Systems Integration

Overview Paper 7

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment
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The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and other materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

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EXECUTIVE SUMMARY

A growing body of research demonstrates that integrated services produce better outcomes for individuals with co-occurring disorders (COD), particularly those with more serious or complex conditions. Systems integration supports the provision of integrated services. In addition to distinguishing between systems integration and services integration, this paper describes the organizational structures and processes that can promote or inhibit systems integration. The paper encourages the use of creative thinking to obtain and effectively use funding and provides examples of successful initiatives in systems integration at the local and State levels. Although evaluation of the process of systems integration is still in its infancy, one measure of systems integration outcomes is discussed.

Systems integration involves the development of infrastructure within mental health and substance abuse systems that supports the provision of integrated mental health and substance abuse services (integrated treatment within integrated programs) to individuals with COD. Systems integration may include any or all of the following: integrated system planning and implementation; continuous quality improvement; and mechanisms for addressing financing, regulations and policies, program design and certification, interprogram collaboration and consultation, clinical "best practice" development, clinician licensure, competency and training, information systems, data collection, and outcome evaluation.

The concept of systems integration for COD is relatively new and the research base supporting its effectiveness in improving patient outcomes is limited. However, the theoretical appeal of systems integration is increasingly recognized, based in part on the critical role systems play in shaping (or constraining) the activities of those who work in these systems.

TABLE 1: KEY DEFINITIONS

Systems of Care	Health and behavioral health systems (including those that address the needs of persons with COD) are composed of the State and local governmental and private agencies, organizations, and individuals who are collectively responsible for providing patient or client care. The agencies, organizations, and individuals subsumed by a given system may be defined as those who are currently involved in patient or client care for persons with COD, but may also include those who are *not* currently involved but should be in order to achieve optimal outcomes.
Integration	As used in this paper, integration refers to strategies for combining mental health and substance abuse services and/or systems, as well as other health and social services to address the needs of individuals with COD.
Services Integration	Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients.
Systems Integration	The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families.
Funding: Flexible vs. Categorical	*Categorical funding* is provided to an agency or organization to be used exclusively for services related to substance abuse or mental health and may carry other restrictions related to target population, types of services, etc. *Flexible funding* provides some level of discretion to recipients concerning the disorders, target population, or services for which the funds may be used.
Funding: Blended and Merged	Blended or merged funding refers to a strategy by which an agency or organization pools resources or some portion of resources allocated for substance abuse and/or mental health in order to meet the needs of persons with COD. Blending or merging may occur at the level of the funding provider (e.g., a State), the funding recipients, or both.

LITERATURE HIGHLIGHTS

Persons with COD are found in all service populations and settings. These clients will never be served adequately by implementing a few programs in a system with scant resources. Rather, COCE takes the position that

> Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming. (See COCE Overview Paper 3, *Overarching Principles To Address the Needs of Persons with Co-Occurring Disorders*, p. 2; CSAT, 2005).

Systems integration is one important mechanism for reaching this goal. It provides support to the programs and providers who are ultimately responsible for treating persons with COD. As such, systems integration is a means to an end (improved services and outcomes for persons with COD) rather than an end in and of itself. Former SAMHSA Administrator Charles Curie and his colleagues (2005) note that meeting the needs of people with COD requires a systemic approach "that addresses the challenge of organizing the entire infrastructure of the behavioral health system."

Systems integration is the output of the various processes by which systems work individually and collaboratively to develop structures or mechanisms to address individuals with multiple needs. Integration can occur in systems of any size (entire States, regions, counties, complex agencies, or individual programs) and in any population or funding stream (adults, elders, children, urban/rural, culturally diverse populations, Medicaid, private payors, or State block grant funds) (Minkoff & Cline, 2004; Ridgely et al., 1998).

As noted by Minkoff and Cline (2004), the implementation of a complex multilayered systems integration model requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process. All layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the system's size or complexity, must interact.

In order to guide systems integration efforts for COD, Minkoff (1991, 2002) and Minkoff and Cline (2001*a*, *b*) have developed the Comprehensive, Continuous Integrated System of Care (CCISC) model and its associated "Twelve-Step Program of Implementation" (Minkoff & Cline, 2004). Other examples of models that are intended to facilitate the development of integrated systems of care are briefly described by Ridgely and colleagues (1998) and incorporate comprehensive local planning; comprehensive screening, assessment, and referral arrangements; and managed care strategies. Despite these advances, the concepts related to systems integration are still evolving, and the implementation of these concepts in practice is not widespread.

The literature on organizational development and the implementation of innovative practices (see Fixsen et al., 2005 for a recent review) supports the theoretical appeal of systems integration. The well-documented role of organizational structure and support in promoting and sustaining practice changes clearly suggests that activities involving the integration of mental health and substance abuse systems should increase the likelihood of integrated care for persons with COD. However, empirical support for systems integration is currently lacking. Formative evaluation of current systems integration efforts (e.g., SAMHSA's Co-Occurring State Incentive Grants) may inform hypotheses to be tested in future formal research.

KEY QUESTIONS AND ANSWERS

1. What is meant by "integration" and "integrated"?

The terms "integration" and "integrated" appear throughout the literature on COD: for example, systems integration, services integration, integrated care, integrated screening, integrated assessment, integrated treatment plan, integrated interventions or treatment, integrated models, integrated systems, integration continuum, and so on. The pervasiveness of "integration" and "integrated" in the language of COD reflects the following factors:

- The awareness that the co-occurrence of these disorders is not simply by chance and occurs frequently
- An understanding that there is always a relationship between the disorders that affects outcomes
- The recognition that effective responses to persons with either mental illness or substance use disorders are compatible

Therefore, integration is a logical strategy for unifying approaches derived from independent efforts to achieve positive outcomes with narrowly defined target populations.

COCE's Overview Paper 3 (*Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders;* CSAT, 2005) embeds these factors in the following principle:

> The interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly. It is a disservice to the person with COD to emphasize attention to one disorder at the expense of the other. There is always a relationship between the two disorders that must be evaluated and managed (p. 4).

The various types of integration listed above refer to different service components (e.g., screening, assessment, treatment planning, treatment provision) or levels of the service system (e.g., individual practitioners, agencies, local systems of care, States). The specifics of what is to be integrated and the mechanisms by which integration is accomplished will, of course, be different for different service components and at different levels of care. However, the goal of integration is always the same—identifying and managing both disorders and the interaction between them. Moreover, the objective of all forms of integration is *to support integrated treatment for the individual client.* Integration that *does not result in changes in services at the client level serves no useful purpose*.

2. What is systems integration and how does it fit with other kinds of integration?

Systems integration (see Table 1) is a process by which individual systems (e.g., mental health) or collaborating systems (e.g., mental health and substance abuse) organize themselves to implement services integration to clients with COD and their families. The goal of this process is to promote the adoption of best practices for engaging clients with COD in care and to provide for integrated screening, integrated assessment, and integrated services and interventions, in the service of producing the best possible outcomes.

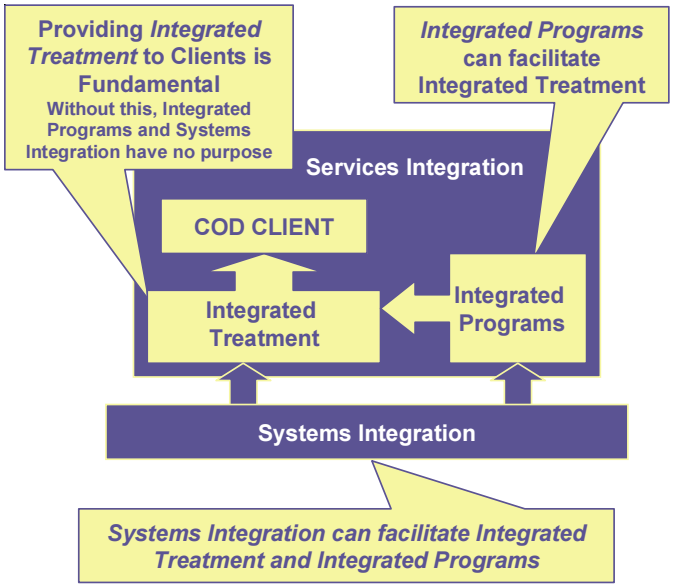
Systems outside of substance abuse and mental health may also participate in systems integration efforts, as when persons with COD are recruited into treatment from homeless shelters, emergency rooms, the criminal justice system, and so on, or when COD treatment services are located in homeless, healthcare, or correctional settings.

Systems integration initiatives range from the implementation of one or more of the strategies mentioned in Question 4 (see pages 3 and 4) to comprehensive initiatives by which mental health and substance abuse systems collaborate to create an overarching, integrated vision of system design that addresses individuals with COD, as well as those with a mental health or a substance use disorder.

As shown in Figure 1, systems integration can facilitate services integration (integrated treatment and integrated programs) in service of the overall goal of providing integrated treatment to clients. Systems integration efforts that are not ultimately designed specifically and concretely to support services integration are not likely to have a demonstrated impact on client outcome.

Services integration can occur, at least to some degree, in the absence of systems integration. For example, individual practitioners or agencies may take it upon themselves to provide integrated services to their clients. Systems can, and frequently do, fund "special" COD programs that work

Figure 1. Systems Integration and Other Forms of Integration



around the lack of integration in the system. These demonstration or pilot programs are then evaluated for dissemination potential. However, absent the infrastructure supports provided by systems integration, isolated efforts at services integration may be limited in impact and difficult to sustain.

3. Is systems integration the same thing as the creation of an integrated State mental health and substance abuse department?

No. Creation of an "integrated" State mental health and substance abuse department is in no way synonymous with systems integration. Depending on the system, creation of an integrated mental health and substance abuse department may provide a starting place for the organized integrated planning and implementation efforts that are requisites for systems integration. Alternatively, such a merger may create resistance within the existing systems that actually impedes the operationalization of systems integration efforts.

4. What types of organizational structure promote or inhibit systems integration?

Systems integration is not dependent on any specific organizational structure. In general, systems integration is facilitated by organizational structures that support an integrated planning process and is complicated by organizational structures that impede such processes (see Fixsen et al., 2005; Rogers, 2003). SAMHSA's Co-Occurring State Incentive Grants (COSIGs) have provided resources to experiment with a variety of systems integration models. However, neither the models developed by the COSIGs or other systems integration models have been well researched. Accordingly, science-based guidelines for implementation are not currently available, and systems integration should be undertaken with a clear organizational commitment to

evaluating outcomes and impacts within a process of continuous quality improvement.

Former SAMHSA Administrator Charles Curie and his colleagues (2005) describe seven organizational processes that may support systems integration:

- *Committed leadership:* individuals or teams who have the authority and vision to organize and sustain a complex change process.
- *Integrated system planning and implementation:* an organized structure or mechanism that creates a standard method for complex overarching strategic planning and stepwise strategic implementation.
- *Value-driven, evidence-based priorities:* the articulation of a rationale to drive the change process based on data demonstrating poor outcomes for the target population and high costs, and the clinical and economic value of system transformation.
- *Shared vision and integrated philosophy:* the development of a set of principles that encompasses validation and recognition of the role of mental health systems, programs, and approaches along with addiction systems, programs, and approaches (e.g., the national consensus Four Quadrant Model – See Overview Paper 1, *Definitions and Terms Relating to Co-Occurring Disorders;* CSAT, 2006).
- *Dissemination of evidence-based technology to define clinical practice and program design:* the use of technology transfer (including training and technical assistance), not as an end in itself, but as a vehicle to stimulate diverse changes in clinical practice throughout a complex delivery system, building on the burgeoning availability of evidence-based technology for a wide variety of problems and populations.
- *True partnership among all levels of the system:* a critically important reliance on a continuous quality improvement model that uses a top-down, bottom-up, linked, and empowered collaboration between every level of the system, including top administrators as well as frontline clinicians, consumers, and families, in organizing and implementing the change process.
- *Data-driven, incentivized, and interactive performance improvement processes:* using data connected to all aspects of system performance to organize the incremental implementation of complex change processes that support systems integration within a continuous quality improvement framework.

5. *Does systems integration rely on a specific funding model?*

No, but it does rely on both improving resource availability and using resources efficiently. The Institute of Medicine *Report on Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006) succinctly highlights the existing phenomenon of adverse selection, in which powerful economic incentives exist to *not* serve individuals with complicated clinical conditions. Because the person with COD is such an individual, these negative incentives must be acknowledged and addressed. Systems integration can proceed under a variety of funding mechanisms. However, a systems integration approach may require creative thinking on the part of both funders and systems to identify how various funding streams (including those that are categorical) can support integrated services. For example, SAMHSA has provided States with explicit instructions that both mental health and substance abuse block grant dollars could separately fund integrated services within the programs those funds were already intended to support (SAMHSA, 1999). SAMHSA's 1997 State Incentive Grant for prevention was the first cooperative agreement that promoted blended/braided funding and infrastructure change at the State agency. The overall success of the program led to the development of the COSIGs mentioned in Question 4.

Blended or merged funding streams may be a creative technique to facilitate the development of specialized programs, but reliance only on blended funding is both inefficient and likely to result in funding uncertainty and confusion. Legitimate concerns may be raised about maintaining the integrity of addiction or mental health treatment services when mental health and substance abuse dollars are merged into an "integrated" behavioral health pool. To avoid these pitfalls, systems integration strategies often begin by supporting the integrity of existing funding streams while articulating the expectation that all funding streams, whether flexible or categorical, should carry instructions for appropriate integration at the client level.

6. *What are some real world examples of systems integration initiatives?*

Many States and communities have shared with COCE their experiences related to systems integration as part of COCE's technical assistance and training activities. The following example is a composite based on these experiences.

A Local Community Mental Health Clinic Integrates To Improve COD Services

This local community mental health clinic (publicly funded) in a medium-sized county in the Midwest recognized the need to address COD within its existing client population but did not have funds to create a specialized co-occurring program. The mental health clinic subsequently hired cross-trained clinicians with certifications or licenses in substance abuse treatment to address COD through a case management approach as a supplement to existing mental health programs. The clinicians were tasked with implementing COD therapy groups within the clinic, and existing mental

health staff rotated in as co-facilitators to develop their COD competencies. The clinic's policies were modified to support this approach by requiring integrated screenings, integrated assessments if indicated through screening, and treatment through integrated case management. A subsequent analysis of client outcomes revealed significant improvement in medication compliance and levels of abstinence for clients with COD.

7. What methodologies are available to evaluate systems integration, and how effective are they?

Figure 1 makes clear that the ultimate outcome of systems integration (as well as all other types of integration related to COD) is improved outcomes for clients and their families. Methods for measuring these outcomes are well documented.

However, methods for measuring and evaluating the *process* of systems integration are still in their infancy. Goldman and colleagues (2002) used a measure, based on the number of integration strategies (e.g., coordinating groups, co-location of services, pooled funding, cross-training), used by systems attempting to address COD and homelessness. The CCISC Toolkit (Minkoff & Cline, 2002) includes one, as yet unvalidated, measure of systems integration outcome (CO-FIT100). This measure of fidelity for the CCISC assesses implementation processes and achievement of welcoming, accessible, integrated, continuous, and comprehensive services for individuals with COD throughout the system. This toolkit awaits further research support.

The General Organizational Index (GOI) (Center for Mental Health Services, 2005) has been used to measure an organization's operating characteristics associated with the capacity to implement evidence-based practices, including integrated approaches to COD. The GOI provides an objective, structured method to evaluate the organizational processes associated with systems integration.

FUTURE DIRECTIONS

The theoretical appeal of systems integration is undeniable. However, there is a need for further evaluation of the impact of systems integration on the effectiveness and efficiency of care for persons with COD. There is also a need to compare various organizational and reimbursement models and approaches and to further explore methods for overcoming barriers to systems integration.

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