# Strategic Implementation of Systems Change for Individuals with Mental Health and Substance Use Disorders

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The focus of this article on the Comprehensive Continuous Integrated System of Care (CCISC) model is not intended to suggest or imply an endorsement by the U.S. Department of Health and Human Services or its agencies. It is one of a number of approaches for developing services for individuals with co-occurring disorders in the U.S. community and state leaders interested in developing services for individuals with co-occurring disorders should select programs and strategies based on their community and state needs.

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**ABSTRACT.** The parallels or similarities between the federal approach to systems change to support services integration, and between the Comprehensive Continuous Integrated System of Care implementation process at the state or county and regional level, imply that there may be common strategic elements in the process of achieving system transformation to support widespread availability of integrated services in any system for any population. These approaches both involve fairly complex mechanisms of promoting change, built on established data-driven methodologies, such as continuous quality improvement, which have not been well-studied in large behavioral health systems attempting to implement technology transfer. This article discusses those strategies and the parallels between them. Recognition of these mechanisms may facilitate better alignment between federal and state or regional activity, provide a template for other systems seeking to create their own design process to improve services integration and, finally, suggest opportunities for design of large-scale systems research on the implementation and outcomes of integrated services development. 

**KEYWORDS.** Systems change, systems integration, SAMHSA, continuous quality improvment

Individuals with co-occurring psychiatric and substance use disorders have long been recognized as a population with poor outcomes and higher costs in multiple domains. Recent epidemiologic data[1,2] have further demonstrated the high prevalence of comorbidity in community populations, and even higher prevalence in active treatment populations, in both mental health and substance abuse treatment settings, so that it is increasingly understood that comorbidity is an "expectation, not an exception" throughout the service delivery system.[3] The combination of high prevalence, poor outcome, and high cost has led to a realization that addressing the needs of individuals with co-occurring disorders must be a priority for behavioral health system development, and that these needs will not be met simply by creating a few specialized programs with scarce dollars. Rather, there has been national recognition that a systemic approach is required, that addresses the challenge of

organizing the entire infrastructure of the behavioral health system to address the needs of individuals with comorbid conditions and issues, and to facilitate the provision of appropriately matched evidence-based and consensus-based best practice interventions within the core capacity and funding base of both mental health service delivery and substance abuse service delivery nationwide.[3]

In the past five years, the implementation of systemic strategies for developing services for individuals with co-occurring disorders has occurred at multiple levels and in multiple locations throughout the United States. At the national level, the Substance Abuse and Mental Health Services Administration within the US Department of Health and Human Services (SAMHSA), under the leadership of two of the authors of this paper (CC, GH) and others on SAMHSA's Executive Leadership Team, has developed a strategic approach to implementation that is based on working in partnership with state (primarily), county, and local behavioral health systems to facilitate the ability of those "subsystems" to engage in system redesign for the purpose of improving services integration at the client or consumer level. At the same time, state and county systems–both independently, and in response to federal incentives–have initiated system change efforts as well. Although there have been a variety of approaches to system design utilized in these state and county initiatives, arguably the most common approach has been the utilization of the Comprehensive Continuous Integrated System of Care (CCISC) model, developed by the other two authors of this paper (KM, CAC), as a framework for the design and implementation of system and service integration.[4] Currently, there are or have been CCISC projects (state, county, regional) in over 25 states and two Canadian provinces. As these processes have unfolded, it has become apparent that there are significant parallels between the strategic design utilized by SAMHSA to engage the states in the system change process, and the strategic design utilized by CCISC, in which states have to work in partnership with counties or other regional intermediaries, and counties work in partnership with providers, providers with clinicians, and clinicians with clients and families. The aim is to design a comprehensive "top-down, bottom-up" quality improvement process that aligns infrastructure changes at the system level, with the development of improvement in clinical practice and client outcomes at the clinician-consumer level. The purpose of this paper is to delineate these parallels in order to help to clarify some of the key elements that seem to contribute to success in complex system change efforts, and thereby to provide guidance to systems that may undertake similar efforts in the future, not

only with regard to mental health and substance abuse services, but with regard to other key system integration challenges, such as the integration of primary health care and behavioral health service delivery. In addition, this paper attempts to illustrate what we are learning about systemic strategies for implementation of integrated services (and potentially for other best practices) from these experiences, to illustrate some of the similarities in application at multiple levels of the system, and to make recommendations for further evolution and evaluation of system change that reflects an understanding of these processes, and utilizes methodologies for systemic design and evaluation already developed in other industries.

The first step in this process will be to provide some background on both the SAMHSA strategic vision and the CCISC model, and then to explore in more detail the strategies of implementation that have been employed.

## *SAMHSA'S VISION*

*Systems change must be part of an overall strategy designed to improve people's lives*. SAMHSA has a vision of *a life in the community for everyone*, a full life that includes a job, a home, education, and meaningful personal relationships. In service of this vision, the Agency's mission is to *build resilience and facilitate recovery* for every man, woman, and child who suffers from, or is at risk for, a mental or substance use disorder. To advance the mission, SAMHSA focuses on promoting *accountability*, *capacity*, and *effectiveness* in mental health services, and substance abuse prevention and treatment programs and systems. The issue of co-occurring disorders affects many of the Agency's other program priorities and cross-cutting principles, expressed in matrix form; these include transforming the mental health care system; strengthening prevention efforts; expanding substance abuse treatment capacity; improving services for people who are homeless, for children, and for individuals in the criminal justice system; and performing measurement and management. The problems resulting from co-occurring disorders interact in a reciprocal way with all of these priority areas.

For the past four years, SAMHSA has articulated this commitment to a vision of a recovery-oriented system of care, with particular emphasis on attempting to reach out to provide services to individuals who may "fall through the cracks" of the existing system, and therefore not have the opportunity to achieve their recovery potential. Within this vision,

individuals with co-occurring disorders have been a prominent priority for attention, not only because they have poorer outcomes and higher costs than individuals with single disorders, and are particularly high risk for involvement in the criminal justice system and homelessness, but especially because historically they have "fallen between the cracks" inherent in the very structure of SAMHSA itself, in separate mental health and substance abuse treatment and prevention centers (CMHS, CSAT, CSAP). Consequently, a key component of SAMHSA's vision has been the concept of "One SAMHSA" providing unifying direction and leadership that overarches all behavioral health populations, as evidenced by its matrix-based approach to addressing its priority issues and programs.

Another component of SAMHSA's vision has been the need for partnership, not only between the different components of SAMHSA, but between SAMHSA and the state and county systems that have primary responsibility for organizing service delivery at the local level. Rather than work around the states to directly fund new programs, SAMHSA–in its Report to Congress[3]–articulated a clear strategy for working in partnership with state and county systems to facilitate system change strategies that would be supported by SAMHSA, but designed, organized, and implemented at the state level to reflect the unique needs of each state.

A third component of SAMHSA's vision has been summarized in the concept of "science to service": that is, an overarching commitment to improve care and facilitate recovery by bringing evidence-based advances in treatment technology into the field ("technology transfer"). With regard to individuals with co-occurring disorders, this approach has been facilitated by the tremendous advances in knowledge regarding both the epidemiologic data supporting the high prevalence of comorbidity[1,2] and successful approaches (including both program models and clinical intervention strategies) for a wide variety of co-occurring disordered populations. Among the more notable contributions to this evidence have been the work of Drake, Mueser, and others in the development of SAMHSA's evidence-based toolkit on Integrated Dual Diagnosis Treatment for adults with severe mental illness and substance use disorders[5]; the impending release of a revised CSAT Treatment Improvement Protocol[6] describing a wide range of evidence and consensus-supported approaches for adults and adolescents with substance use disorders who present with a wide range of co-occurring mental health conditions; an accumulation of data on program models for specialized populations with co-occurring disorders (pregnant and parenting

women,[7] individuals in the correctional system,[8,9] individuals with histories of trauma,[10] homeless individuals,[11] adolescents (Multi-systemic therapy)[12]), as well as increasing data supporting treatment interventions that seem to have applicability in a wide variety of populations and settings (improved screening and assessment methodologies, stage-specific treatment and motivational enhancement,[13,14] cognitive behavioral skills training techniques,[15] psychopharmacologic strategies for both mental illness and substance disorders,[16] contingency management,[17] and so on). The breadth of knowledge in the field has contributed greatly to the capacity of a broad systemic vision for addressing individuals with co-occurring disorders everywhere in the system, as opposed to only in a few specialized settings.

Within the framework of this broad vision, SAMHSA has designed a strategic approach for implementation, which will be discussed in more detail below. It is important to recognize that this strategic design has had to rely on considerable ingenuity and innovation, because there has been no well-established methodology to leverage large-scale system redesign for implementing a wide array of best practices for this challenging population. Despite the increasing array of evidence and consensus-based practices for *treating* individuals with co-occurring disorders, the available evidence and experience about how to translate this knowledge base into core system application, beyond setting up specialized programs with limited new resources, has been scarce by comparison. One issue that emerges immediately is that there is not even a clear definition of "system integration" or "integrated system." The ACCESS project in Ohio, for example, reported that "systems integration" (as defined by the project evaluators) did not correlate with clinical outcomes for homeless individuals with co-occurring disorders[18]; however, the measure of "systems integration" was primarily based on the volume of interagency referral phone calls, which is not only not a sufficiently sensitive measurement of system integration, it may actually vary inversely to the degree to which integrated practices are built into system and program design as a core capacity, thus reducing the need for interagency referral calls, as the services are designed by the system to be more routinely integrated at the client level. A related development has been the expansion of numbers of state and county systems that have created "integrated" behavioral health agencies; but it was then discovered that an "integrated administrative structure" does not in and of itself lead to the development of "integrated programs" or the universal delivery of "integrated services" without a fairly complex process of system redesign, a process which may be im-

peded as much as facilitated by creating a new organizational chart. Consequently, without having even a definition of system integration to work from, SAMHSA's strategy has had to recognize the complexity of the problem, and the need for flexibility in developing solutions that made sense at the state and local level.

## *CCISC*

More or less simultaneously with the evolution of SAMHSA's strategic vision at the federal level, there has been a growing experiential literature, and some limited formal evaluation, describing state and regional approaches to systemic change for individuals with co-occurring disorders. These systemic change approaches have supported a slowly evolving capacity to understand what technologies are available to support systemic implementation of innovative practice in behavioral health, and to organize the strategic process of implementation in real world systems. In this regard, the literature on co-occurring disorders has begun to carefully distinguish between integrated systems, integrated programs, and integrated services or interventions at the client level,[6] and to begin to attend to developing (and eventually having the capacity to evaluate) models where the "system integration" is defined not by a particular *structure* but by the capacity of a system to have an integrated planning and implementation *process* that engages multiple levels of the system and that actually results in a strategic plan for implementation of integrated services as a core expectation in each program as appropriate for that program's clientele.

Probably the best known model for system design that incorporates this approach has been the Comprehensive Continuous Integrated System of Care (CCISC) developed by Minkoff, and progressively refined and implemented by Minkoff and Cline. CCISC has been well-described elsewhere,[4] but for the purpose of discussion here, the model has two critical elements: a framework for system design to support universal delivery of properly matched integrated services, and a methodology for systemic implementation of that design. The framework for system design is based on the idea that because individuals with co-occurring disorders are an expectation, associated with poor outcomes and high costs, every component of the system and every level of the system should be designed based on the idea that the next person served anywhere is likely to have a co-occurring disorder. This means that every program becomes defined as a "dual diagnosis program," meeting at

least minimal standards of dual diagnosis capability (DDC) (some program elements are dual diagnosis enhanced or DDE), but each program has a different "job," based first on what it is already designed to be doing (psychiatric inpatient unit, outpatient addiction service, etc.) and the people with co-occurring disorders who are already there, but having an organized plan to routinely provide matched interventions to those individuals as a fundamental element of program design. (See Minkoff & Cline[4] for a more detailed description of the CCISC model, the integrated philosophy and the evidence-based service matching principles upon which the model is based.) More important for this discussion, CCISC incorporates an organized implementation process based on application of recognized management technologies of strategic planning and quality improvement involving partnership between multiple layers of the system simultaneously (system management, agency and program level, clinical practice, and clinician competency and training); this process is termed "The Twelve Step Program for CCISC Implementation."[4] The wide array of CCISC implementation projects in multiple states and counties provides a mechanism for beginning to accumulate some information about systemic implementation of integrated services in diverse systems at that level, and for analyzing the similarities between the SAMHSA strategic implementation approach and the CCISC Twelve Step Program approach.

The next section of this paper will elaborate on the key elements of strategic implementation at the SAMHSA level.

## *THE EVOLUTION OF SAMHSA'S STRATEGY FOR SYSTEMS CHANGE*

In the service of implementing the vision described above, the Substance Abuse and Mental Health Services Administration (SAMHSA) has focused strategic planning and attention as well as programs and funding on improving the lives of people with or at risk for co-occurring mental and substance use disorders, recognizing that improving people's lives requires creating an infrastructure and building relationships among behavioral health care and other community providers at all levels to develop a system of care that is seamless to the consumer. This type of systems change is a complex endeavor that requires committed leadership, integrated system planning and implementation, value-driven evidence-based priorities, shared vision and integrated philosophy, dissemination of evidence-based technology to define clinical practice and

program design, true partnership between all the elements of the system, and data-driven, incentivized, and interactive performance improvement and evaluation processes. A number of these key elements converged in SAMHSA to create a dynamic, multifaceted approach to systems change for people with co-occurring mental and substance use disorders.

1. *Committed leadership.* Systems change must be supported, designed, and consistently advanced by the key influence leaders in an organization. In SAMHSA, agency leadership has consistently articulated the system vision described earlier, and made significant policy decisions in a thoughtful, strategic manner to consistently advance the implementation of that vision. These policy decisions are described further below. Moreover, at the Federal level, SAMHSA's ability to pursue this course has depended on support of key influence leaders that have included the President, the Congress, and the Secretary of Health and Human Services, Tommy G. Thompson. SAMHSA's congressionally mandated report on co-occurring disorders in November 2002[3] outlined the Agency's commitment to ensure that states and communities have the incentives, technical assistance, and training they need to promote provider and system accountability, to enhance system capacity, and to ensure more effective coordination and integration of services to address co-occurring disorders. The report's five-year Blueprint for Action pledged SAMHSA's commitment to a concrete set of objectives in support of the strategic implementation of SAMHSA's vision. Further, both SAMHSA's vision and mission are consistent with the President's New Freedom Initiative, and the Agency's goal to comprehensively assess all individuals for the presence of co-occurring disorders was recognized by the 2003 President's New Freedom Commission on Mental Health.[19]

2. *Integrated system planning and implementation.* Designing an integrated system requires a planning and implementation structure that is "over the top" of the separate system components involved in the system, and empowered to organize the various components and to make critical decisions to move the process forward. The vision of "One SAMHSA" could not actually be operationalized without significant infrastructure support. This has occurred within SAMHSA through the strategy of validating CMHS and CSAT as equal partners in the oversight of treatment services in key system development initiatives at the state level (such as the Co-Occurring Disorder State Infrastructure Grants), as well as the hiring of top quality individuals into overarching

positions in SAMHSA to assist the Administrator of SAMHSA in the integrated implementation process.

3. *Value driven, evidence-based priorities.* SAMHSA's strategy has been driven by the utilization of data that showcase unmet need, consistent with the overarching mission and vision of the organization, in a way that creates an alliance with key stakeholders at all levels. According to SAMHSA's 2002 National Survey on Drug Use and Health, an estimated four million adults experienced co-occurring serious mental and substance use disorders during the year.[20] One in five adults with substance abuse or dependence had serious mental illnesses and nearly one in four adults with serious mental illnesses was dependent on or abused alcohol or illicit drugs. However, many people receive treatment only for their mental *or* their substance use disorder, if they receive treatment at all. Few people receive treatment for both. The resulting human and societal costs are high. People with co-occurring disorders are at risk for a range of negative outcomes–including HIV/AIDS, homelessness, contact with the criminal justice system, violence, and suicide–all of which burden systems that are poorly prepared to manage them. Clearly, the data point to the need for a significant public policy response.

4. *Shared vision and integrated philosophy.* SAMHSA's strategy for integrated system change required the development of a shared vision to promote the capacity for a collaborative "horizontal" partnership between mental health and substance abuse treatment systems at the federal and state levels. Many barriers confront systems that seek to integrate mental health and substance abuse services for clients. Traditionally, these systems have had separate administrative structures, funding mechanisms, priority populations, treatment philosophies, clinician competencies, and eligibility criteria. To help break those barriers, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), supported by SAMHSA, developed a conceptual framework for co-occurring disorders that provides a common language and establishes shared priorities between the mental health services and substance abuse treatment systems for people who have co-occurring disorders.[21] It also recognizes the historical contributions and ongoing roles of both the mental health services and substance abuse treatment systems. Specifically, the framework delineates co-occurring disorders along a continuum of symptom severity and level of service system coordination from consultation and collaboration to integration. The framework has represented an important tool for bringing

the substance abuse and mental health systems to the table as equal partners for planning service coordination and systems change.

5. *Dissemination of evidence-based technology to define clinical practice and program design*. Systems change must be built on the foundation of evidence-based and consensus-based practices that articulate a broad vision of good clinical care and support the achievement of good clinical outcomes for consumers and families. Many effective practices have emerged in recent years that combine the best available research with clinical expertise and patient values in the prevention and treatment of co-occurring mental and substance use disorders. Increasingly, it is possible to identify a research-supported array of best practice interventions (starting with welcoming engagement and integrated screening and assessment processes) that may have application for any client with any combination of co-occurring disorders in any setting. For example, studies in substance abuse and mental health settings have demonstrated that properly matched integrated treatment of each primary disorder is successful in retaining individuals who have co-occurring disorders in substance abuse treatment, reducing substance abuse, and reducing symptoms of mental disorders. Research also shows an increase in stable, independent housing and a decrease in criminal justice activity, as well as client reports of a better quality of life.[22] The evidence base also is growing about the effectiveness of using a wider and wider array of intervention strategies, such as building an empathic integrated therapeutic relationship between client and clinician, motivational interviewing and stages of change, and offering services for other needs in the person's life such as housing and work.[23] SAMHSA has not only continued to support services research to expand the research base, it has concentrated its efforts on knowledge dissemination and technology transfer through a variety of technical assistance mechanisms, such as the COCE and the ATTCs (see below). Further, through its National Registry of Effective Programs and Practices (NREPP), SAMHSA identifies, evaluates, and certifies model programs and practices that serve people with mental and substance use disorders, including those with co-occurring disorders. As more information and expertise become available at the program and clinician level, it is easier for the overarching system to develop an infrastructure to anchor and support the implementation of new clinical practices and new program capacities.

6. *True partnership between all levels of the system.* This is one of the most critically important elements of SAMHSA's strategy. SAMHSA recognizes that the responsibility for actual service delivery is organized through state behavioral health systems that in turn must work in collab-

oration with county or regional systems, as well as with providers, clinicians, consumers, and families. Rather than working around that structure, SAMHSA has deliberately decided to work in collaboration with it. This means that SAMHSA has recognized that it does not know "the answer" for how a state should design an integrated behavioral health system; rather, SAMHSA needs to work with states to encourage and support them to figure out the answer that works best in each state. This has required SAMHSA to demonstrate its faith in the capacity of state and sub-state systems to solve the problem without micromanagement. It has also required SAMHSA to develop formal processes where the states are positioned to inform SAMHSA about policy direction (e.g., the COSIG [Co-Occuring State Incentive Grant] states helping to design National Outcome Measure requirements for co-occurring disorders), rather than SAMHSA simply directing states from a "top down" perspective. This partnership approach has stimulated natural energy to participate in systems change that is engendered by the shared values and priorities described above, as all systems are struggling for better ways to serve individuals with co-occurring disorders.

7. *Data-driven, incentivized, and interactive performance improvement processes*. It has been well-recognized by industry for many years that systems change to implement innovation requires organized performance improvement processes, that require both strategic incentivization and empowerment at multiple levels, as well as methodologies for performance measurement and performance management to create a feedback loop to drive the improvement process. At SAMHSA, the strategy for performance improvement is fundamentally built on the partnership described in the previous paragraph. The partnership involves a collaboration in problem solving, utilizing SAMHSA's leadership to establish some core consumer-driven "outcomes," and incentives for states to work–*with SAMHSA's* assistance–to figure out collectively how to achieve those outcomes. The art of SAMHSA's strategy is in its capacity to use relatively incremental outcome expectations and relatively small financial and training incentives to leverage enormous system change in each and every state.

The "outcomes" are very basic system performance drivers that SAMHSA has connected to the mental health and substance abuse block grants and to its largest discretionary grant programs. States will be required by FY 2006 to demonstrate the capacity to collect certain types of information, including information specifically about individuals with co-occurring disorders, which has never been required before. These National Outcome measures are being designed in partnership

with NASMHPD, NASADAD, and the COSIG states, and involve some very basic processes: the capacity to identify who has a co-occurring disorder, and to track integrated screening, integrated assessment, integrated treatment, and integrated outcomes *throughout the whole public behavioral health system in the state*. The approach to performance measurement is to use simple and straightforward measurements as markers of system performance. The more effectively systems perform, the greater the number of people served and the greater the chance for a life in the community for everyone. In addition, SAMHSA's National Outcomes, developed in close collaboration with states, highlight specific domains of resilience and recovery. They are: (1) abstinence from alcohol abuse or drug use, or decreased symptoms of mental illness; (2) increased or retained employment and school enrollment; (3) decreased involvement with the criminal justice system; (4) increased stability in family and living conditions; (5) increased access to services; (6) increased retention in substance abuse services or decreased use of psychiatric inpatient beds; and (7) increased social connectedness. The proposed measures for co-occurring disorders are aligned with these National Outcome measures and are being pilot tested by the COSIG states and four additional states that receive SAMHSA Data Infrastructure Grants.

These performance management expectations are balanced by SAMHSA's provision of a range of incentives to states and sub-state systems, including opportunities for financial support for systems change, as well as training and technical assistance. SAMHSA's Co-Occurring State Incentive Grant (COSIG) program, established as a discretionary grant program in 2002, is designed to enable states to develop or enhance their infrastructure to provide comprehensive, coordinated/integrated, and evidence-based practices to people with co-occurring disorders. SAMHSA awarded $25 million in October 2003 to seven states: Alaska, Arkansas, Hawaii, Louisiana, Missouri, Pennsylvania, and Texas. In October 2004, four additional states received COSIG awards: Arizona, New Mexico, Oklahoma, and Virginia. SAMHSA has also developed Children's COSIG grants, system transformation grants, and other funding awards designed to support systemic change that includes services integration. The focus of these grant activities is timely and accurate assessment, creation of a system in which "any door is the right door" to receive needed services for co-occurring disorders, and development of integrated substance abuse treatment and mental health services for those who need a significant level of service. COSIG states also are evaluating the feasibility, validity, and

reliability of proposed co-occurring performance measures. The goal is for each state to receive a COSIG grant; as new states come on-line, the cohorts that preceded them will share data and lessons learned.

In addition, SAMHSA supports a range of technical assistance and training activities to guide states, administrators, providers, consumers, and family members who are seeking the best evidence-based practices and strategies to achieve systems change to benefit people with co-occurring disorders. Products and services include:

- SAMHSA's Co-Occurring Center for Excellence (COCE) is designed to be a national resource for the field of co-occurring disorders. COCE's role is to provide technical assistance and training to states, communities, tribes, and community-based providers. The Center will also prepare and distribute state-of-the-art materials, manage a co-occurring disorders Web site, support national and regional meetings, and aid in the development and evaluation of the co-occurring disorders performance measures.
- Two key written clinical resources developed by SAMHSA to assist the field include: Treatment Improvement Protocol, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*,[6] a consensus document organizing best practice recommendations for practitioners, with a primary emphasis on addiction treatment settings; and *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit*,[5] an evidence-based practice guide designed primarily for systems treating adults with serious and persistent mental illness (part of a series of implementation resource kits designed to move the mental health system toward recovery).
- The SAMHSA-funded Addiction Technology Transfer Centers (ATTC) have contributed to the development and dissemination of materials and training regarding co-occurring disorders. The Mid-America ATTC, in particular (in Kansas City), has developed a co-occurring disorders curriculum, and is in the process of adapting curricular material in alignment with the new Treatment Improvement Protocol.
- The first two of three planned Co-Occurring Disorders Policy Academies were held in April 2004 and January 2005 to facilitate the development and implementation of state action plans to address co-occurring disorders. In each Policy Academy, high-level teams from 10 states shared ideas, practices, and lessons learned in the areas of prevention, evidence-based practices, funding, and

service system change. SAMHSA will review and comment on the action plans they developed.

SAMHSA will continue to capitalize on the elements of systems change that have placed the Agency at the forefront of efforts to create comprehensive, integrated, and coordinated systems of care for people with co-occurring mental and substance use disorders.

## *PARALLEL STRATEGIES FOR IMPLEMENTATION OF CCISC*

Similar strategies to those listed above have been described and utilized at the state and county level for the purpose of implementation of systems change using the CCISC model. The CCISC Twelve Step Program of Implementation organizes the change process in any system using the template of "top-down, bottom-up, and back again" strategically planned and collaborative quality improvement. The specific steps are as follows:

1. Develop a structure for integrated system planning and implementation.
2. Develop a consensus vision based on CCISC principles and a collaborative plan of action involving all components of the system.
3. Agree to proceed with implementation, and develop strategies for incentivization of participation, within the context of existing resources.
4. Utilize the Four Quadrant model as a method for organizing assignment of priority populations in the system.
5. Develop a consensus for all programs to begin to move toward Dual Diagnosis Capability.
6. Develop initial structures for interagency care coordination and collaboration between mental health and addiction providers.
7. Disseminate evidence-based and consensus best practice guidelines.
8. Identify priorities for best practice implementation in all programs, starting with welcoming, removal of access barriers, and universal integrated screening and data capture to support federal PPG requirements.

9. Design policies to support integrated scopes of practice and integrated treatment documentation for each clinician within each funding stream and licensure.
10. Identify initial clinician competency goals related to the above practice priorities.
11. Develop a system-wide training plan, including train-the-trainer activities, and availability of program specific technical assistance.
12. Address service system gaps with regard to evidence-based practices, consumer and family involvement, and comprehensive array of services at all levels of care.

Let us review how the application of this framework in real world CCISC implementation projects parallels the strategies utilized by SAMHSA. Experiences with COSIG and non-COSIG projects in Vermont, District of Columbia, Alaska, California, Montana, British Columbia, Manitoba, Michigan, Maryland, Pennsylvania, Louisiana, Florida, and New Mexico will be utilized for this discussion (Cline & Minkoff, 2002).

1. *Committed leadership.* In all CCISC projects, there has been either one individual or an organized leadership team that has provided continuing energy, inspiration, and direction to the project. Interestingly, the prime leaders have generally not been the formal top level system managers in most instances, but the most successful projects have clearly been able to garner consistent support from top leadership in order to make progress.

2. *Integrated system planning and implementation.* Each project has organized a structure for project oversight that incorporated representation from key system components related to mental health treatment (adult and/or child) and addiction treatment. Progress in implementation has often been a function of the structure and positioning of this leadership team within the system, and the degree to which the team meets regularly, with a consistent structure allowing it to make critical decisions regarding the progress of the system change initiative.

3. *Value driven, evidence-based priorities.* Although there are a multitude of administrative and financial drivers that have contributed to the initiation of each CCISC project, the heart and soul of the initiative, as outlined in the consensus documents, is the recognition of the need to provide welcoming, accessible, integrated, continuous, and comprehensive services for individuals who are currently falling through the cracks, with poor outcomes and high costs. There are various ways in

which systems visualize these priorities. In New Mexico, for example, the initiative was built out of data generated by mortality review indicating that individuals with co-occurring disorders were dying at a higher rate than individuals with single disorders, were often undiagnosed with comorbidity until autopsy, and frequently died in close proximity to an unsuccessful attempt to get help.[24]

4. *Shared vision and integrated philosophy.* The CCISC model goes beyond the Four Quadrant model to create an integrated philosophical umbrella for system design that incorporates the full range of programs and practices for mental health and substance disorder treatment. CCISC is based on evidence and consensus-based principles of treatment[25,26] that are placed within the context of an integrated common language that makes sense from the perspective of both mental health and addiction systems. The principles are applied to the design of a set of practice guidelines for assessment and treatment matching,[26,27] as well as to the assignment of the "job" of each program within the CCISC. Each consensus document lists the eight principles and the core characteristics of the model[4] as the basic vision within which specific action steps are outlined.

5. *Dissemination of evidence-based technology to define clinical practice and program design.* As noted in the previous paragraph, CCISC principles organize the full range of existing evidence regarding mental health, substance abuse, and treatment in order to create a set of evidence-based and consensus-based practice guidelines[27] that can be applied to service planning for any client in any setting. One of the most important elements of this framework is the recognition that the co-occurring population is not unitary, but includes any possible combination of hundreds of mental illnesses and dozens of substance disorders, in individuals with a wide range of age, gender, culture, language, acuity, severity, and disability. Consequently, there is no single best practice, but rather each individual requires properly matched treatment, with the beginning framework that their mental illness and substance disorder are both primary problems, and the best intervention is to integrate best practice treatment for each disorder at the same time. The increasingly broad array of best practices available for all behavioral health disorders supports the diversity of programming that can be provided under the CCISC practice guidelines.

6. *True partnership between all levels of the system. As with SAMHSA's strategy, this is probably one of the most significant components of the CCISC implementation process*. The twelve step program is not intended to be a sequential process. Rather, it is designed so all lev-

els of the system are moving together simultaneously and interactively. Further, just as SAMHSA has had to recognize that it cannot work around states to implement change, states are recognizing that their intermediaries are necessary partners in designing a change process that balances both central direction and flexibility at the next layer. The intermediaries vary from county systems (e.g., Michigan, Pennsylvania, Maryland, and California), to regional care coordination agencies (New Mexico), to districts and regions (Louisiana), to catchment area designated agencies (Vermont), but the need for a collaborative partnership is characteristic of all the projects. In state level projects, the partnership is developed across the whole system from the beginning, but in many states, the projects have begun in a few counties as "models" or "pilots," and over time the state has been able to position itself to learn from those pilots to create a broader approach. Some states (Michigan, Maryland, California) have organized this process using formal policy academies in which the broad CCISC vision is used as a template to assist individual counties to develop their own action plans based on local structure and need.

The same concept of partnership is consistently reiterated at the next level of the system as well. Counties and other intermediaries have to work in partnership with provider agencies, and the agencies have to work in partnership with their clinicians. No single level of the system can unilaterally solve all of the complexities involved in shifting administrative infrastructure, clinical practice, and clinician competency simultaneously across all system components. Consequently, just as the federal government has created a broad direction for the states while encouraging each state to create its own method for moving in that direction, and CCISC states have done the same with counties and regions, so, too, in CCISC projects the counties have developed the broad goal of DDC for all agencies and programs, but each agency has the flexibility to design its own strength-based action plan within the system's consensus priorities.

Further, partnerships are developed between system managers and clinical supervisors and trainers, as well as front-line clinicians, across both mental health and addiction services. This is part of the design of the training plan described as follows, but the key element is the concept that the implementation of new clinical practice requires a bilateral interaction between clinicians and managers. Every effort to teach new clinical practices for co-occurring disorders is met quickly by the recognition of system barriers that are inconsistent with or impede implementation. Clinicians in CCISC projects are told not to work around these

barriers or ignore them, but actually to seek them out and provide administrators the opportunity to fix them, so that the infrastructure moves in the direction of anchoring dual diagnosis capability in policies and procedures that support the practice outcomes that the system wishes to achieve.

7. *Data-driven, incentivized, and interactive performance improvement processes.* The partnerships described previously are a necessary precondition for the creation of the performance improvement processes that are fundamental to CCISC implementation. CCISC projects are designed to collect data at all levels using the CCISC toolkit [28,29,30] at the system, program, and clinician level, and to design quality improvement action plans (or, for clinicians, training/competency development plans) that result in incremental progress by building on existing system strengths and capacities, then using the tools to generate data to track progress over time. In addition, systems are required to address core management information system data, in alignment with National Outcome performance requirements, but not solely because of the federal drivers. Rather, the capacity of the system to generate reasonably accurate data on the prevalence of comorbidity into its own information system has been found to be a marker for the degree to which system infrastructure supports integrated practice and promotes integrated outcomes.

Further, like the SAMHSA strategy, CCISC projects are all designed to leverage large amounts of change within the existing resource base, through a combination of relatively small financial incentives for participation (e.g., Vermont, New Mexico) and the provision of training (via the development of a train-the-trainer initiative in which each participating program can be involved) and technical assistance, so that each participating program can have access to specific help with designing and implementing a quality improvement plan to move in the direction of DDC. Programs are "monitored" but the initial requirement is only that they are evaluated on the quality of their participation and the honesty of their quality improvement efforts, to emphasize the capacity of the initiative to engage each system component exactly where it is and help it to make progress.

## *CONCLUSION*

The parallels or similarities between the federal approach to systems change to support services integration, and between the CCISC imple-

mentation process at the state, or county, and regional level, imply that there may be common strategic elements in the process of achieving system transformation to support widespread availability of better practices for any population. These approaches both involve fairly complex mechanisms of promoting change, built on established data-driven methodologies, such as continuous quality improvement, which have not been well-studied in large behavioral health systems attempting to implement technology transfer. Recognition of the potential value of these mechanisms may facilitate better alignment between federal and state or regional activity, provide a template for other systems seeking to create their own design process to improve services integration and, finally, suggest opportunities for design of large-scale systems research on the implementation and outcomes of integrated services development.

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