CHANGING THE WORLD: WELCOMING, ACCESSIBLE RECOVERY-ORIENTED CULTURALLY FLUENT
COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEMS OF CARE FOR INDIVIDUALS AND FAMILIES WITH PSYCHIATRIC AND SUBSTANCE USE DISORDERS

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TRANSFORMATION

The process of recovery for systems

- UNIVERSAL WELCOMING PARTICIPATION
- HOPEFUL VISION
- PRINCIPLE DRIVEN
- EMPOWERED PARTNERSHIP
- CONTINUOUS QUALITY IMPROVEMENT
- STRENGTH-BASED
- HONEST SELF-ASSESSMENT
- STEP-BY-STEP MEASURABLE PROGRESS
- *Serenity Prayer of System Change*

"Co-occurring Psychiatric & Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies & Training Curricula"

CENTER FOR MENTAL HEALTH SERVICES

MANAGED CARE INITIATIVE

CONSENSUS PANEL REPORT

1998

FIVE SECTIONS OF PANEL REPORT

- I. CONSUMER/FAMILY STANDARDS
- II. SYSTEM STANDARDS/PROGRAM COMPETENCIES
- III. PRACTICE GUIDELINES
- IV. WORKFORCE COMPETENCIES
- V. TRAINING CURRICULA

CONSUMER/FAMILY SYSTEM STANDARDS

- WELCOMING
- ACCESSIBLE
- INTEGRATED
- CONTINUOUS
- COMPREHENSIVE

Individuals with Co-occurring Disorders

PRINCIPLES OF SUCCESSFUL TREATMENT:

Dual diagnosis is an **expectation**, not an **exception.**

This expectation must be incorporated in a **welcoming** manner into all clinical contact, to promote **access** to care and **accurate identification** of the population.

Treatment success derives from the implementation of an **empathic**, **hopeful**, **continuous** treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.

EMPATHY MANTRA

- When individuals with mental illness and substance disorder are not following recommendations, they are doing their job.
- It is our job to understand their job, to join them in it, and help them to do it better.
- Their job involves coming to terms with the painful reality of having both mental illness and substance disorder, wanting neither one, yet having to build an identity that involves rx for both.

HOPE

- FOUR STEP PROCESS

1. Empathize with reality of despair.
2. Establish legitimacy of need to ASK for extensive help.
3. Identify meaningful, attainable measures of successful progress.
4. Emphasize a hopeful vision of pride and dignity to counter self-stigmatization.

INTEGRATED TREATMENT

- Integrated treatment refers to any of a number of mechanisms by which established diagnosis-specific and stage-specific treatments for each disorder are combined into a person-centered coherent whole at the level of the consumer, and each rx can be modified as needed to accommodate issues related to the other disorder.

CONTINUITY

- Course of treatment for individuals with chronic co-morbid conditions ideally combines continuous integrated relationships which are unconditional, with multiple episodic interventions or programmatic episodes of care which have expectations, conditions, and/or time limits.

The Four Quadrant Model is a viable mechanism for categorizing individuals with co-occurring disorders for purpose of service planning and system responsibility.

SUB-GROUPS OF PEOPLE WITH COEXISTING DISORDERS

Patients with "Dual Diagnosis" - combined psychiatric and substance abuse problems - who are eligible for services fall into four major quadrants

PSYCH. HIGH SUBSTANCE HIGH Serious & Persistent Mental Illness with Substance Dependence **QUADRANT IV**	PSYCH. LOW SUBSTANCE HIGH Psychiatrically Complicated Substance Dependence **QUADRANT III**
PSYCH. HIGH SUBSTANCE LOW Serious & Persistent Mental Illness with Substance Abuse **QUADRANT II**	PSYCH. LOW SUBSTANCE LOW Mild Psychopathology with Substance Abuse **QUADRANT I**

PSYCH HIGH / SUBSTANCE LOW
SERIOUS & PERSISTENT MENTAL ILLNESS WITH SUBSTANCE ABUSE QUADRANT II

- Patients with serious and persistent mental illness (e.g. Schizophrenia, Major Affective Disorders with Psychosis, Serious PTSD) which is complicated by substance abuse, whether or not the patient sees substances as a problem.

PSYCH HIGH / SUBSTANCE HIGH

SERIOUS & PERSISTENT MENTAL ILLNESS WITH SUBSTANCE DEPENDENCE QUADRANT IVA

- Patients with serious and persistent mental illness, who also have alcoholism and.or drug addiction, **and** who need treatment for addiction, for mental illness, or for both. This may include **sober** individuals who may benefit from **psychiatric** treatment in a setting which also provides sobriety support and Twelve-step Programs.

PSYCH LOW / SUBSTANCE HIGH

PSYCHIATRICALLY COMPLICATED SUBSTANCE DEPENDENCE QUAD III (mild-mod); QUAD IVB (severe)

- Patients with alcoholism and/or drug addiction who have significant psychiatric symptomatology and /or disability but who do **NOT** have serious and persistent mental illness.
- Includes both **substance-induced** psychiatric disorders and **substance-exacerbated** psychiatric disorders.
- Includes the following psychiatric syndromes:
  - Anxiety/Panic Disorder - Suicidality
  - Depression/Hypomania - Violence
  - Psychosis/Confusion - PTSD Symptoms
  - Symptoms Secondary to Misuse/Abuse of Psychotropic Medication
  - Personality Traits/Disorder

PSYCH LOW / SUBSTANCE LOW

MILD PSYCHOPATHOLOGY WITH SUBSTANCE ABUSE QUADRANT I

- Patients who usually present in outpatient setting with various combinations of psychiatric symptoms (e.g. anxiety, depression, family conflict) and patterns of substance misuse and abuse, but not clear cut substance dependence.

DSM III-R Diagnostic Criteria

PSYCHOACTIVE SUBSTANCE ABUSE

- **A maladaptive pattern of psychoactive substance use indicated by at least one of the following:**
  - Continued substance use despite having persistent or recurrent social, occupational, psychological, or physical problems caused or exacerbated by the effects of the substance use
  - Recurrent substance use in situations in which it is physically hazardous
  - Recurrent substance-related legal problems
- **Some symptoms of the disturbance have lasted for at least one month, or have occurred repeatedly over a longer period of time.**
- **The symptoms have never met the criteria for Substance Dependence for this class of substance**.

DSM IV Diagnostic Criteria

PSYCHOACTIVE SUBSTANCE DEPENDENCE

- **A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:**
  - Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of substance to achieve intoxication or desired effect
    - Markedly diminished effect with continued use of the same amount of the substance
  - Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for the substance
    - The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
- The substance is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control substance use

(Continued)

DSM IV Diagnostic Criteria

PSYCHOACTIVE SUBSTANCE DEPENDENCE

(Continued)

- A great deal of time spent in activities necessary to obtain the substance, use the substance, or recover from its effects
- Important social, occupation, or recreational activities are given up or reduced because of substance use
- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

NOTE: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP)

- Characteristic withdrawal symptoms
- Substance often taken to relieve or avoid withdrawal symptoms

Within the context of the empathic, hopeful, continuous, integrated relationship, **case management/care** (based on level of impairment) and **empathic detachment/confrontation** (based on strengths and contingencies) are appropriately balanced at each point in time.

When substance disorder and psychiatric disorder co-exist, each disorder should be considered **primary**, and **integrated dual primary treatment** is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.

Both substance dependence and serious mental illness are examples of primary, chronic, biologic mental illnesses, which can be understood using a **disease and recovery** model, with **parallel phases of recovery**.

PARALLELS
PROCESS OF RECOVERY

- PHASE 1: **Stabilization**
  - Stabilization of active substance use or acute psychiatric symptoms
- PHASE 2: **Engagement/ Motivational Enhancement**
  - Engagement in treatment
  - Contemplation, Preparation, Persuasion
- PHASE 3: **Prolonged Stabilization**
  - Active treatment, Maintenance, Relapse Prevention
- PHASE 4: **Recovery & Rehabilitation**
  - Continued sobriety and stability
  - One year - ongoing

SUMMARY

- EMPATHIC, HOPEFUL, CONTINUOUS, INTEGRATED MULTIPLE PRIMARY PROBLEM, ADEQUATELY SUPPORTED, ADEQUATELY REWARDED, STRENGTH-BASED, SKILL-BASED, STAGE-MATCHED COMMUNITY BASED LEARNING.

There is no one type of dual diagnosis program or intervention. For each person, the correct treatment intervention must be individualized according to subtype of dual disorder and diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder.

In a **managed care system**, individualized treatment matching also requires multidimensional level of care assessment involving **acuity**, **dangerousness**, **motivation**, **capacity for treatment adherence**, and availability of continuing empathic treatment relationships and other recovery supports.

CCISC CHARACTERISTICS

- 1. SYSTEM LEVEL CHANGE
- 2. USE OF EXISTING RESOURCES
- 3. BEST PRACTICES UTILIZATION
- 4. INTEGRATED TREATMENT PHILOSOPHY

CHANGING THE WORLD

- A. SYSTEMS
- B. PROGRAM
- C. CLINICAL PRACTICE
- D. CLINICIAN

12 STEPS OF IMPLEMENTATION

- 1. INTEGRATED SYSTEM PLANNING
- 2. CONSENSUS ON CCISC MODEL
- 3. CONSENSUS ON FUNDING PLAN
- 4. IDENTIFICATION OF PRIORITY POPULATIONS WITH 4 BOX MODEL
- 5. DDC/DDE PROGRAM STANDARDS
- 6. INTERSYSTEM CARE COORDINATION

12 STEPS OF IMPLEMENTATION

- 7. PRACTICE GUIDELINES
- 8. IDENTIFICATION, WELCOMING, ACCESSIBILITY: NO WRONG DOOR
- 9. SCOPE OF PRACTICE FOR INTEGRATED TREATMENT
- 10. DDC CLINICIAN COMPETENCIES
- 11. SYSTEM WIDE TRAINING PLAN

12 STEPS OF IMPLEMENTATION

- 12. PLAN FOR COMPREHENSIVE PROGRAM ARRAY
  - A. EVIDENCE-BASED BEST PRACTICE
  - B. PEER DUAL RECOVERY SUPPORT
  - C. RESIDENTIAL ARRAY: WET, DAMP, DRY, MODIFIED TC
  - D. CONTINUUM OF LEVELS OF CARE IN MANAGED CARE SYSTEM: ASAM-2R, LOCUS 2.0

DUAL DIAGNOSIS CAPABLE

ROUTINELY ACCEPTS DUAL DIAGNOSIS PATIENT
WELCOMING ATTITUDES TO COMORBIDITY

CD PROGRAM: MH CONDITION STABLE AND PATIENT CAN PARTICIPATE IN TREATMENT
MH PROGRAM: COORDINATES PHASE-SPECIFIC INTERVENTIONS FOR ANY SUBSTANCE DX.
POLICIES AND PROCEDURES ROUTINELY LOOK AT COMORBIDITY IN ASSESSMENT, RX PLAN, DX PLAN, PROGRAMMING
CARE COORDINATION RE MEDS (CD)

Dual Diagnosis Capable: DDC-CD

- Routinely accepts dual patients, provided:
- Low MH symptom acuity and/or disability, that do not seriously interfere with CD Rx
- Policies and procedures present re: dual assessment, rx and d/c planning, meds
- Groups address comorbidity openly
- Staff cross-trained in basic competencies
- Routine access to MH/MD consultation/coord.
- Standard addiction program staffing level/cost

Dual Diagnosis Capable: DDC-MH

- Welcomes active substance users
- Policies and procedures address dual assessment, rx & d/c planning
- Assessment includes integrated mh/sa hx, substance diagnosis, phase-specific needs
- Rx plan: 2 primary problems/goals
- D/c plan identifies substance specific skills
- Staff competencies: assessment, motiv.enh., rx planning, continuity of engagement
- Continuous integrated case mgt/ phase-specific groups provided: standard staffing levels

DUAL DIAGNOSIS ENHANCED (DDE)

MEETS DDC CRITERIA PLUS:

CD: MODIFICATION TO ACCOMMODATE MH ACUITY OR DISABILITY

MH SPECIFIC PROGRAMMING, STAFF, AND COMPTENCIES, INCLUDING MD

FLEXIBLE EXPECTATIONS; CONTINUITY

MH: ADDICTION TREATMENT IN PSYCH MANAGED SETTINGS (DUAL DX INPT UNIT) OR

INTENSIVE CASE MGT/OUTREACH TO MOST SERIOUSLY MI AND ADDICTED PEOPLE

Dual Diagnosis Enhanced: DDE-CD

- Meets criteria for DDC-CD, plus:
- Accepts moderate MH symptomatology or disability, that would affect usual rx.
- Higher staff/patient ratio; higher cost
- Braided/blended funding needed
- More flexible expectations re:group work
- Programming addresses mh as well as dual
- Staff more cross-trained/ senior mh supervision
- More consistent on site psychiatry/psych RN
- More continuity if patient slips

Dual Diagnosis Enhanced DDE-MH

- Meets all criteria for DDC-MH, plus:
- Supervisors and staff: advanced competencies
- Standard staffing; specialized programming:

  a. Intensive addiction programming in psychiatrically managed setting (dual inpt unit; dry dual dx housing, supported sober house)

  b. Range of phase-specific rx options in ongoing care setting: dual dx day treatment; damp dual dx housing

  c. Intensive case mgt outreach/motiv. enh.: CTT, wet housing, payeeship management

CCISC INITIATIVES State/Province

- Alaska – CCISC implementation, COSIG
- Arizona – CCISC implementation, COSIG
- Arkansas – COSIG, CCISC consultation
- California – CCISC consultation
- Colorado – CCISC consult, tool license
- District of Columbia – CCISC implementation, COSIG
- Florida – CCISC consultation, state provider association tool license
- Hawaii – CCISC implementation, COSIG
- Idaho – CCISC consultation 2001
- Louisiana – CCISC implementation, COSIG
- Maine – CCISC implementation, COSIG
- Manitoba – CCISC implementation
- Maryland – CCISC consultation, tool license
- Massachusetts – CCISC consensus 1999

Michigan – CCISC implementation multiple local projects, tool license
Minnesota – CCISC consultation, statewide provider network tool license
Montana – CCISC implementation
New Mexico – CCISC implementation (BHSD), COSIG
New York – CCISC consultation
Oklahoma – CCISC implementation, COSIG
Pennsylvania – CCISC implementation, COSIG
South Carolina – CCISC consultation, tool license
South Dakota – CCISC implementation
Texas – CCISC consultation (state hospitals), COSIG
Vermont – CCISC implementation, COSIG
Virginia – CCISC implementation, COSIG
Wisconsin – CCISC consult, tool license

CCISC INITIATIVES Local/Network (non-state)

- Alabama – Birmingham
- British Columbia – Vancouver Island Health Authority, and multiple locations with tool licenses
- California – San Diego, San Francisco, Placer, Kern, San Mateo Counties, Mental Health Systems, Inc (network)
- Colorado – Larimer County
- Florida – Tampa, Miami, Ft. Lauderdale, West Palm Beach, Pensacola Districts
- Illinois – Peoria (Fayette Companies)
- Indiana – Regional provider network
- Maryland – Montgomery, Worcester, Kent Counties
- Manitoba – Winnipeg RHA
- Michigan – Kent, Oakland, Venture Behavioral Health, CareLink network, Washtenaw, and multiple other networks and counties.
- Minnesota – Crookston
- Missouri – Mark Twain Area Counseling Ctr
- New York – Oneida County
- Nova Scotia – Cape Breton RHA
- Ohio – Akron
- Ontario - Hamilton
- Oregon – Mid Valley Behavioral Care Network
- Pennsylvania – Blair County
- Virginia – Lynchburg (CVCSB)
- Washington – Spokane RSN
- Wisconsin – Green Bay, Milwaukee consultation

SYSTEM FEATURES

- **All systems are complex with unique structures and cultures**
- **All systems work within the context of limited resources and with complex funding issues**
- **Data is often inconsistent with epidemiologic findings**
- **Each has significant strengths and weaknesses at all levels (system, program, clinical practice, and clinician)**
- **Under utilization of leverage (carrots and sticks)**
- **Everyone falls into the training trap at some point**
- **Each is becoming more sophisticated about outcomes measurement (system and clinical) and continuous quality improvement approaches**

PUBLIC BEHAVIORAL HEALTH CARE

- Multiple State Agencies and Governing Bodies
- Multiple Funding Streams
- Multiple Systems of Care
- Severely Limited Resources
- Poverty
- Rural and Urban
- Cultural Diversity

IDENTIFICATION OF NEED

- Morbidity and Mortality
- Gross Under Identification
- Inefficient Use of Resources
- Unmet Needs

STRATEGIC ALIGNMENT

- CCISC – Principle-driven Systems Improvement Approach
- CCISC – Supports Implementation of Evidence-based Approaches and Improves Routine Practices
- CCISC – Can be Implemented with Existing Resources Using Traditional Funding Streams

IMPLEMENTATION

- Top-down/Bottom-up Development
- Aligning the Parts of the System
- Inclusion, not Exclusion (programs and populations)
- Strategic Use of Leverage (Incentives, Contracts, Standards, Licensure, etc….)
- Outcomes and CQI (CO-FIT 100™)
- Model Programs
- Evaluation of Core Competencies (COMPASS™ and CODECAT™)
- "Action Planning"
- Train-the-Trainers
- "Backfilling"

STARTING PLACES

- Identification of the Population in Need
- Administrative Barriers – Access: Welcoming, No Wrong Door
- Administrative Barriers – Data Capture: MIS system; feedback
- Administrative Barriers – Fiscal: Billing and auditing practice
- Universal Integrated Screening
- Assessment Process (ILSA™)
- Treatment Matching
- Treatment Planning
- Engagement, Stage of Change and Contingency Management
- Evaluation of Trauma
- Interagency Coordination

PRINCIPLES OF SUCCESSFUL TREATEMENT…

- Co-morbidity is an expectation, not an exception.
- Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.
- Within the context of the empathic, hopeful, continuous, integrated relationship, case management/care and empathic detachment/confrontation are appropriately balanced at each point in time.

…PRINCIPLES OF SUCCESSFUL TREATEMENT…

- When substance disorder and psychiatric disorder co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.
- Both major mental illness and substance dependence are examples of primary mental illnesses which can be understood using a disease and recovery model, with parallel phases of recovery, each requiring phase-specific treatment.

…PRINCIPLES OF SUCCESSFUL TREATEMENT

- *There is no one type of dual diagnosis program or intervention.* For each person, the correct treatment intervention must be individualized according to diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder, and level of acuity, dangerousness, motivation, capacity for treatment adherence, and availability of continuing empathic treatment relationships and other recovery supports.

LINKING PRINCIPLES, IMPLEMENTATION AND OUTCOMES

- Examples:
  - Principle: Co-morbidity is an Expectation, not an Exception
  - CQI Initiative: Removal of Administrative Barriers to Data Collection
  - Measure of Success: Improved Population Identification and Data Collection

LINKING PRINCIPLES, IMPLEMENTATION AND OUTCOMES

- Examples:
  - Principle: Individualized Treatment Matching according to diagnosis, phase of recovery/treatment, level of functioning/disability, level of acuity, dangerousness, motivation, capacity for treatment adherence, availability of continuing empathic treatment relationships and recovery supports
  - CQI Initiative: Integrated Longitudinal Strength-based Assessments (ILSA™)
  - Measure of Success: Improved Identification of Need and Improved Treatment Matching

TRAIN THE TRAINER PROGRAM

ROLES OF THE TRAINER

- Develops Systems and Clinicians
- Identifies Barriers to Implementation
- Informs Policy and Procedure
- Bridges Systems and Clinicians
- Extends Training and TA Capacity

COMPONENTS OF THE PROGRAM

- Master Trainers
- Master Trainer Sessions
- Master Trainer Curriculum
- Trainings and Technical Assistance
- Development and Feedback Loops