Barriers to the Care of Persons With Dual Diagnoses: Organizational and Financing Issues

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Abstract

Among the frustrations of managing the dual disorders of chronic mental illness and alcohol and drug abuse is the fact that knowing what to do (by way of special programming) is insufficient to address the problem. The *system* problems are at least as intractable as the chronic illnesses themselves. Organizing and financing care of patients with comorbities is complicated. At issue are the ways in which we administer mental health and alcohol and drug treatment as well as finance that care. Separate administrative divisions and funding pools, while appropriate for political expediency, visibility, and administrative efficiency, have compounded the problems inherent in serving persons with multiple disabilities. Arbitrary service divisions and categorical boundaries at the State level prevent local governments and programs from organizing joint projects or creatively managing patients across service boundaries. When patients cannot adapt to the way services are organized, we risk reinforcing their overutilization of inpatient and emergency services, which are ineffective mechanisms for delivering the care these patients need. This article reviews the barriers in organization and financing of care (categoric and third party financing, including the special problem of diagnosis-related groups limitations) and proposes strategies to enhance the delivery of appropriate treatment.

The National Institute of Mental Health (NIMH) Epidemiologic Catchment Area (ECA) study, which investigated the prevalence of mental, alcohol, and drug abuse disorders among the general population, found the co-occurrence of these disorders is quite frequent (Boyd et al. 1984). Recent reviews of the mental health and the alcohol and drug abuse literature (Ridgely et al. 1986; Galanter et al. 1988) indicate that the problem of multiple illnesses or disabilities is the rule rather than the exception among individuals seeking mental health and alcohol and drug treatment in the public sector. In addition, the clinical and social consequences of co-occurrence have been the focus of much attention. Within the mental health literature, the combination of alcohol and drug abuse and chronic mental illness has been found to exacerbate psychiatric illness (Janowsky and Davis 1976; Knudsen and Vilmar 1984; Negrete et al. 1986), result in costly rehospitalization and other treatment (Bassuk 1980; Safer 1987; Drake et al. 1989), and often increase the chance of acting-out and suicidal behavior (Caton 1981; Richardson et al. 1985). Within the alcohol and drug abuse literature, the co-occurrence of psychiatric symptomatology with alcohol and drug abuse is associated with poor prognosis, regardless of treatment modality (Alterman et al. 1982; McLellan et al. 1983). Mental health interventions that do not attend to alcohol and drug abuse problems produce poor outcomes

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for individuals with dual diagnoses[1] (Cohen and Klein 1974; Hall et al. 1975; Safer 1987).

Patterns of service utilization are of particular concern. Commentators have noted that chronic mentally ill young adults have become regulars of the general hospital emergency and psychiatric emergency units (Bassuk 1980; Egri and Caton 1982; Goldfinger et al. 1984). Richardson et al. (1985), reporting on a retrospective longitudinal treatment utilization study of 56 young schizophrenic patients, characterized their treatment utilization as "heavy, discontinuous, and episodic with these patterns intensified for patients with histories of drug abuse" (p. 104). They also reported significantly more inpatient admissions, admissions of shorter duration, and more nontreatment periods for the drug-abusing study group. Less than 10 percent of the drug-abusing sample received any care from a drug abuse facility. These findings were consistent with studies by other investigators in the late 1970's (Cohen and Klein 1974; Hall et al. 1977). In addition to the reticence of patients to seek care and remain in treatment, it is clear that persons with dual disorders are often refused admission or discharged prematurely from care facilities in both sectors (Galanter et al. 1988).

Current approaches to treating persons with dual diagnoses emphasize the necessity of providing intensive and specific treatments for both illnesses concomitantly, combining the resources of mental health and alcohol and drug abuse services (Ridgely et al. 1987; Lehman et al. 1989; Minkoff 1989; Osher and Kofoed 1989). However, producing *hybrid* services requires breaking out of the conventional categorical boundaries now separating the two service systems. This act of organizational innovation and coordination has rarely been initiated, despite the far-reaching consequences of not doing so. Beyond the cost of inappropriate service utilization and the mutual frustration it engenders in caregivers and patients are the tragic and costly deterioration, lost productivity, and lost lives it ultimately produces. Individuals with dual diagnoses are a challenging clientele, under the best of organizational arrangements, but now they are suffering from the excess burden of trying to deal with service systems designed for *single disabilities* and as yet unable to accommodate their particular needs (Ridgely et al. 1986). Bachrach (1987) refers to this problem as an externally imposed disability, but one amenable to intervention.

Historical Perspective on the Organization and Financing of Mental Health, Alcohol, and Drug Services

By the 20th century, public treatment of persons with mental disorders was the domain of the States. Early treatment of mental disorder amounted mostly to custodial care within State asylums. Later reforms brought a shift of mentally ill patients out of asylums and into a variety of specialized private and public mental health facilities. Public hospitals cared for the most disturbed and disadvantaged patients. The advent of health insurance in the 1930's (and public insurance, Medicaid, and Medicare in the 1960's) spurred a new private industry in mental health services, especially inpatient services (for which there were more comprehensive benefits). One of the reasons for the limitations of insurance benefits was the large well-developed system of public services already in place. Insurers had little incentive to cover illnesses already financed by government. With the advent of third-party payment, payers (and regulators) were concerned with the appropriateness, effectiveness, and cost of care (Ridgely and Goldman 1989).

The Federal Government had a principal role in financing the development of community-based inpatient and outpatient services in the 1960's and 1970's (through the establishment of the Community Mental Health Center and Community Support Program grant-funding mechanisms at NIMH). With consolidation of the various grant mechanisms into block grants under the Omnibus Reconciliation Act (OBRA) of 1981, the States

[1]The authors are aware that the term *dual diagnosis* is not acceptable to some, although we choose to use it as a shorthand descriptor for the co-occurrence of chronic mental illness and alcohol or other drug abuse. *Chronic mental illness* refers to several mental disorders, including, primarily, schizophrenia, but also personality disorders and major affective disorders. Regardless of diagnosis, mental illness is considered chronic if it is sufficiently severe and enduring to cause lasting disability and recurrent contact with the mental health system. *Alcohol or other drug abuse* refers to the use of drugs and/or alcohol singly or in combination, resulting in a *DSM-III-R* (American Psychiatric Association 1987) diagnosis of substance abuse or substance dependence. Co-occurrence, co-morbidity, and dual diagnosis are used interchangeably.

It is also recognized that the broad category of "dually diagnosed" patients includes a diagnostically and functionally heterogeneous group of individuals with a variety of clinical needs.

resumed their role as principal player in determining the character of mental health services (La Jolla Management Corporation 1988).

Alcohol and drug treatment developed in a distinct, though parallel way, from the development of psychiatric care. In 1935, Alcoholics Anonymous (AA) was founded by two recovering individuals as a means to help each other become sober through mutual support. Proponents of AA were clearly frustrated that many physicians (and, especially, psychiatrists) subscribed to the view that alcoholism was due to an underlying personality disorder (Vaillant 1980). Many of the public felt that alcohol and other drug abuse reflected moral weakness rather than medical illness. Modern treatment approaches, such as the "Minnesota model," began to be developed in the 1950's and 1960's (Laundergan 1982). In the 1950's the American Medical Association and the World Health Organization recognized alcoholism as a disease amenable to medical treatment, and the courts began challenging the criminality of public drunkenness. Passage of decriminalization laws in the early 1970's served to redirect the responsibility for "inebriety" from the criminal justice to the health sector (Finn 1985) where a continuum of coordinated treatment (and rehabilitation) services was to be available. Before the passage of decriminalization legislation in 34 States in the last 20 years, custodial care was also provided for many public inebriates—in jails. Even with decriminalization, in many places detoxification continues to be the principal service available to the indigent.

Early services relied on lay counselors—many of whom were recovering individuals. However the development of an alcohol and drug treatment industry[2] included a push to bring alcohol and drug treatment into the medical field for legitimacy and access to third-party payment. It led to the development of services in a variety of settings; in general hospitals, detoxification centers, freestanding treatment centers, and private hospitals. Typically, coverage for alcohol and drug treatment was limited in health insurance, however, because of the continued belief that alcohol and drug abuse is a self-inflicted disorder. (Limitations in coverage for alcohol, drug, and mental disorders are discussed in more detail below.) Legitimization brought to the field licensing rules, training requirements and accountability which had not characterized AA and lay treatment services, and which were not necessarily welcomed by the industry. Alcohol and drug treatment is an evolving field; while many programs still treat all entrants in essentially the same way, it is increasingly recognized that different treatment may be required for different people with different problems (Zinberg and Bean 1981).

Notwithstanding the move by the treatment industry toward increasing professionalization, many in the alcohol and drug field continue to distrust medicine—in particular, psychiatry—and consider the use of any mind-altering substance to be unacceptable. At the extremes, alcohol and drug abuse counselors may believe that mental illness is simply a symptom or manifestation of alcohol or drug abuse. Alternatively, mental health workers may believe that alcohol and drug abuse is merely self-medication for an underlying mental disorder. While these extremes do not represent the fields at large, such conflicts are often played out in the day-to-day management of patients with dual diagnoses. Even within the alcohol and drug field, there is no clear consensus about the optimal treatment for patients with dual diagnoses.

The Federal Government exerted its influence through legislation creating grant-funding mechanisms to expand service capacity and developing national institutes on Alcohol Abuse and Alcoholism (PL 91-616) and Drug Abuse (PL 92-255). State agencies carried the prime responsibility for providing public alcohol and drug abuse services and for funding private services. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) funded no service projects from 1981 to 1988, when NIAAA resumed using its demonstration authority with appropriations from the Stewart B. McKinney Act to provide treatment services for homeless persons. Currently the Federal Government also asserts its influence on the availability of alcohol, drug, and mental health services across the States through the benefit structure of Medicare and Medicaid.

[2]This treatment industry is to be differentiated from AA, even though AA principles may be part of treatment and staff may themselves be recovering individuals. The alcohol and drug treatment industry is similar to other medical business concerns, with lobbyists and official spokespersons, in contradiction of the traditions of AA (e.g., no one individual can speak for the organization).

Organizational and Categorical Funding Barriers: The Public Systems of Care

The lack of a common administrative structure for alcohol, drug, and mental health services in most States cannot be overemphasized as an impediment in developing systems of care for individuals with comorbid conditions. Before there was a focus on the need for concurrent treatment of patients with dual diagnoses, highlighting the need for collaboration across service system boundaries, the chasm between alcohol/drug and mental health systems in many States and communities was widely acknowledged. The organizational discontinuities are manifested in some areas in the lack of one *authority* to which both systems are responsible and in the reality that separate authorities may mean different structures and the lack of contiguous service or planning areas across the State.

According to the National Association of State Mental Health Program Directors (personal communication, October 1989), in 22 of the 55 States and territories, the State Mental Health Authority (SMHA) administers the State's alcohol and drug programs. In at least 12 additional States, the SMHA and the Alcohol and Drug Abuse Authority are separate but relate to the same State administrative department (usually the State's Health or Human Services Department). That means that *in the remaining 21 States/territories, the SMHA and the Alcohol and Drug Authority are entirely separate administrative structures and report to separate State supraordinate departments.* And, according to data from the National Drug and Alcoholism Treatment Utilization Survey (personal communication, October 1989), in at least eight States/territories, Alcohol Authorities and Drug Authorities are distinct entities.

Further complicating the landscape, in some States/territories, *separate levels of government* are in charge. For example, in the case of New York, the city has a Mental Health, Mental Retardation and Alcoholism agency that is responsible for oversight of programs in these three fields. Drug abuse treatment, however, is purely a State responsibility. In Iowa, Polk County (Des Moines) is responsible for administering hospital and community mental health programs, but the State's Alcohol and Drug Authority funds community alcohol and drug treatment in Polk County by direct contract with individual agencies. The county's mental health authority has no administrative or planning oversight. Interestingly, the SMHA provides the only State-funded, hospital-based care for alcohol and drug abuse—within the State mental hospitals.

The fact that there are three separate institutes that make up the Federal Alcohol, Drug Abuse, and Mental Health Administration (NIMH, NIAAA, and NIDA) both reflects and exacerbates the problem at the State level. Even though there is a Federal Alcohol, Drug Abuse and Mental Health block grant, monies are distributed to State categorical agencies and no significant comingling of such funds has been noted.

These service divisions are not an accident of history but, rather, reflect purposeful attempts to create structures to improve administrative efficiency and visibility for various illness/disability groups. To ensure that categorical monies were spent for appropriate target populations, service systems set up eligibility requirements, usually focused on diagnosis. Utilization review and licensing standards were mechanisms used to ensure that *eligible* individuals were served with categorical monies. When categorical funding became especially tight, competition for scarce resources reinforced the necessity to screen out ineligible, though often needy, individuals. When individuals with multiple needs approached service systems, the initial view was toward determining the *primary diagnosis* as a way of determining eligibility. This might result in one of two poor outcomes: identifying persons as needing what one is equipped to provide (without reference to other needs) or identifying persons as needing what someone else provides, as a way of denying access to services. Both are forms of *institutional denial*. An associated problem results from the fact that individuals requesting services are likely to be assigned to programs according to their immediate, presenting problem. Because both chronic mental illness and alcohol and drug abuse are chronic disorders characterized by acute exacerbations, attention to immediate symptoms may not result in good long-term placement.

Concerns about scarce resources result in requests for collaboration being seen as attempts to encroach on one another's territory. Though remarking on phenomena in other parts of the psychiatric system, Goldberg and Fogel (1989) have noted that "paranoia tends to develop when institutions approach each other with issues involving loss of control" (p. 1060). If it is not agreed that there are mutual patients across the service systems, there is the suspicion that "they want our money to treat their clients."

Added to this suspicion is the history of mistrust and philosophical differences across the service systems. As characterized in a recent policy report in New York State,

> The Commission was aware that this problem has existed for decades, that it has been exacerbated by ingrained patterns of behavior of separate service delivery systems. . .and that these patterns of behavior are themselves reflective of the absence of a clear clinical consensus on appropriate treatment strategies. [Sundrum 1986, p. iii]

Philosophical conflicts, different training and credentialing of caregivers (especially the differential focus on professional credentials in the mental health field), and lack of respect for one another's competency have exacerbated the barriers between the service systems. Stereotyped attitudes are fueled by a lack of information about the respective fields, as well as a general lack of questioning of preconceptions about effective treatment approaches (Harrison et al. 1985). The problem might be addressable were it not for the complication of the multiplicity of views within each field about the nature of the disorders and philosophies of intervention.

Regardless of the origins or reasons for the perpetuation of existing administrative boundaries, for direct providers of service who wish to serve persons with dual diagnoses, the result is devastating. In most States, providers are licensed and funded exclusively either as mental health or alcohol and drug treatment facilities. They respond to differing administrative structures with specific rules regarding suitable buildings, staffing, and, to a lesser extent, programming. In most cases funding is granted to them to provide specific units of service, allowing them little to no ability to comingle funds (or even provide mental health and alcohol/drug services in the same location). Were it possible to draw down funding from separate funding pools, programs would still be faced with potentially conflicting rules and regulations, and would be subject to audit and other controls of more than one State administrative authority. All of these factors aid and abet institutional denial. There are negative incentives for the identification of individuals with dual diagnoses and certainly no positive incentives for stretching a program beyond its institutional bounds to address individual needs.

Barriers "Outside" of the Public Systems: The Private Sector and Third-Party Funding

The proliferation of facility types providing mental health and alcohol and drug services (mentioned above) was largely the result of the introduction of public and private insurance and the fields' response to these new payer sources. Of note is that mental health and alcohol and drug abuse treatment coverage was mandated in a number of States.

Before the issues in third-party payment are addressed, it is important to note the increasing importance of the private sector facility in psychiatric care. Because of restrictions on payment to freestanding psychiatric facilities (e.g., Medicaid prohibitions on paying for care to beneficiaries in such "Institutions for Mental Disease"), general hospitals have become increasingly important providers of acute psychiatric care. Similarly, general hospitals (and private, freestanding psychiatric hospitals) have been major players in the provision of alcohol and drug treatment. In general hospitals, alcohol and drug treatment programs are often profitable ventures and help to subsidize other hospital services. Although these endeavors may increase the overall availability of treatment beds, they may also systematically exclude public, indigent patients. Even when there are designated "indigent beds," these programs generally demand "motivation" and involvement of the family as prerequisites to admission, allowing them to enroll the less difficult patients (who cost less to treat). Apart from its effect on access to care, the proliferation of multiple providers has created a patchwork of providers who can act as "free agents" in a system, resulting in lack of systemwide coordination. Similarly, a patchwork of payers operates to fund various aspects of needed treatment and support in local communities.

Problems in Third-Party Funding: Eligibility Limits

For some individuals, having a history of mental illness *or* alcohol or drug abuse may prevent them from being eligible for coverage by a third-party payer. Some private insurance companies impose strict underwriting rules on preexisting conditions, blocking individuals with a history of illness from joining the risk pool of insured individuals. Although this is an understandable risk protection mechanism for the third-party payer, it poses serious problems in access to health care for an individual disabled by mental ill-

ness and/or alcohol and drug abuse disorders.

For individuals with general medical conditions who are denied private insurance through underwriting, it is expected that the most disabled among them will be served in the public sector. It is assumed that they will qualify for disability benefits, making them eligible for public health care benefits, as well. For example, they may qualify for disability benefits from the Veterans' Administration (VA) or the Social Security Administration (SSA). Thereby, the disabled veteran gains access to the VA health care system, and the SSA disabled individual gains access to Medicare (after 2 years, if eligible for Social Security Disability Insurance [SSDI] payments) or Medicaid (in 34 States, if eligible for Supplemental Security Income [SSI]). This mechanism, however, is more complicated and less certain for the individual who is disabled by mental illness, alcoholism, or other drug abuse—or some combinations of such problems.

In recent years individuals disabled by mental illness have encountered difficulty in claiming their entitlements from the SSA (Goldman and Gattozzi 1988). Although these problems have been rectified for individuals with schizophrenia and other mental disorders, access to the disability programs of the VA and SSA may be severely limited for individuals who are disabled by alcohol and drug abuse disorders. Both the VA and the SSA have special restrictions on benefits for such individuals. In recent years, moreover, there has been a tendency to expect full recovery from alcohol and drug dependence among SSI recipients, which is seldom, if ever, achieved. Recipients may be denied benefits for failing to continue in treatment, even though the only treatment available may be inappropriate to their needs. Claimants with dual diagnoses, however, may be able to qualify for benefits under the criteria for schizophrenia or some other nonalcohol- and drug-related disorder. Special restrictions impose significant limitations in access to both income support and health care benefits.

Problems in Third-Party Funding: Benefit Limits

Once individuals have qualified for coverage by a third-party payer, they then must be able to gain access to covered services. A new barrier is encountered for individuals with dual diagnoses, who may find that services designed to serve them are not covered or are covered with limits, restricting their utility. Many insurance programs do not provide services for the treatment of alcohol and drug abuse. Almost all policies provide separate limits for mental illness and related treatments. This is true for both private and public sector payers. Until recently, benefits have favored inpatient programs in hospitals, rather than residential and nonresidential alternatives to the hospital. Cost-containment efforts, however, have begun to encourage the alternatives. Programs developed in inpatient settings may now be confronted with efforts to restrict hospital stays, denying patients access to special programs. For older benefit packages, newer programs developed in ambulatory settings may not be covered. Basically, an emerging treatment technology is trapped in a period of transition from strict limits of one type (on benefits) to limits of another type (on costs). As a result, access to coverage may be limited in insurance programs.

Problems in Third-Party Funding: Payment Limits

Cost-containment policies have brought with them new payment strategies, including the use of various prospective payment mechanisms (Scherl et al. 1988). Any prospective system that pays for care at a prearranged rate for a category of service will tend to underpay for complicated cases. That is true, unless the distinguishing characteristics of those complicated patients are reflected in some adjustment to the payment system (such as a casemix measure like diagnosis-related groups [DRGs]). If no distinctions are made for different types of patients, as in health maintenance organizations (HMOs), then there are limited financial incentives to provide costly care to patients with special needs, such as patients with comorbidities. The tendency is for special needs patients (especially the chronically ill) to be underserved in such settings.

When the DRGs were introduced for use in Medicare, the categories for alcohol and drug abuse made no distinctions for different types of treatment needs. Although DRGs have limited explanatory power for resource use (or length of stay) for alcohol, drug abuse, and mental illness categories (Jencks et al. 1987), they were improved for alcohol and drug abuse. Modifications adjusted, first, for patients' need for rehabilitation services, and, second, for the presence of comorbid conditions, such as mental illness.

In all cases, if there is to be an

incentive to provide care for patients with dual diagnoses, payment systems must recognize the increased costs associated with their care. A specific issue raised by some providers is that DRGs force short hospital stays when longer initial lengths of stay might be appropriate for diagnosis and assessment of complicated cases, due to the length of time required to detoxify patients from some specific psychoactive substances. Saving on the initial admission may be lost in repeated readmission.

In addition, rates of reimbursement for specialized programs must be high enough to provide the incentive to deliver quality services. Only then will intensive, specific treatment for comorbidities be available.

Strategies to Enhance Service Delivery to Individuals With Dual Diagnoses

While there is some evidence of a developing treatment technology for these comorbid conditions (Harrison et al. 1985; Ridgely et al. 1987; Lehman et al. 1989; Minkoff 1989; Osher and Kofoed 1989), there is by no means a consensus in the field; and the inertia of the systems of care threatens the implementation of newly developed treatment interventions. As we have asserted above, instead of being based on individual need, treatment may be provided according to historical system structure, treatment philosophy, training of staff, or other factors not related to the costs or benefits of the various alternatives. Changing the status quo may mean altering the behavior of administrators, payers, providers, and individual clinicians. Unfortunately, therefore, the potential solutions are rarely simple or short term. We will address them below, from the simpler to the more complex, starting with organizational barriers.

Permeating Organizational Barriers

At the highest levels of administration (as well as at the local level), it is possible to permeate the barriers through the use of cooperative agreements and jointly funded programs. Although cynics will assert that cooperative agreements "aren't worth the paper they are written on," those inclined to make changes in the administration of systems of care have made use of such arrangements. (The most important ingredient for success may be the will of the parties and the power of signatories to institute the agreed upon initiatives.) For instance, in New Jersey, one of the first States to engage in a statewide effort to address the special needs of individuals with dual diagnoses, the Division of Mental Health and Hospitals (within the New Jersey Department of Human Services) and the Divisions of Alcoholism and Narcotic & Drug Abuse Control (in the New Jersey Department of Health) have established joint working agreements for data collection, planning, and program development. One of the "outputs" has been the development of "service oriented guidelines" that are being utilized statewide by county authorities and treatment providers (alcohol, drug, and mental health) in the development of appropriate services for individuals with dual diagnoses (Bonnie Schorske, New Jersey Division of Mental Health and Hospitals, personal communication March 1986).

In addition to cooperative agreements, joint funding of local programs has been used as a mechanism for developing specialized programs to treat patients with dual diagnoses. In Los Angeles County, the county's Alcohol, Drug, and Mental Health authorities jointly funded a 26-bed residential program called the River Community. While this endeavor has not been without its problems (early clashes over philosophy and later problems with oversight by all three authorities), it provides an example of joint funding with lessons for future endeavors. Observers have concluded that while three funding streams can be used, one authority should be designated for day-to-day administration, oversight, and evaluation of any joint programs. The consultation of the other two authorities will be important to maintaining a quality hybridized program.

The State of Virginia represents a case study in the importance of "top-level interaction and collaboration" along with the use of financial incentives to alter the status quo of program development in the community (Thacker and Tremaine 1989). The State Office of Substance Abuse Services and the Office of Mental Health Services designed a request for proposal (RFP) for mental health funds (which had been earmarked for day support and psychosocial rehabilitation) to focus on the needs of persons with dual diagnoses. The response was a significant number of proposals for treating comorbidity and the development of 18 new community-based dual-diagnosis programs within a single funding cycle.

Briefly, among the approaches to overcoming organizational barriers

in local communities are the following: comprehensive local planning, the development of comprehensive assessment and referral programs, and the development of managed care programs. Most observers would agree that regardless of what level of government is empowered to administer or finance mental health and alcohol and drug abuse treatment, comprehensive planning (involving the alcohol, drug, and mental health authorities) must be done at the local level. Local planning does not necessarily mean local control. It does imply, however, that there is local agreement (with the participation of State authorities) on what services should be provided within the overall system of care and by whom.

Local planning does not address the fact that there are many "doors" into which individuals can enter the system and that their needs are often defined by which door they have entered. Comprehensive evaluation can be an expensive undertaking but is necessary to match individuals to appropriate treatment opportunities. The development of a communitywide assessment and triage program may be an appropriate endeavor, provided the program is staffed with the appropriate expertise and has access to the referral networks across the two (or three) systems of care. There is potential for cost savings as well; triage allows for the substitution of less expensive outpatient alternatives. Interagency tracking mechanisms can enhance the total system's ability to prevent people from "falling through the cracks."

While not an organizational strategy, per se, the development of educational programs at the local level is important to mention. Educational programs (that impart information but also build skill and competency) should be undertaken for agency personnel. Training programs should focus on the uniqueness and special needs of patients with dual diagnoses, preparing clinicians to address the practical issues faced by caregivers in either system.

Managed care has been proposed as a solution to the discontinuities of care, especially for high-risk, high-cost patients. Balancing access and cost containment are two goals of such a system. High-risk patients are identified for more intensive management (often employing case managers). Instead of relying on patient demand or willingness of the provider, a managed care program determines the appropriateness of a particular intervention (for that patient at that time), only allowing access to the most appropriate, efficient service. Managed care programs would, for example, offer alternative programming to decrease the repetitive use of psychiatric hospitalization and residential treatment for alcohol and drug abuse—expensive services without clear evidence of superiority to less expensive outpatient alternatives. Substitution is only possible in those communities where such quality alternatives exist.

Altering Fiscal Incentives

Approaches to addressing the financing problems were imbedded in the earlier discussion (e.g., expansion of benefits, removing barriers to access). Two additional approaches deserve mention: performance contracting and capitation financing.

Performance contracting for service is a third-party payment mechanism that might be used to provide specialized services to persons with dual diagnoses. A Mental Health or Alcohol or Drug Authority or agency might agree to contract with a specialized provider of services, instead of developing a program of its own. Or an agency might require that a certain proportion of the services provided by a contractor will be devoted to patients with dual diagnoses. In either case, the rate of payment is a concern. Contracts should specify the expected quantity of service and the specific target population. Without such specification and without adequate reimbursement, the incentive for a contract provider is to treat only lower cost (or less impaired) clients or to underserve most clients.

Capitation is a method of payment in which the provider is at financial risk to provide an unspecified amount of service to a predetermined population for a fixed amount per time period. The idea of capitated financing is often raised in connection with managed care. Such a mechanism provides a fiscal incentive to reduce cost. What is not yet clear from current experimentation, is whether it is possible to construct risk-adjusted capitation rates for vulnerable populations (such as mentally ill persons) based on factors such as age, disability, and poverty (Lehman 1986; Ridgely and Goldman 1989). It is more complicated for patients with dual diagnoses because of the higher costs associated with their care. None of the current capitation experiments have been targeted to systems of care for persons with dual diagnoses. The lack of clear experience

with the development of such rates makes capitation a strategy fraught with difficulties.

Conclusion

As Talbott et al. (1986) have noted, systems can fail in one of two ways: because of *structural deficits* (the lack of an appropriate range of alternative services) or because of *process failures* (in which the system fails to provide continuity of care). Both structural deficits and process failures are evident in the mental health and alcohol and drug abuse treatment systems in many communities.

As has been noted, these problems are not accidents of history but represent negative (prejudice and turf protection) and positive (attention to target populations, administrative efficiency) aspects of the way we have organized and financed services. Altering the status quo will take the concerted effort of all stakeholders. It is hoped that as consensus develops around appropriate treatment interventions for individuals with dual diagnoses, agreement about appropriate organizational and financing changes will also evolve.

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