ZiaLogic

Innovative Strategies for Behavioral Health Systems

June 23, 2006

Summer King
SAMHSA Reports Clearance Officer
Room 7-1044
One Choke Cherry Road
Rockville, MD 20857

Re: Proposed Co-occurring Infrastructure Measures for COSIG

Dear Ms. King:

We are writing to comment on the above initiative, as referenced in the Federal Register, volume 71, number 86, pp. 26382-3, dated May 4, 2006.

We are writing from the perspective of being very actively involved in the system infrastructure development activities funded by COSIG, in that we have provided or are providing direct state, regional, and provider level consultation, technical assistance, and training in almost all of the COSIG states. With regard to current active consultation statewide, we are working with Alaska, Louisiana, Maine, Oklahoma, Pennsylvania, Vermont, and Virginia. We have provided extensive consultation in the past in Arizona, Hawaii, New Mexico, and the District of Columbia, and we have provided targeted consultation in Arkansas, Missouri, and Texas. In addition, we are providing similar statewide consultations currently in the following non-COSIG states: Michigan, Montana, and South Dakota, as well as current extensive regional consultations in California and Florida. We have worked extensively as well with Maryland, and are beginning a statewide and regional project with Wisconsin

Further, in most of the COSIG states with which we are working, we were written in to the grant application, and our participation in the design of the application contributed to the award of the grant. In addition, we were both members of the CSAT consensus panel that produced TIP 42, and Dr. Minkoff co-authored the subcommittee report on co-occurring disorders to the President's New Freedom Commission, and is a member of the Senior Advisory Board to SAMHSA's Co-occurring Disorder Center of Excellence(COCE).

In this context we have an in depth view of the actual infrastructure development activities in each generation of COSIG awardees, as well as knowledge of the differences (or lack thereof) between the process of change in non-COSIG states compared to COSIG states.

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Further, in our work, we utilize a SAMHSA recognized best practice model for integrated system development, termed the Comprehensive, Continuous, Integrated System of Care (CCISC), referenced in SAMHSA's Report to Congress on Co-occurring Disorders (2002). For recent articles on the utilization of CCISC in these processes we reference the following:

1. Minkoff K & Cline C, "Changing the World: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatr Clin N.Am* 27:727-743, 2004

2. Minkoff K & Cline C, "Developing welcoming systems for individuals with co-occurring disorders: the role of the comprehensive continuous integrated system of care model." *J. Dual Diagnosis, 1(1):*39-64, 2005

3. Curie C, Minkoff K, Hutchins, G, and Cline C, "Strategic Implementation of Systems Change for Individuals with Mental Health and Substance Use Disorders" *J. Dual Diagnosis,* 1(4): 75-95. 2005.

With this background, we are writing to express our serious concerns about the proposed data collection process, and to urge SAMHSA to seriously re-consider both the process and content of the proposed measurement. Our goal in this process is to assist SAMHSA in developing a process that will be reinforcing to the tremendous energy that is going on currently in the states regarding system transformation, and will assist in the development of a partnership between the COSIG states and SAMHSA that will facilitate the movement toward system transformation and integrated services development over time. (The article referenced above, with Charles Curie as the lead author, describes the role of this strategic partnership at all levels of the system transformation process.)

In this regard, there are four major points that we wish to make:

1. The **PROCESS** of data collection is defined outside the partnership between the states and SAMHSA, and outside the emerging partnerships between the states and their own systems, not just programs, but the intermediary entities that coordinate behavioral health services in many states (e.g counties in Pennsylvania, Community Service Boards in Virginia). Consequently, it is outside the state's own infrastructure development activity, skips over the activities of any significant intermediaries, and asks programs to report information that may be disconnected from the priorities that the state is working on with them. To the extent that occurs, it both inhibits the state's ability to provide SAMHSA with real information on its own infrastructure activities, and creates a distracting burden for all the levels of the state system involved in that process. ***In this regard, what we would recommend is that the data collection be organized to reflect primarily the collection of information that is managed through the state's actual infrastructure, as well as any intermediaries that are participants in the infrastructure of the state system. (See below).***

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2. Secondly, the data collected is based on an incorrect or misleading model for what the majority of COSIG states are doing with regard to infrastructure development. The original purpose of COSIG was NOT to develop specialized co-occurring disorder programming, but based on "co-occurring is an expectation, not an exception" to create basic infrastructure capacity in all elements of the system (each clinician, each program, each subsystem, each state) to provide appropriately matched interventions for co-occurring clients that present anywhere in the system. Consequently, the goal is universality of what is termed "co-occurring disorder capability" in each type of program. This includes not only screening and assessment, but the capacity to deliver an integrated service to a co-occurring client who is being served in a typical mental health setting or a typical substance abuse treatment setting. In this regard, all programs are "co-occurring disorder" programs, and your language should reflect this development. Note that the CCISC framework offers a specific methodology for designing and implementing universal co-occurring capability, but that all COSIG states, whether they are using CCISC or not, are trying to implement universal capability into their infrastructure. ***In this regard, data collection should not be divided into "mh, sa, and cod" programs, so much as positioned with language that says: How does the state communicate with its intermediaries or programs the following question, and how does it retrieve the information that is responsive to the question? "The goal of COSIG is that all programs develop core capability for co-occurring services. Identify the type of services your program currently provides, and describe your vision of how you will become co-occurring capable".***

3. Further, the definitions that are used to describe the different functions are not fully consistent with what is happening in the field, and not fully aligned with definitions that have been already developed and articulated by COCE. Specifically, the definition of co-occurring disorder capability is not mentioned; this is a much more current concept than the "consultation, coordination, collaboration, integration" continuum that you are using in this request. Those functions are all components of the development of co-occurring capability in an organization; asking questions as if they are distinct is not helpful or relevant to what states are working on. The definition of screening would not correspond with waiting a month to perform the screening function Further, there is an entire position paper describing "integrated services", and delineating how these services can be provided in any setting, and are distinct from formal "integrated treatment programs"; ***the definitions you use for integrated services (and other items) should correspond to the current COCE definitions, and the definition of co-occurring capability should be included..***

4. Finally, as noted in item #1, the specific data elements requested are not consistent with either assessing the state's actual infrastructure development, does not acknowledge the need to collect the information through counties or community service boards, and requests information at the program level that is beyond the core universal developmental activities that COSIG is designed to

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promote in state infrastructure. In this regard, to help SAMHSA collect information more relevant to its purpose, as well as more aligned with, and less burdensome to, the states and their participating intermediaries and programs, ***we would propose the following for data collection:***

Ask the states the following:

1. At the state level: what definitions have been adopted for defining the population, and for screening, assessment, and integrated services?
2. At the state level: what are the current level of intermediary (county) and program requirements for screening, assessment, and development of co-occurring capable services?
3. At the state level, what mechanisms are in place to track participation at the intermediary level and at the program level for participation in the process of developing routine co-occurring capability as a feature of system/program infrastructure? How many intermediaries/programs are participating in this process?
4. At the state level: what mechanisms are in place to facilitate access to welcoming engagement for individuals with cod who present routinely and in crisis? Is there a welcoming policy that addresses removal of access barriers? How much penetration is there of these policies at the intermediary level, and at the program level? Is there a statewide mechanism for tracking data for quality improvement purposes regarding basic access to care for individuals with cod?
5. At the state level: what mechanism is in place to collect information on what intermediaries/programs are providing in terms of screening? Assessment? Identification of co-occurring clients? Tracking whether the program is providing appropriately integrated services to the clients?
6. At the state level, what data can you currently report, in your data infrastructure, that says: (If you wish to survey your intermediaries or programs to obtain this information, please let us know the methodology you will use to do so)
    - How many counties/programs have a co-occurring disorder screening policy?
    - How many counties/ programs have identified a co-occurring disorder screening process?
    - How many clients receive a screening for cod (as defined by the county or program)?
    - How many clients are screened positively (identified as cod) in the county or program data system?, and
    - How many clients receive an appropriate integrated assessment and/or service in the county/ program (depending on what the screening indicates is needed)?

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This would be a substantial amount of information, and would make more sense than the questions currently being asked. If states were to pass these requests along to their providers, they would be consistent with what the states are actually doing with regard to infrastructure development and basic data collection, and would require less than 10 data elements to be reported.

We want to thank you for your time and consideration of our input. Please feel free to contact us directly if further information is required, or for further elaboration of our comments. We have copied these comments to the COSIG project managers in the states in which we are part of the COSIG implementation process, in order that they are aware of our input. We look forward to your response.

Respectfully submitted,

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