California County Co-occurring Disorders Policy Academy

December 8, 2004

Summary Report of County Feedback Forms

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CALIFORNIA INSTITUTE FOR MENTAL HEALTH

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Background

On December 8, 2004, The California Institute for Mental Health (CIMH), with representatives from Alcohol and Drug Program Institute (ADPI), and co-sponsorship by the California Department of Mental Health (DMH), Department of Alcohol and Drug Programs (ADP), County Alcohol and Drug Program Administrators Association of California (CADPAAC), and California Mental Health Directors Association (CMHDA), organized a Policy Academy for California counties. Participants discussed the development of county-level system approaches for providing integrated services to individuals and families with co-occurring mental health and substance abuse conditions.

Drs. Christie A. Cline and Kenneth Minkoff of ZiaLogic, who are nationally recognized as experts in the development of implementation strategies for systems, facilitated the meeting and provided content technical assistance. ZiaLogic has worked with California's Co-occurring Disorder Task Force and other state agencies in applying for a co-occurring disorders state infrastructure grant (COSIG) from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). ZiaLogic encouraged the Policy Academy to further the aims of the COSIG, although the grant itself was not funded last year.

All 58 California counties were invited to send representatives to the Policy Academy. In all, 47 counties (plus the City of Berkeley) participated in the meeting. After a brief overview of the Comprehensive Continuous Integrated System of Care model (CCISC), developed by ZiaLogic's Dr. Minkoff, presentations were made by representatives from the counties of Humboldt, Los Angeles, and San Diego on their progress in developing systemwide integrated services. Presenters emphasized strategies for collaboration and planning, as well as models for policy, program, and clinician development, and discussed lessons learned. Following the presentations, the county teams met in groups, based on their county's size, to share information on activities, barriers, and possible solutions. Each county group then reported back to the larger group, and ZiaLogic facilitated a discussion to articulate lessons learned, as well as to distill a set of recommendations on how the state could work with the counties to improve services integration.

At the end of the day, each county team was requested to submit both a conference evaluation, and a feedback form describing their current structure, activities, and level of priority, as well as future plans and communications with the state. This report is based largely on the data submitted in those forms, but is aligned with the discussions that occurred at the conclusion of the Policy Academy.

Target Audiences of this Report

This report is intended to provide summary information to DMH and ADP from California counties regarding recommendations for providing support to current county efforts. The report is directed to the California State Policy Academy Team (funded by SAMHSA), which met in Washington, D.C., January 11-13, 2005, to determine how the Policy Academy Team (which has state, county, provider, and stakeholder representation) can most effectively align state and county activities. In addition, the report is designed to assist the county director associations in organizing advocacy, support, and technical assistance for integrated services development to their members. And, finally, the report is intended to assist CIMH and ADPI plan for funding and activities in the coming year to work in partnership with each other (within the current organizational structure at the state level), and with counties to improve the integration of services throughout the California behavioral health delivery system for adults and children.

Data Analysis

ZiaLogic performed a qualitative analysis of the aggregate information provided in the feedback forms. A total of 36 forms were submitted, plus presentation information from Los Angeles, representing 38 counties of the 46 in attendance. No information is available regarding differences in integrated services planning from among those that did not attend, or whether the counties that submitted feedback forms are significantly different from those that did not. Nonetheless, the feedback represents information from 66 percent of all counties, and attendees represented 80 percent of all counties.

The data were analyzed to determine the following elements: organizational structure, level of priority for integrated services, stage of change regarding system planning and implementation, existence of an integrated planning structure or format, types of activities accomplished and/or planned, and suggestions to the state. In addition, an effort was made to analyze the combined picture from the feedback forms and from Policy Academy discussions to distill an impression of specific strengths and needs for assistance within the system.

Organizational structure is arbitrarily divided into three types: (1) merged (mental health and addiction combined into an integrated behavioral health department); (2) mixed (mental health and addiction combined into an integrated behavioral health department but retaining separate divisions); and (3) separate (mental health and addictions existing as separate entities, either as full-fledged departments or within larger health and human services agencies in which they might be on par with other departments, e.g. public health, and/or operate as relatively autonomous divisions). However, the boundaries between these three types are not always clean, and many systems exist in between merger and mixed, or mixed and separate, so it became a judgment call how to define them.

Prioritization is based on self-report in the form. *Stage of change* is based on extrapolation from the descriptions in the report—contemplation implies that the county was considering initiating a change process with no immediate plan, preparation implies an immediate plan to begin but not yet started, early action implies recently moving to system-level planning with some start-up activities, action implies being in the middle of a system change process in integrated services. *Regular planning* is based on whether the form described a particular team or meeting involving representation from both mental health and addictions with a consistent focus on this issue. *Activities* and *suggestions* are distilled from descriptions in the forms, and are simplified summaries of complex comments and ideas.

Findings

Organizational structures: merged 7, mixed 14, separate 17. Almost all of the separate structures were part of an umbrella health and/or human services agency.

Prioritization: very high 7, high 24, above-average or inconsistently high 3, medium 1, not high 1, not reported 2. High prioritization extended across all types of structure.

Stage of change: action 17, early action 5, preparation 13, contemplation 3. Action extends across all types of structures. None of the three presenters is or plans to be merged, but the county that appears the furthest in its development (Stanislaus) has a merged structure.

Planning structure: 22 counties reported having some kind of regular systemwide meeting empowered to create a plan for integrated services; 7 were mixed, in that the meetings were irregular, just beginning, in only part of the system (e.g. children), at a low level, or not focused. A total of nine counties had no regular meetings, but almost half of those were planning to initiate a plan.

Activities: In line with the presenters, many of the counties commented on the importance of a long-range approach (one county mentioned a 12-year task force), building collaborative relationships at all levels, mutual support and validation between partners, and ongoing staff development through formal cross training, supervision and case conferencing. A total of 6 counties (mostly smaller) reported some type of co-location strategy for clinical staff. A number of counties mentioned strategic planning and designing functionally organized and/or principle-driven systems of care. Very few, however, had an organized systems approach to discuss change at all levels. Most counties had not yet developed guidelines or policies and procedures, and several expressed interest in examining San Diego's welcoming and funding policy. Many smaller counties discussed co-occurring disorder groups. Large and small counties reviewed pilot projects and examined initiatives across a wide range of activities, including AB 2034, IDDT toolkit implementation, stage matched treatment, screening, Proposition 36, youth (children's system of care) and youth in transition, child welfare reform, access and crisis intervention. A significant number of counties discussed co-occurring disorders and integrated service development, including system development, in Proposition 63 planning. Six counties mentioned past, current, or future plans to obtain formal consultation or technical assistance on systems approaches to developing integrated services.

Suggestions to state. A total of 16 counties agreed that the state should encourage and support integrated planning and formal collaborations between mental health and addictions at the county level. This included very general suggestions, such as "anything to help us get started," to very specific suggestions, such as providing joint ADP-DMH policy direction comunicate one system, require formal collaboration in county plans, make integrated services development a required feature of QI plans, include integrated planning for co-occurring service capacity development as a feature of Proposition 63 planning, provide access to technical assistance for strategic planning and system development. At the end of the Policy Academy meeting, 21 counties agreed the state should provide clearer instructions on how to use current funding streams, particularly MediCal, to support integrated treatment, and how to minimize any administrative burden attached to that. Five counties suggested it would be helpful to reduce administrative burden attached to reporting data, and one mentioned alignment of site visits. Five counties suggested help with screening, assessment, and outcome tools. Four counties encouraged support of cross training and integrated human resource development. In addition, participants discussed the need for funding of medical detoxification, jail diversion, supported employment and housing, and continued support for Proposition 36.

Qualitative Assessment

1. Counties have shown an impressive level of interest and a high degree of prioritization for implementing system approaches to integrated services.
2. Considerable activity is taking place, or about to take place, at the county level. Sixty percent of reporting counties have a regular planning process, and most of the rest are developing one. All but three counties have begun, or are about to begin, some kind of systems integration planning effort .
3. Most counties have been involved with this for many years at the clinical program or project level, rather than at the systems level, and are starting, or just about to start, system-level planning and implementation. However, a few counties are well into developing either their strategic design or implementation efforts. Stanislaus, San Diego, Los Angeles, Humboldt, San Francisco, San Joaquin, and Butte are among the counties that stood out by self report. These counties may be able to provide assistance to their peers who are not as far along.
4. The counties that have made the most progress tend to talk about how their services are organized to achieve particular principles of treatment and/or to provide particular functions, rather than the services being organized to fit into preordained administrative, fiscal, or clinical boxes.
5. Although a high percentage of the counties are currently engaged in, or about to be engaged in this effort, many differences exist between counties in their approaches to achieving the goal of improving integrated services. This would suggest that a state-level initiative should be designed to utilize tools or models that can be adapted to the structure, needs, and priorities of very diverse local systems in order to achieve common system outcomes, rather than trying to make every county comply to the same methods.
6. Counties in the earlier stages of change appear to require more assistance from the state in activities related to getting started, including incentives for engaging in integrated planning, technical assistance with organizing an interagency change process, and permission to use existing funding more flexibly to support integrated treatment. Those counties that are further along are more likely to require assistance with "implementation activities," such as policies, practice development, human resource development, quality improvement and evaluation, and specific strategies to overcome clinical barriers (confidentiality, harm reduction vs. abstinence, psycho-pharmacology), administrative barriers (reporting and data collection) and funding requirements and policies. Consequently, future technical assistance depends upon the stage of change within a county.
7. During the past five years, through the leadership of SAMHSA in supporting infrastructure development, systems transformation, integrated services expansion, and technology transfer at the state and county level, there has been a considerable expansion of knowledge acquired about clinical interventions for co-occurring disorders and also about system change strategies for supporting integrated services. Although the counties appear to be aware of the literature on integrated services and integrated programs, they appear much less aware of the latest advances in system change technology, and methods for finding information on those advances.
8. The counties appear to be interested in participating in productive activities that would help them to achieve better functioning systems with regard to

integrated services. Almost every participant indicated an interest in scheduling further policy academies, and many expressed interest in more specific technical assistance—either on site or as part of the Policy Academy.

9. The counties appear to be very interested in receiving more state support for their efforts; however, county representatives put less emphasis on funding, and focused more on clearer direction from both DMH and ADP acting in concert, encouragement to initiate or continue integrated strategic planning and collaboration, and much clearer instructions about how to legitimately adapt existing funding streams or administrative practices to support integrated treatment without fear of administrative reprisal. In addition, the counties are requesting support in the form of technical assistance, resource and clinical best practice dissemination, and access to training, but no mandates for a particular structure or approach. This, in general, presents an opportunity for state agencies to leverage significant change by supporting counties through a creative partnership.

Recommendations

Based on the above, the following action steps are recommended:

1. **Response from DMH and ADP.** DMH and ADP should issue — as soon as possible — a joint statement to the counties through the county director associations thanking them for participation and organization in providing this information, and indicating a commitment to be responsive (even though the precise response may not yet be determined). Responsiveness might include statements such as referring this report to the state Policy Academy for action, a commitment to issuing continued joint communications to counties, support for future policy academies, willingness to initiate processes to provide clearer direction in encouraging county collaboration, Proposition 63 planning, and use of existing funding streams to support the delivery of integrated services. (See below) Some of these problem-solving strategies might be referred to the Co-occurring Disorder Committee of CADPAAC and CMHDA to discuss with the state Policy Academy Team.
2. **Plan a follow-up Policy Academy for counties.** The goal of this Academy should be to provide more detailed assistance to participants, who might also benefit from a two-day session instead of just one day. A provision could be made for background information on system change technologies to support integrated services, adaptation of clinical practice advances to diverse systems, clinicians, and clients, and specific workshops on getting started (with a focus on organizing a change team and developing an initial consensus document and strategic plan) as well as workshops on self-assessment tools for systems and programs, quality improvement and evaluation methodology, funding and billing strategies, policy and practice development, competency development, record keeping and documentation. These "content" workshops would supplement time for county teams to meet and develop their own plans.
3. **Organize regular communication between the State Policy Academy Team plus other state leadership and the counties, transmitted through the County Director Associations and the Co-occurring Disorder Workgroup.** Communication will help the individual counties feel less isolated, and align state-level activities with local needs and requests.
4. **Provide state-level direction and support to county activity.** Beyond the joint response letter mentioned in item one, state leadership can do a lot to stimulate and encourage

change at the county level with relatively little effort and resources. Examples:

a. A position statement—like the San Diego County policy—that clarifies current MediCal funding (whether specialty mental health, or drug, or fee-for-service) supports integrated assessment for any client to determine needs and treatments for individuals eligible for services.

b. A joint policy indicating that each county system should initiate a collaborative planning process for integrated services development throughout the county, and report on its progress to both DMH and ADP as part of routine county reporting efforts.

c. A joint position statement that Proposition 63 planning in each county should meet with representatives from alcohol and drug services to discuss improving the capacity of each system to provide integrated services.

d. A joint commitment to seek funding for a statewide initiative that will support some or all counties that embark on infrastructure development to support integrated services in both mental health and alcohol and drug services, such as the federal government funding of Co-occurring Disorder State Infrastructure Grants.

5. **Introduce the availability of technical assistance on a small scale.** Counties are engaging in system change activities and seeking assistance, yet have little knowledge of existing tools and strategies of how to adapt them to local needs. The state could partner with willing counties that have created an initial proposal to meet with the county planning group and assist in designing and implementing a strategic plan for systemic development of integrated services, and to select appropriate tools and resources. Even without state support, the county director associations could develop a plan to make such assistance available.

6. **Develop communication strategies to facilitate information sharing between counties.** A clear benefit exists for counties to have access to lessons learned and strategies developed by other counties, as well as access to resources on co-occurring disorder service development, program models, and intervention techniques. CIMH and ADP could develop a communications vehicle (e.g., newsletter or Web site) to promote this type of connection on a regular basis. This vehicle also could be used to provide access to resources, perhaps with the assistance of SAMHSA's Co-occurring Disorder Center of Excellence (COCE).

Conclusion

The California Policy Academy for counties was successful in creating a venue for organizing and analyzing current county efforts to develop systemic approaches to services integration, and to create a framework in which counties could provide assistance to one another while offering collective suggestions to the state for how to support their efforts. This process is particularly valuable as California has just begun a Policy Academy Team at the state level, with SAMHSA support. A unique opportunity exists for state-county partnership in both mental health and addictions in the creation of system change to promote integrated services in a fashion that preserves the value and integrity of each service system while allowing for collaboration to improve outcomes for those clients who are most in need.

Respectfully submitted,
Christie A. Cline, M.D., M.B.A., P.C.,
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The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of "a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness."

Based in Sacramento, CIMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CIMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.

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