White believed, it leads to other exchanges.

This basic exchange model was extended by Benson (1975), who built on Yuchtman and Seashore's (1967) model of acquisition of resources. Benson described organizations as acting to gain money and authority to fulfill program requirements. He also argued that organizations maintain their domain, ensure adequate input of needed resources, and define the organization's way of doing things.

Another model of interorganizational relationships is based on an extension of March and Simon's (1958) conceptualization of intraorganizational coordination. This second model of interorganizational interaction emphasizes relationships that are mandated either by law or administrative regulation (Aldrich 1976).

Another model of coordination has been called "standardized-voluntary" interaction (Hall et al. 1977). In this third type of interaction, the basis for organizational interaction is voluntary but standardized through formal agreement. Hall and others (1977) describe the relationship as follows: "Exchanges occur in the development of the formal agreement, but interactions subsequent to the agreement are guided by it" (p. 458).

Once an agreement is signed, it determines the activities of the organization, although exchanges may continue through interlocking boards of directors (Pfeffer 1972). The formal agreements may stipulate sharing facilities, information about particular patients, or personnel. Interorganizational relationships are typically not just of one kind. Organizations may interact with other organizations at any given time on a voluntary basis, on the basis of a formal agreement, or on the basis of a legal mandate (Hall et al. 1977).

Barriers to Coordination

Lacking a specific mandate requiring ADM organizations to coordinate their activities or to even give specific attention to patients with co-occurring ADM disorders, coordination depends on voluntary coordination. A number of barriers to coordination have been identified:

- Separate and confusing streams of funding for different categories of disabilities.
- Organizations selecting the "best" patients on the basis of type of disability, difficulty of the patient's presenting symptoms, their perceived manageability, ability to pay, or some other characteristic (Grusky 1989).

- Attempts by the leaders of service agencies to maximize the autonomy of their organization in terms of how they commit their resources, what programs or services they will provide, and the types of patients they will serve (Aiken et al. 1975).
- Professional ideologies that define what is proper professional behavior and the right approach to providing service. Differences in professional perspectives interfere with staff working together, particularly because different staff members are likely to view the main problem of a multiple-problem patient in different ways (Baker 1982).
- Geopolitical considerations that act as barriers to coordination; separate political jurisdictions and proliferation of authorities and resource controllers divide the people and organizations who need to work together to achieve coordinated service. This barrier is particularly difficult with patients with multiple and difficult problems.

Working Principles of Services Coordination

A synthesis of the results of key studies and reviews of factors that seem to relate to increased interaction between services agencies (Baker and Isaacs 1972; Baker et al. 1972; Baker et al. 1980; Morrill 1976) shows that the following working principles seem consistent with the experience of those attempting to coordinate ADM services:

1. Services coordination is usually a slow, evolutionary process.
2. Services coordination is primarily a consensus-building process.
3. Organizational changes do not necessarily lead to services coordination.
4. Successful service coordination depends on the leadership and talents of responsible individuals.
5. Service coordination may reduce short-term costs, but other funding incentives are crucial.
6. Perception of benefit by service providers from services coordination is crucial.
7. At the delivery level, effective coordination requires shared information systems.
8. A common services strategy for State and local governments facilitates services coordination.
9. Formal interorganizational agreements facilitate the coordination process.
10. Being responsible to a common superordinate authority facilitates coordination.
11. Linkages may be likely to be adopted outside major urban areas, but comprehensiveness is difficult to achieve.
12. Travel times of more than 45 minutes seem to interfere with coordination between agencies.
13. Efforts to develop the sharing of an ideology that supports coordination appear worthwhile.
14. Relevant training and continuing education are necessary for staff dealing with patients as well as for their supervisors in a newly coordinated system of services.

Services coordination efforts are best thought of as an ongoing process rather than a perfect state to be achieved once and for all. As long as consumers and patients influence the considerations of administrators, clinicians, and policymakers, the search for better coordinated services is likely to continue.

Chapter 5—Mechanisms and Models

A number of different approaches to coordination of health and human services have been developed. Most of the models and mechanisms for coordination to be discussed in this chapter have been developed in mental health and social services, but they are also applicable to drug and alcohol services, particularly when they are coordinated with these other services. Table 5-1 presents some of the major advantages and disadvantages of each coordination approach.

Colocation

Colocation of services involves placing the deliverers of services from a number of different agencies in the same physical setting. Generally, it is the hope of the participating agencies that being housed in the same facility will help in the coordination of cases that require multiple services. Sometimes these colocated services share a common intake process or at least a common reception area; other times the only common element is the same facility. Typically, there is no facility supervisory structure, and agency chains of command are respected (Wilson 1977).

Being located in the same facility can enhance physical accessibility since patients will not have to travel to get to other agencies at different sites. The physical proximity may also facilitate face-to-face interaction (both formally and informally) among staff from different agencies. Costs and maintenance may be minimized by the use of shared space. However, being housed at the same site is no guarantee of more coordinated services and still requires the development of supporting structures and processes to encourage the necessary staff activities. Sometimes the absence of a facility supervisory structure can disrupt service, because supervisors may not be located with their staff. Not all buildings facilitate coordination of services delivery, and attention to choosing or building an appropriate facility is necessary.

Case Example

An example of colocated services for young chronic mentally ill substance abusers is provided by the Dual Disorder Project, a special project of Pathways in Ashland, Kentucky. Pathways, one of 14 mental health centers in Kentucky, covers a 10-county area. This innovative program provides a full range of services at a main services center, including a 24-hour help line, crisis services, intake and walk-in services, a crisis stabilization unit, a detoxification unit, and substance abuse outpatient services. Also located in this same building is an acute crisis team (an outreach arm of the crisis stabilization team), which is responsible to social services, the jails, and police. The colocated services also use multiple intake points at other sites. Housing sponsored by the Department of Housing and Urban Development is also available for these individuals. Persons living in these housing units are assigned a case manager, a substance abuse counselor, and a mental health counselor.

In South Carolina, mental health and substance services were colocated by moving mental health services to the county substance abuse building. Because the chronically mentally ill patients received their mental health services in a building identified with substance abuse services, they were more likely to be receptive to the substance abuse services they also needed. Being located in the same building did not increase written communication in this instance of colocation, but there was some noticeable appreciation for the services offered by those working with the other disability group.

Information and Referral

An I & R program may be defined as a system for directing people needing assistance to agencies that can meet their needs (Murphy 1977). This function essentially includes the commitment of staff time and the use of an inventory or directory of services and service organizations in the community. Development of the service inventory may take some special

Table 5-1. Advantages and Disadvantages of Various Services Coordination Mechanisms

Coordination mechanism	Advantages	Disadvantages
Colocation of services	Enhances physical accessibility Facilitates case coordination Facilitates interaction of staff representatives from different organizational units Allows agency chains of command to be preserved Offers cost and maintenance advantages from sharing space	By itself, insufficient to assure cooperation of service delivery Lack of a facility supervisory structure may disrupt service Requires appropriate physical structure
Information and referral	Encourages disciplined identification of services in community Provides access to best quality services through use of specialists Uses generalist staff efficiently May be small and relatively inexpensive Avoids duplication of services	May stimulate client expectations to unrealistic levels May result in high client dropout rate Works best on small scale and may be inadequate for demand May duplicate diagnostic services Eligibility requirements differ Client information may not be adequately shared Problems exist in continuity of care
Centralized intake and referral	Provides single point accountability Can assure continuity of care Uses drug treatment resources well May monitor movement of client through service system Avoids duplication of services Serves as a treatment broker	Requires cooperation of agencies to accept referrals Requires additional mechanism for followup May be difficult to fund Tends to "front-end load" by focusing on assessment without assuring treatment at the site May stimulate client expectations to unrealistic levels May be difficult to fund

Table 5-1. Advantages and Disadvantages of Various Services Coordination Mechanisms (Cont.)

Coordination mechanism	Advantages	Disadvantages
Interagency network models: Multidisciplinary team	Makes variety of services available Enhances accessibility of services Enhances continuity of care	Huge team may be needed to provide all the necessary services High cost comes with large size Responsibility is difficult to determine Decisionmaking regarding provision of services is difficult Works poorly outside population centers Services are duplicated across teams
Bilateral coordination	Easier to accomplish than multilateral efforts May deal with societal attitude of viewing alcohol as less serious; can emphasize common recovery issues, common rehabilitation elements, and mutual perspectives	Limited services are included Staff may lack necessary knowledge and experience Gaining cooperation of multiple agencies is difficult Requires external force to stimulate coordination
Case management	May provide both cross-sectional and longitudinal continuity of care Can help clients negotiate the system Provides single-point accountability By fixing responsibility for developing and implementing a coordinated service plan, it can assure continuity of care Provides assessment, planning, linking, monitoring, evaluation, and followup functions	Depends on high degree of personal commitment by case managers Requires a relatively small caseload for case managers Case managers may be subject to burnout because of high demand of job Requires specialized training Requires long-term commitment to clients Involves case manager going to where client is

Table 5-1. Advantages and Disadvantages of Various Services Coordination Mechanisms (Cont.)

Coordination mechanism	Advantages	Disadvantages
Sharing staff	Extends capabilities at site Staff knowing each other as coworkers may facilitate coordination of services Can reduce costs Aids continuity of care Access to services may be enhanced	Jurisdictional disputes may create work-related problems If public and private staff are brought together, civil service advocates may be antagonized Different philosophies of treatment can cause conflict Supervision and authority relations may be difficult
Financing models	Provides incentives for agency cooperation Stimulates interest in other methods of coordination May reduce costs of overlapping and duplicative services Facilitates accountability Facilitates central control of services	Requires authority and/or legal mandate Often produces expensive and complicated bureaucratic structures May be difficult to implement because of agency resistance and professional resistance Concern about cost controls may conflict with continuity of care concerns
Education and training	Can sensitize staff, administrators, and policymakers to coordination needs Can counter negative attitudes toward certain clients Can provide needed knowledge and skills to deal with unfamiliar client problems Can motivate coordinated care	Funds for continuing training and education may be difficult to obtain Cross-training, while helpful, may be insufficient for client with multiple problems Training and education staff may not be readily available Universities and professional schools are slow to change to train professionals to meet changing needs

effort if none has been previously constructed. Even when an adequate directory of relevant services is already available, further effort is required to keep it current with changes in agency eligibility requirements, funding, and focus.

I & R programs differ in terms of their specific functions, the training of their staff, their target population, and their linkage to a hot line. Sometimes the I & R function includes advocacy for the patient. I & R programs may employ as intake counselors skilled staff who take on responsibilities for interviewing patients and needs assessment. Others may employ volunteers. I & R programs may serve all those who need human services in a particular community, or they may specialize in particular target populations such as substance abusers or senior citizens. Some are integrated with a hot line, others are not.

I & R programs can also play an important role in generating data for use in planning and monitoring services in a community. These data can help identify gaps in service and serve as a basis for identifying the need for developing additional programs, which depend on having competent staff with appropriate training in needs

assessment and identifying the best service available for a particular need or set of needs. Sometimes I & R programs do not include sufficient followup on whether patients reached the service agency, actually received the needed services, and were satisfied with what they received. This type of feedback is important because it affects whether other individuals are referred to the agency and because it helps identify needed changes in services.

I & R systems offer a number of other advantages, including the effective use of specialists to provide quality services and the efficient use of generalist staff to make the referrals to specialists. An I & R program may be relatively small and inexpensive and can help prevent duplication of services.

However, problems may arise in referrals. Being referred to a service may have the negative consequence of first unrealistically raising patients' expectations that their needs will be met and then frustrating them by denying them access to the services they require. Patient dropout from services may be quite high, particularly if inadequate followup is provided. On the other hand, I & R services tend to work best on a small scale and may be inadequate for a high level of demand.

Differences in agency requirements and patterns of functioning may interfere with the success of I & R. Among these problem areas are differences in eligibility requirements, inadequate sharing of patient information, and conflicting treatment plans developed by different agencies. I & R programs may duplicate the diagnostic services of other agencies under certain conditions. Furthermore, in moving from one agency to another, patients may interrupt continuity of care.

Case Example

In New York City, there is an innovative I & R program called the State Homeless Assistance and Referral Program (SHARP). Located in the shelters for the homeless in New York, SHARP is staffed by representatives of alcohol abuse, substance abuse, and mental health programs. These representatives provide screening and referral services at the shelters.

In the State of Maryland, an I & R system is operating within the State hospital system. A printed booklet of residential placements, outpatient treatment, emergency services, and inpatient facilities is available to nursing and social work staff as an aid in discharge planning. The booklet includes addresses, phone numbers, and the names of the contact person for each service.

Centralized Intake and Referral

Centralized intake and referral provides a number of advantages for coordination of services. It provides a single point of accountability. By fixing responsibility for developing and implementing a coordinated service plan, it can assure continuity of care. It may provide access to the full range of services needed by patients and may make good use of drug treatment resources. This type of program provides assessment, planning, linking, monitoring, evaluation, and followup. The service model allows for the different levels of expertise needed at each stage and level of care, and it may prevent duplication of services by acting as an effective broker of treatment.

Like all models of care, this approach also may pose some difficulties. It requires a high level of cooperation among agencies, including willingness to accept referrals and development of strong interagency agreements and commitments. An additional problem is that this type of program may be difficult to fund.

Among its disadvantages is the tendency to "front-end load" effort by disproportionately focusing on assessment without assuring treatment at the site. Additional mechanisms are required for followup to determine whether individuals who are referred to an agency actually receive services there. Patient expectations may be stimulated to unrealistic levels, because services may not be available for all identified needs.

Case Example

The State of Virginia offers centralized intake for mentally ill and substance-abusing patients. The centralized intake is serviced by one agency but shared by several units in that agency. An individual is seen initially by an intake worker, who then assigns the case to either the mental health unit or the substance abuse unit. One unit is increasingly insufficient to meet patient needs. Community boards in the State vary in the degree to which they integrate services based on local needs and availability of funds. For example, Fairfax County, which is an affluent area of the State, combines centralized intake with sophisticated case management and has a high demand for substance abuse services.

Interagency Network Models

Several types of interagency network models have been identified: multidisciplinary teams, bilateral coordination, and multilateral coordination (Wilson 1977).

Multidisciplinary Teams

This model provides a variety of services by including a variety of disciplines on a team. Accessibility of services and continuity of care are enhanced.

There are a number of disadvantages, however. To

provide all the needed services, the team may have to be huge. With larger size comes high cost. There may be difficulties in determining responsibility and in decisionmaking about providing services. This program does not work well outside of population centers, because it requires availability of a number of different professionals. Services may be duplicated across teams.

Bilateral Coordination

It is common for two human service agencies to develop mechanisms for coordinating specific shared programs. Such programs are easier to accomplish than multilateral efforts, but they are limited in the services that they include.

Case Example

An example of a joint program is provided by the private-sector, dual-addiction, treatment and rehabilitation agencies in Maine, which receive partial funding from the State. Before 1973, when Maine passed its Alcoholism and Drug Abuse Act, separate "tracks" for alcoholism and drug abuse services were common. The 1973 legislation mandated an integrated approach to substance abuse prevention, treatment, and rehabilitation. As Thorpe and others (1987) note,

> The State's preference for an integrated approach to substance abuse was reaffirmed in 1981, when legislation established the Alcohol and Drug Abuse Planning Committee, consisting of the Commissioners of the Maine Departments of Human Services, Corrections, Education and Cultural Services, and Mental Health and Retardation (p. 29).

Four years later, all 31 State-supported substance abuse treatment programs offered combined alcohol and drug services (NASADAD 1986, p. 12).

Among the advantages of such a joint program are the following:

- Joint treatment programs for alcohol and cocaine abusers deal with society's double standard, in which alcohol abuse is viewed as less serious than cocaine abuse.
- An enriched treatment experience may be offered by emphasizing common components in recovery issues for both cocaine and alcohol abuse.
- Group treatment in a therapeutic milieu in which elements of the rehabilitation program are the same for all patients based on their similarities strengthens group bonds and the sense of fellowship.
- A combined treatment program promotes a focus on the general issues of addiction and offers an opportunity for profiting from others' perspectives (e.g., cocaine abusers can warn alcoholics of dangers of substituting one drug for another, and alcoholics can help cocaine abusers deal with issues of denial) (Thorpe et al. 1987).

Experience with these programs in Maine also indicates that there are some problems, at least initially. Until sufficient experience is obtained, staff may lack some of the necessary knowledge and sensitivity. For example, for the cocaine abuser, successful role models for long-term recovery may be unavailable and self-help groups may not be available. Alcohol counselors may not be less sensitive to abstinence violation in cocaine abusers (Thorpe et al. 1987).

In Michigan, NIMH CSP funds are being used to add mental illness and substance abuse specialists to an existing mobile outreach team. The Community Treatment/ Support and Chemically Dependent Demonstration Project is an addition to the Harbinger Program in Grand Rapids. The project is seeking to develop a model for treating dual-diagnosed mentally ill substance abusers.

Multilateral Coordination

Agreements among multiple agencies pose more challenges for coordination. Such networks of services facilitate access to a greater variety of services for patients, but networks are more difficult to accomplish because more agencies are involved. Sometimes an external force is required to stimulate coordination.

Case Example

An example of multilateral coordination is provided by the Task Force on Integrated Projects (TFIP), which was set up by the New York State Legislature in 1987 to administer Federal grant monies under the Anti-Drug Abuse Act and to ensure coordination of State agencies that provide services to the multiply disabled and at-risk youth. TFIP funds are designated for dozens of projects throughout New York State primarily serving youth with drug or alcohol problems, and administration of them involves the New York State Division of Substance Abuse Services, Division of Alcoholism and Alcohol Services, State Office of Mental Health, and Education Department.

Case Management

Case management, although not a new idea, has become quite popular in recent years as a mechanism for coordinating services at the patient level. Definitions differ, but most agree that case management is a method or process for ensuring that individuals are provided needed services in a coordinated, effective, and efficient manner (Baker and Intagliata in press).

Although many objectives have been identified with case management systems, four seem most commonly associated with this approach: continuity of care, accessibility, accountability, and efficiency. Continuity of care

includes both assuring comprehensive services at a given time and adapting to the changing needs of the client over time. Case management systems are also charged with making services more accessible—that is, barrier free—to individuals. A case management system enhances accountability by making a single person or agency responsible for the overall effect of the service system (Baker and Northman 1981). By fixing responsibility for developing and implementing a coordinated service plan at a single point, case management can improve the efficiency of the service system.

Case management has been described as a process with multiple functions (Baker and Intagliata in press). Five basic functions appear in most descriptions of case management: assessment, planning, linkage, monitoring, and evaluation (Agranoff 1977).

Structurally, case management systems include two basic components: a case manager and a core agency. The most common element is the role for a person designated as a "case manager," who acts to coordinate service for the individual patient by serving as a human link between the person being helped and the service system. The other component common to case management systems is a "core agency" to which is allocated special coordinating power and authority. The core agency for a locality has responsibility for developing contracts that tie providers to providing specified services for case-managed patients (Mittenthal 1976; Ross 1980). The degree of authority allocated to a core agency varies, but functions may include negotiating agreements among other agencies, controlling funds that allow needed services to be purchased for case-managed patients, acting as a single entry point into a local provider system, and developing missing service elements.

Case management may be offered by an individual case manager, or the case management functions may be shared by a team. Case management teams have been recommended as more appropriate than individual case managers for chronic psychiatric patients (Altshuler and Forward 1978; Gittelman 1974; Kirk and Therrien 1975; May 1975; Test 1979; Turner and TenHoor 1978). Such a team comprises a group of individuals who jointly share the responsibility for the case management functions of assessing, linking, and monitoring to assure continuity of appropriate care for patients. Members of the team might all be case managers, or the team might include only one case manager along with professionals from other disciplines (e.g., psychiatrist, nurse, psychologist, social worker).

Among the advantages claimed for a team structure are that it provides (1) more continuous coverage and coordination, because the unavailability of a single case manager does not incapacitate the patient; (2) better planning, based on the availability of more points of view for managing difficult problems; and (3) a way to avoid isolation and burnout (Test 1979).

Whether offered by an individual case manager or a team, the advantages of case management are multiple. This coordination approach can be particularly helpful to patients in negotiating the complexities of an otherwise unintegrated service system. By fixing responsibility for developing and implementing a coordinated service plan, case management can assure continuity of care. As noted previously, a case management system can act as a single point for accountability.

Disadvantages include the dependence of case management on the high degree of commitment required of case managers. The job makes great demands on the people performing as case managers, and burnout is a likely problem. The necessary long-term commitment to patients also adds to the burden of the job. To be effective, the approach requires a relatively small case load per case manager. Specialized training is likely to be required. Typically, the case manager finds it necessary to go to the individual rather than meet in the case manager's office, which adds to the danger and inconvenience of the job.

The availability of services is an important factor that can enhance or impair the effectiveness of case management services, independent of the characteristics of case managers, the individuals they serve, and the work environment. Case management alone cannot be expected to solve the problems created by incomplete and inadequate service systems.

A further problem should be mentioned. Unfortunately, the term "case management" has recently been appropriated by those concerned with controlling the use of services to reduce costs (Baker and Vischi 1989). This association of case management with managed care in the alcohol treatment field resulted in the Institute of Medicine's Committee for the Study of Treatment and Rehabilitation Services for Alcoholism and Alcohol Abuse deciding not to use the term at all. Instead of "case manager," they felt it necessary to use the awkward phrase, "the person who assures continuity of care" (Institute of Medicine 1990). Financial and clinical goals for case management do not necessarily have to be incompatible, but it is unfortunate that the managed care exponents have confused matters by borrowing a term with an opposite clinical meaning.

Case Examples

The Addiction Research Foundation of Ontario, Canada, developed a coordinated services

model for problem drinkers, which included case management as a central component. After a comprehensive assessment, each individual was assigned a case manager to help him or her move through the treatment system. The case manager's role involved tracking individuals in the community to provide continuity of care, facilitate access to community services, and help them with crises (Ogborne and Rush 1983).

In Illinois, the directors of the Department of Alcoholism and Substance Abuse and the Department of Mental Health and Developmental Disabilities convened the Task Force for the Mentally Ill Substance Abuser. The task force defined key core service components: alcohol and substance abuse treatment, mental health treatment, screening and assessment, medication monitoring, crisis intervention, and linkage to detox and self-help groups. To coordinate all these core service components, the task force decided on case management.

According to the Illinois task force plan, case managers would be responsible for developing a coordinated, nonconflicting treatment, aftercare, and discharge plan among multiple providers. Further, as patients were discharged from either mental health or substance abuse treatment, case managers would continue to provide linkage to other necessary components such as housing, medical, and employment services. Case managers would also be charged with monitoring patients in case support and intervention were necessary to help prevent relapse or rehospitalization.

Other functions that case managers would be responsible for in the Illinois model program include advocacy, assertive outreach, and engaging and maintaining the patient in the treatment system. Case managers would also have a role in providing the data and reports that would allow tracking of patients. The service utilization data provided by case managers would be used to identify gaps in services, such as a lack of detoxification services or the need for specialized residential and outpatient services. Jointly funded by both the mental health and the substance abuse systems in Illinois, the case management services would be delivered by specially trained staff.

In Hennepin and Ramsey counties in Minnesota, the State funds two case management teams to deal with perinatal addiction. Interorganizational coordination is facilitated by having representatives on the teams from relevant community agencies. The addicted pregnant women are seen first by a primary intervention team, which includes a social worker, a chemical dependency counselor, a staff member from public health services, and a child protection worker. After initial intervention, each patient is referred to a continuous service team, which sees that she is referred appropriately for care of her prenatal, housing, employment, and educational needs.

Rhode Island has established intensive case management for a small population who have very special needs—drug-abusing women who are pregnant (or already have children) and who test positive for HIV infection. Some are on methadone maintenance, and all have multiple needs, one of the most difficult of which to provide is housing.

The State of Washington also has a case management program for pregnant substance abusers. Among the resources that are particularly important for this group of patients are transportation and housing. Because many of the women already have children, child care is also an important service to which the case managers try to link their patients.

Another interesting type of case management program in Washington State is a program developed for alcoholics and drug addicts who, because of the degree of their chemical dependency, were unable to work. They were eligible for welfare, but they tended to use their support funds to purchase alcohol or drugs. In an effort to deal with this problem, the State legislature established a "protective payee" program in which case managers received the checks for their patients and took responsibility for disbursing these funds for them (Morgan et al. 1990). Each case manager had a case load of about 35 patients, and in addition to making sure that welfare funds were not spent to support patients' addictions, the case managers sought to improve patient hygiene, housing, and nutrition. This model of case management is more directive and controlling than some others.

In Virginia, community service boards have case managers available for alcoholics, drug abusers, and the severely mentally ill. These case managers are responsible for assessing needs, making referrals, and coordinating services. The degree of intensity of case management differs for the mentally ill and substance abusers. For the mentally ill patients, case management is offered as a primary service, and relatively intensive service is offered indefinitely; the philosophy of treatment is to "empower" the patients. For substance abuse patients, case management is an ancillary service and has a different focus; for these patients the emphasis is on getting them to be responsible for their illness and their behavior. Case managers working with substance abusers must be careful not to become overinvolved in primary care activities for patients; rather, they must focus on providing plans of care so that the patient is ultimately responsible for carrying out the necessary activities. If the case manager becomes overinvolved in providing care for

substance abusers, who generally function at a higher level than the chronically mentally ill, the patient may be "enabled" to continue the behaviors associated with substance abuse without experiencing the consequences of those behaviors.

Sharing Staff

By sharing staff, agencies can make budgets go farther and gain competence otherwise missing from their ranks. This type of arrangement can also improve services coordination. When staff are shared and the staff members operate as coworkers, capabilities can be extended and providing coordinated services is facilitated. Access to services is facilitated by linking staff to multiple providers at a single location; patients are freed of the transportation problems associated with seeking treatment at different sites.

The disadvantages of the shared staff approach include the possibility of jurisdictional disputes affecting work relationships, and conflict brought on by different treatment philosophies. If public and private staff are brought together, civil service advocates may be antagonized. Also, supervision and authority relationships may be difficult for this type of coordination technique.

Financing Models

A number of different financing models may facilitate coordination of services. Vischi (1988) described these in some detail. Generally, such mechanisms can provide incentives for agency cooperation, stimulate interest in other methods of coordination, reduce costs of overlapping and duplicative services, facilitate accountability, and aid central control of services.

However, financing models typically require authority or legal mandates that may be difficult to obtain. They often produce the disadvantage of expensive and complicated bureaucratic structures. Resistance from agencies and professional groups can make financing solutions difficult to achieve. Concern about cost controls may conflict with concerns about continuity of care.

Among the different types of financing models that relate to coordination are

- incentive programs, which reward or penalize agencies on the basis of coordination efforts, such as performance contracts, unified budgets, and variable matching rates;
- strengthening local entities such as local governments and providers as managers of funding and services; and
- capitation of funds, in which money is pooled and funds are distributed at a certain dollar level per person (Vischi 1988).

Approaches to coordination that result in the loss of a distinctive identity for providers of alcohol and drug abuse services are likely to be resisted. Experience has made these providers wary of the dangers of losing needed funding by giving up too much of their own distinctiveness. Governors and State legislators faced with tight budgets are all too willing to see sharing facilities, staff, or programs as a way of cutting allocations to the participating agencies. To convince agencies to participate in these programs, it is necessary to find a way to deal with their fears about such losses.

Case Examples

Minnesota has developed a unique funding arrangement to provide treatment to low-income, chemically dependent persons. Called the Consolidated Chemical Dependency Treatment Fund, this financing system operates like an insurance policy that provides comprehensive coordinated treatment to Minnesota's poorest citizens. Before the fund began operations on January 1, 1988, treatment services for the chemically dependent varied according to the peculiarities of various funding sources. Assessment and placement were neither uniform nor timely. The clinical options for patients were narrow; there were few incentives for lower treatment costs; and there was little encouragement for innovation or growth in services for minorities, women, and persons with special needs (Gostovich 1990). The fund was created to deal with these problems. Constructed from funds from a variety of State, county, and Federal sources, the fund uses a standard set of assessment criteria ("Rule 25") for placement by counties and Native American reservations with licensed treatment providers. The funding follows the individual through inpatient, outpatient, halfway house, and extended care services. The costs of treatment are negotiated in contracts between counties and treatment providers in their area, and because the fund assures a stream of patients and payments, vendors have an incentive to negotiate contracts with the counties at favorable rates.

South Carolina offers an example of interagency financing. The mental health department provides inpatient substance abuse treatment, and the alcohol and drug abuse commission provides outpatient treatment. Although this is a difficult organizational arrangement, it has led to coordination of services. Staff are not shared; instead service contracts or memorandums of agreement are used. Contracts have been used to increase outpatient services, open a detoxification unit in the mental health department, and purchase counseling services from county alcohol and drug abuse agencies. State-level planning occurred between the agencies, and work has been proceeding at the service level to coordinate services. The fact that the Federal Block Grant distributes

funds to either mental health *or* substance abuse is a difficulty that has discouraged coordination instead of providing needed incentives.

An example of cross-financing is provided by the Community Integrated Living Act (CILA) in Illinois. CILA makes it possible for a preferred provider organization to integrate alcohol and drug abuse services into the community support team framework. On the basis of agreed-upon service plans and cost factors, these services may be provided by private or public providers and may be financed by funds from the Illinois Department of Mental Health. The community support team may recommend the purchase of targeted services from other departments and public services systems.

Illustrative of the role that reimbursement plays in determining whether multiproblem patients are provided coordinated services is the situation in Washington State, where there is case management for pregnant addicted and alcoholic women. Providing case management to nonaddicted pregnant women yields a reimbursement of $60 per month; the reimbursement rate for addicted women is $90. With these reimbursement rates, it is difficult to recruit case managers.

Case managers appear to be employed far more frequently for mentally ill patients than for drug- or alcohol-dependent persons in the community treatment setting. Perhaps this situation needs to be addressed through changes in reimbursement methods so that drug or alcohol case managers can be paid for outpatient services by Medicaid or by private insurance plans.

Publicly funded mental health programs in New York now have an added category of intensive case managers for patients who have more difficult problems and who are living in the community; these case managers are allowed to have smaller case loads and receive higher pay. Team approaches have been used, in which a pool of individuals is served by the team. However, no equivalent exists for drug-dependent persons.

In Virginia, special monies are made available for the dual diagnosed through a competitive request-for-proposal mechanism. Through this approach, Block Grant funds are distributed to the stated disability, but programs that include the dual diagnosed have a better chance of getting funded because extra bonus points are assigned to programs that serve this population. Specialized program review is provided by both mental health and substance abuse staff, who review programs and also provide technical assistance.

Education and Training

Conferences, seminars, and other educational forums can help to sensitize staff, administrators, and policymakers to the need for coordination and some of the particular problems that arise in achieving it. Recently the dual diagnosed as a population requiring coordinated services have received considerable attention at conferences. Similarly, the homeless, mentally ill substance abusers with AIDS, and other high-risk populations have been discussed at national, State, and local meetings. Such educational meetings can help set the stage for planning and developing needed services for these challenging patient groups.

Negative attitudes can act as barriers between certain patients and the treatment they need. For example, substance abuse patients may be viewed negatively by mental health staff, who may not want to deal with them. Likewise, mentally ill patients who also have chemical dependencies may find it difficult to get services for their addictions because of prejudice. Training and education efforts can help counter these attitudes.

Continuing education and training can provide needed knowledge and skills to deal with patient problems that staff did not learn about in their original education and training. New problems and new techniques of treatment require special attention.

Education of professional staff can also provide motivation for finding better ways of working together. Changing professional ideologies have been instrumental in the past in encouraging new approaches to treatment and prevention.

There are problems in this area as well. Funds for training and continuing education may be difficult to obtain. Federal cutbacks of training funds have left gaps at the State and local levels, although some programs of technical assistance are still active.

Cross-training, which is a popular solution for preparing staff to deal with the dual diagnosed, may be insufficient. It is not enough for mental health personnel to get some training in substance abuse treatment and for substance abuse staff to get training in how to deal with mental disorders. New training must be developed for dealing with patients with multiple disabilities that neither traditional treatment approach is adequate to handle.

To do good training and continuing education not only requires funds but also takes staff with appropriate teaching skills and abilities. These prerequisites may not be readily available.

Some training is best done while professionals are still in school. For example, Peyser (1989) explains why alcohol and drug abuse are often unrecognized and untreated by mental health professionals:

> Why are patients like these so often misdiagnosed? Because we do not adequately teach about

> alcohol and drug abuse in our schools of medicine, social work, and psychology. Where it is taught, it is minimized as a second-class disorder. Major medical teaching centers lack alcohol and drug treatment programs, and residency and other graduate mental health training programs do not include the subject in their curriculums (p. 221).

The basic changes that are needed in universities and professional school curriculums may be slow to occur. Furthermore, it takes time for prospective staff to finish their professional education. Placements and internships can be helpful in getting new approaches incorporated faster into the preparation of students.

Case Examples

Examples of training and educational efforts to encourage coordination of services for people with multiple needs include broadly focused conferences, general training in mental health and substance abuse, and specific cross-training in dealing with the dual diagnosed for staff previously trained only in mental health *or* substance abuse treatment.

Rhode Island held a statewide conference called "Finding Common Ground," which brought together more than 300 mental health and substance abuse workers and other services representatives. Leaders in the field were brought in as speakers. The conference included closing remarks by the Governor of Rhode Island. The planning committee will continue to look at the issue of providing more effective treatment for mentally ill patients with substance abuse problems.

Rhode Island also provides an example of a general training program for those working with patients with multiple problems. The State's Division of Mental Health and Substance Abuse developed for State staff a model curriculum on all aspects of substance abuse and mental health and attempted to fund this training by submitting a Federal grant application.

A task force on the dual diagnosed established by the Tennessee Commissioner of Mental Health and Mental Retardation made cross-training of existing staff a major focus of its activities. Staff of the Tennessee Mental Health Institute and Center and substance abuse staff received cross-training to help them with the previously unfamiliar services they were attempting to deliver for patients with both mental health and substance abuse problems. Funds were also allocated to put an alcohol counselor in the mental health facility.

Another example of cross-training is provided by the Kelley Institute, a freestanding, not-for-profit institute in Minnesota that provides outpatient treatment for dual-diagnosed patients. Mental health patients are referred to the institute if they have substance abuse problems. All full-time staff at the Kelley Institute are cross-trained.

In New York State there are a number of cross-training courses for the staff of psychiatric hospitals and clinics, and for professionals working in alcohol and drug abuse agencies dealing with mental illness and substance abuse problems. One such set of programs is offered by Narcotic and Drug Research, Inc., of Colonie, NY, operating under contract to the Division of Substance Abuse Services.

Chapter 6—Recommendations

Choosing Coordination Mechanisms

In choosing coordination mechanisms, it is appropriate to attempt to match the approach chosen to (1) the specific goals for coordination, (2) the specific environmental context, (3) the resources available, (4) the developmental stage that has been achieved, and (5) the results of evaluative feedback.

The goals that are shared by agencies at a particular time should be considered when decisions are being made about what mechanisms to use in trying to coordinate services. If coordination is thought of as an evolutionary process, some mechanisms are probably more appropriate at a particular stage in the developmental process. Although research has not yet been carried out to determine whether this hypothesis is supported, it seems logical that some mechanisms require less commitment by other organizations and relatively less funding.

Task forces and other types of committees can be effective as initial steps in coordination, particularly if they are set up with the clout of the State's governor or legislature behind them. I & R has several advantages as an initial effort, not the least of which is that it is likely to cost relatively little. The development and updating of a good directory of community services can reveal service gaps and barriers that may point to the directions that further coordination efforts should take. Such a resource assessment can also reveal whether eligibility requirements are interfering with individuals getting needed services and causing difficulties in accessibility. Bilateral coordination—because it involves only two organizations—also is probably easier to develop at a stage of more limited goals. Cross-training can be undertaken at an early stage of development and can do much to make staff receptive to later efforts. The source of the impetus for coordination (e.g., political, administrative, legal) also affects the design of the mechanism selected and impacts the degree to which the mechanism and its implementation succeed.

Some approaches are difficult to achieve in particular environmental situations. The array of services, their distance from one another (both physical and social), the strength of particular governmental units, the strength of existing agencies, the economic and political-ideological climate, and the nature of the local populations in need are examples of the local environmental variables that need to be considered in choosing coordination mechanisms. For example, colocation of services makes much more sense in some environments than in others. I & R can do much to make up for the lack of services in a community.

Finally, it is appropriate to adjust planning and implementation of coordination mechanisms according to feedback from an ongoing formative evaluation. Feeding back process evaluation findings and assessments of progress toward goals can help correct programs that are veering off course.

Six Steps for Developing Coordination

In developing coordination, six steps are recommended:

1. Assess the current environment.
2. Build support for coordination.
3. Design a coordination program.
4. Implement the program.
5. Evaluate the program.
6. Adjust the program and build sustainability.

Assess the Current Environment

Services at the local level vary a great deal, and existing resources differ considerably from community to community. In this first step, geographical and political boundaries are important to establish. Typically, some statewide efforts are involved, but most effort is needed at the regional, county, and municipal levels. Techniques of needs assessment are employed to determine the needs of the people for whom services are to be provided, and methods of resource

assessment are used to establish which organizations in the environment may provide the needed elements of support.

Build Support for Coordination

Because successful coordination depends not only on resource and structural adequacy but also on compatible perceptual assessments, building a positive attitude toward coordination and its goals is also important. Certain characteristics of staff can be built upon. For example, research has shown that staff members who have a strong professional background and place a high value on meeting patient needs tend to support coordination (Whetten 1978). Also, there is evidence that staff members with cosmopolitan beliefs are more willing to take greater risks with unfamiliar staff members from other organizations (Becker 1970). Other studies have demonstrated the motivating power of professional ideologies in changing human service programs (Baker 1982). Professional conferences with invited speakers who can inspire agency staff to believe in the value of coordination and who can demonstrate its worth through accounts of their own experiences can be useful in helping to develop necessary ideological commitment.

Meetings with professionals from other agencies in small task groups focused on examining the potential benefits of coordination can build shared values and facilitate later networking activities. Positive views toward coordination expressed in the statements of top level administrators and demonstrated in organizational policies and rewards can do much to facilitate a positive attitude among staff. Consumers of services and their families should also be provided with an opportunity to learn about and to provide input to the planning of services that will affect them.

Design a Coordination Program

The third step is to design a coordination program based on the needs and resources assessment that have been accomplished. Designing a successful program coordination is a cooperative task, whether one is attempting voluntary cooperation or proceeding on the basis of authority or law. Research has demonstrated that an essential condition for interorganizational coordination is the recognition of partial interdependence (Akinbode and Clark 1976; Davidson 1976). It has been suggested that there is an optimal level of interdependence for promoting coordination (Van de Ven 1976). If organizations have too little in common they will have little motivation to collaborate; and if they share too much, they are likely to see each other as competitors and not want to work together.

Some organizations can be identified as more apt to feel interdependent with other organizations in the same community. Organizations that have broad goals, provide diverse services, and serve a wide range of individuals are more likely to view themselves as interdependent with other agencies in their environment (Whetten and Aldrich 1978).

Implement the Program

To ensure effective implementation of a program, it is necessary to have commitment from program staff and resources adequate to the task. Involvement is a key to effective implementation. If the persons and organizational units who are to deliver program services are involved in the program-planning process, they can be expected to be more committed to the decisions and therefore more likely to do their best to enact these decisions. Previous research has shown that the existence of affiliation agreements is one of the predictors of closely coordinated services (Baker et al. 1972). In working out formal affiliation agreements, commitment to coordination is apparently enhanced by the involvement necessary to develop an affiliation agreement.

Three types of resources are essential to effective planning and implementation of human service programs: people, material resources, and time. Recruitment of the right people and attention to their training and the design of their jobs are all crucial. Further, if the necessary material resources are not available, implementation will be difficult.

A key dimension of the human and material resources needed for implementing a coordination program is appropriate technology. For example, a needs assessment that produces poorly gathered and analyzed information will be less than useful; it may make the situation worse.

Although the importance of committed and effective people and material resources is obvious, the relevance of time may be less so. Timing is crucial in the planning of specific coordination activities. A project management plan with specific time lines for implementation of various tasks is needed.

Time is also an important constraint: the parts of the system have to be available at the time they are needed. Time is important in another way; if elements of a program are too widely dispersed, effective coordination may not be feasible. Previous research on coordination has shown that if staff and patients have to travel 45 minutes or more between the program elements involved, coordination is unlikely.

Evaluate the Program

Both formative evaluation (the feedback of process evaluation data to allow program improvement) and summative evaluation (assessing the effectiveness of the

fully developed program in meeting its outcome goals) are important. Planning for evaluation should be included as part of the initial planning for the coordination program and tied into a periodic needs assessment process.

Adjust the Program and Build Sustainability

On the basis of formative evaluation feedback, the program should be adjusted to correct the program's progress toward its goals. Efforts to achieve change must be complemented by efforts to sustain effective changes.

Role of the Lead Agency

To be effective, coordinated systems require the cooperation of almost all providers of human services. In States that have separate departments serving the mentally disabled and alcohol and substance abusers, a lead agency is important to link its efforts with other departments in the State government. In New York State in the late 1970's, for example, the Office of Mental Health played the lead role in developing and managing CSS services for chronic psychiatric patients in the community. However, the Governor's Interagency Task Force was formed to bring together the various human service departments that relate to CSS patients so that those departments could serve those patients better.

A subcommittee of that task force dealt specifically with case management services, because they were such an essential component of the system. This subcommittee included representatives from the Office of Mental Health, Department of Social Services, Office of Vocational Rehabilitation, Office for Aging, and Office of Mental Retardation/ Developmental Disabilities. Its purpose was to improve the practice of case management by finding out which agencies were fulfilling the functions and recommending ways to reduce duplication and enhance the efficient and effective delivery of case management services to CSS patients (Governor's Interagency Task Force 1979, p. 1).

Such an interagency coordinating body is essential when responsibility for case management services or other coordination mechanisms is delegated to an agency that serves only a particular population, or provides only specific service functions. However, the need for such an organizational structure may be less in States where the responsibility for human services is assigned to a single, generic agency. Clearly, the nature of the State human services structure will determine how ADM coordination efforts may best be organized and administered.

The establishment of mechanisms to facilitate the coordinating efforts of lead agencies is important. The most essential of these is the "purchase of service" power, so that lead agencies can directly buy at least some services from other local agencies (Ross 1980; Washington et al. 1974).

In addition, a local counterpart to the State interagency task force may be useful. For example, local interagency cooperation could be facilitated if the lead agency formed a local interagency committee (New York State Office of Mental Health 1978). Such a committee could facilitate negotiations about which roles would be performed by which agencies and could help identify gaps in the service system. The core agency could use this committee to strengthen its ability to coordinate services for patients and to ensure that the entire range of needed services is available.

Another way to strengthen a core agency is to designate it as the single entry point to the service system in its geographic area. This approach has been used for the mentally retarded in California (i.e., regional centers) and was recommended for use in serving the developmentally disabled in New Jersey (Lippman 1976). A single-entry-point core agency has much greater control over patients than a core agency that must rely on multiple outside agencies to refer patients for coordinated services.

The impact of a service linking and coordination mechanism will be diluted if needed services are not available. For example, if a patient must live in a supervised residence to adjust to community living, and no such residence is available, a case manager cannot solve the problem. Case management can help patients improve the continuity of care they receive from a given service system, but case management cannot wholly succeed in a system that is missing major components. The development of needed services must precede, or at least be contemporaneous with, the development of a case management system if that system is to succeed. In most cases, a case manager should be a part of the core agency. Then, if the core agency has been given adequate authority and power, the case manager is better able to gain the cooperation of other service providers in the area. However, a core agency may choose to contract with another local agency for case manager services. This approach may help avoid potential conflicts of interest, as, for example, when the core agency is a major provider of direct services to patients.

Of course, the use of a core agency as a single point of entry for a disabled population is not without possible drawbacks. If not controlled properly, an agency might monopolize admission to services and stifle competition from other providers who might be more expert.

Final Note

Coordination is not automatically good and lack of coordination automatically bad, coordination has a price, and it should be assessed in a cost-benefit context. However, if the choice is made to attempt to meet the comprehensive needs of patients with ADM disorders, then services coordination should be strongly advocated, if not mandated. In any case, effective coordination of services requires leadership at all levels: local, State, and Federal.

Appendix A

List of Attendees at Conference on Coordination of ADM Services, April 19, 1990

Frank Baker
Consultant
OTI

Henry Bartlett
Supervisor
Third-Party Reimbursement
New York State Division of Substance Abuse Services

Phil Brekken
Program Services Supervisor
Chemical Dependency Program Division
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