***CHANGING THE WORLD: WELCOMING, RECOVERY-ORIENTED, TRAUMA-INFORMED, CULTURALLY FLUENT,* COMPREHENSIVE, CONTINUOUS, *INTEGRATED* SYSTEMS OF CARE for INDIVIDUALS AND FAMILIES with PSYCHIATRIC and SUBSTANCE USE DISORDERS and OTHER CO-OCCURRING CONDITIONS**

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CCISC
Comprehensive, Continuous, Integrated System of Care

- Every program becomes a welcoming, recovery or resiliency-oriented, co-occurring capable program
- Every person providing care becomes a welcoming, recovery or resiliency-oriented, co-occurring competent clinician
- CCISC System Tool: **CO-FIT 100**
- CCISC **12 Step Program of Implementation**

CO-OCCURRING CAPABILITY

- Each program organizes itself, within its mission and resources, to deliver integrated, matched, best practice interventions for multiple issues to the individuals and families with complex needs who are coming to the door.
- CCISC Program Self-Assessment Tool: **COMPASS-EZ**
- **12 Steps** for Agencies and Programs developing co-occurring capability

CO-OCCURRING COMPETENCY

- Each person providing clinical care is helped to develop core competency, within their job, within their level of training, and within their level of licensure or certification (whether they have one license, two licenses, or no license at all) to know how to be helpful to the people and families with complex needs that are likely to already be in their caseloads.
- CCISC Clinician Self-Assessment Tool: **CODECAT-EZ**
- 12 Steps of Co-occurring Competency for clinicians

How we do this clinically

- Evidence based and consensus based **principles of successful treatment** for individuals and families with co-occurring conditions
- The principles are placed in the context of an **integrated recovery/resiliency philosophy** that creates a common language for the whole system.
- Each principle is associated with one or more **intervention strategies that can be applied in any program by any clinician with any population.**

How we get there as a system

- Recovery process for systems: **Quality Improvement Partnership** at every level of the system to make progress toward a common vision
- Each agency organizes a **Continuous Quality Improvement process** so that every program within the agency makes step by step progress toward being welcoming, recovery-oriented and co-occurring capable.
- Each program identifies one or more **"Change Agents"** to represent the voice of front line clinicians and consumers
- The Change Agents organize as an empowered group to work in partnership with leadership to achieve the vision

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

CONSUMER/FAMILY SYSTEM STANDARDS (1998)

- WELCOMING
- ACCESSIBLE
- INTEGRATED
- CONTINUOUS
- COMPREHENSIVE

Individuals with Co-occurring Disorders

PRINCIPLES OF SUCCESSFUL TREATMENT:

PRINCIPLE #1

Co-occurring conditions and issues are 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 screening and identification** of individuals and families with co-occurring conditions and issues.*

PRINCIPLE #2

The foundation of a recovery partnership is an **empathic**, **hopeful**, **integrated, strength-based** relationship.

*Within this partnership, **integrated longitudinal strength-based** assessment, intervention, support, and **continuity** of care promote step by step **community based learning for each issue or condition**.*

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

- **FIVE STEP PROCESS**

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

INTEGRATED SERVICES

- **Integration of services refers to any of a number of mechanisms by which established diagnosis-specific and stage-specific interventions for each disorder or condition are combined into a person-centered coherent whole at the level of the consumer, and**
- **Each intervention can be modified as needed to accommodate issues related to the other disorders or conditions.**

STRENGTH-BASED

- Assessment and intervention are based on understanding in detail the periods of time when the person or family did relatively well, and the strengths they used to be successful in dealing with all their issues.
- Individuals and families are viewed as **recurrently successful,** not as chronic relapsers.

CONTINUITY

- **Course of treatment for individuals with chronic co-occurring 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.**

PRINCIPLE #3
All people with co-occurring conditions and issues are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations.

The Four Quadrant Model is a helpful mechanism for categorizing individuals with co-occurring disorders for purpose of defining system responsibility for populations.

This applies to MH/SA; MH-SA/DD; MH-SA/Medical

The Four Quadrant Model also reinforces the clinical value of distinguishing serious and persistent mental illness or serious emotional disturbance from other persistent mental illness and from transient mental illness, and distinguishing substance use, abuse, and dependence.

THE FOUR QUADRANTS

Persons with "Co-occurring Disorders" - combined psychiatric and substance abuse problems - fall into four major quadrants

NOTE: Serious and Persistent Mental Illness (SPMI) is a term for adults, and can be replaced by Serious Emotional Disturbance (SED) for children and adolescents

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 or SERIOUS EMOTIONAL DISTURBANCE WITH SUBSTANCE ABUSE QUADRANT II

- People with serious and persistent mental illness or serious emotional disturbance (e.g. Schizophrenia, Major Affective Disorders with Psychosis, Serious PTSD and other serious and disabling psychiatric or emotional conditions) which is complicated by substance abuse, whether or not the person sees substances as a problem.

PSYCH HIGH / SUBSTANCE HIGH

SERIOUS & PERSISTENT MENTAL ILLNESS or SERIOUS EMOTIONAL DISTURBANCE WITH SUBSTANCE DEPENDENCE QUADRANT IVA

- People with serious and persistent mental illness or serious emotional disturbance, who also have alcoholism and/or drug addiction, **and** who need treatment for both addiction and for mental illness.

PSYCH LOW / SUBSTANCE HIGH

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

- People with alcoholism and/or drug addiction who have significant psychiatric symptoms and /or disability but who do **NOT** have serious and persistent mental illness.
- Includes both **substance-induced (transient)** psychiatric disorders, and **persistent** psychiatric disorders which may be **substance-exacerbated or** may be **masked or suppressed** by substance use.
- May include the following psychiatric syndromes:
  - Anxiety/Panic Disorder
  - Depression/Hypomania/Mood instability
  - Psychosis/Confusion
  - Personality Traits/Disorders
  - Suicidality
  - Violence and anger
  - PTSD Symptoms
  - ADHD and Cognitive problems

PSYCH LOW / SUBSTANCE LOW

MILD PSYCHOPATHOLOGY WITH SUBSTANCE ABUSE QUADRANT I

- People who usually present in outpatient behavioral health settings or primary health settings 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

PRINCIPLE #4

When co-occurring conditions and issues co-exist, each condition or issue is considered primary.

*The best practice intervention is **integrated dual or multiple primary treatment,** in which each condition or issue receives appropriately matched intervention at the same time.*

PRINCIPLE #5
Parallel Primary Recovery Processes

Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue

Both substance dependence and serious mental illness are examples of primary, "chronic", biologic "mental illness"
*These illnesses, and other chronic, stigmatizing conditions or issues (such as the experience of trauma, or homelessness), can be understood using a **disease and recovery model, or a condition and recovery model, with parallel phases of recovery for each condition or issue.***

Recovery is ultimately not recovery from the condition, but recovery of the human being who has the condition.

Phases of Recovery

- PHASE 1: **Acute Stabilization**
  - Stabilization of active substance use or acute psychiatric symptoms or other immediate risk
- PHASE 2: **Engagement / Motivational Enhancement**
  - Movement through Stages of Change
- PHASE 3: **Prolonged Stabilization**
  - Working to achieve Maintenance, Relapse Prevention
- PHASE 4: **Rehabilitation**
  - Continued growth and learning over time

*Phases of recovery can be listed in **parallel** for each condition, but they don't occur in parallel or in order. Individuals can be in different phases for different conditions at the same time.*

Stages of Change

- **Pre-contemplation:** You may think this is an issue, but I don't, and even if I do, I don't want to do deal with it, so don't bug me.
- **Contemplation:** I'm willing to think with you, and consider if I want to change, but have no interest in changing, at least not now
- **Preparation:** I'm ready to start changing but I haven't started, and I need some help to know how to begin.
- **Early Action:** I've begun to make some changes, and need some help to continue, but I'm not committed to maintenance or to following all your recommendations.
- **Late Action:** I'm working toward maintenance, but I haven't gotten there, and I need some help to get there.
- **Maintenance:** I'm stable and trying to stay that way, as life continues to throw challenges in my path.

NOTE: Stage of change is issue-specific, not person-specific!!!!

Intervention based on Principle 5

STAGE-MATCHED LEARNING

For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.

PRINCIPLE #6
Skills, Supports, and Rewards

Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition and issue

Interventions based on Principle 6

SKILL-BASED LEARNING

For EACH condition OR issue, " active treatment" involves:

- *Getting an **accurate set of recommendations** for how to help that condition*
- *Learning what those recommendations are*
- *Most important: **Skill-Based Learning:** developing the skills to follow those recommendations consistently to achieve success:*
- ***Skills include both self-management skills, and skills for accessing professional, peer, or family support.***

Interventions based on Principle 6

ADEQUATELY SUPPORTED, ADEQUATELY REWARDED LEARNING

- ***Provision of support**, case management, and care, **and provision of expectations** and contingencies, **need to be properly balanced** to promote learning for each condition.*
- *It is necessary to do for people what they can't do for themselves in order to help them succeed. This includes accommodation for disability, and provision of **adequately supported learning:** matching the learning to the client's capability to learn.*
- *When using contingencies to promote learning, **reward is more effective than negative consequences.***

PRINCIPLE #7
Recovery plans, interventions, and outcomes must be individualized, so there is no single "correct" co-occurring program or intervention for everyone.

*For each person, **integrated treatment interventions and treatment outcomes must be individualized** according to the person's hopeful goals, their specific diagnoses ,conditions, or issues, and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition*

SUMMARY

- **EMPATHIC, HOPEFUL, CONTINUOUS, INTEGRATED RELATIONSHIPS** addressing **MULTIPLE PRIMARY PROBLEMS,** providing **ADEQUATELY SUPPORTED, ADEQUATELY REWARDED, STRENGTH-BASED, SKILL-BASED, STAGE-MATCHED COMMUNITY BASED LEARNING** for each problem.

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

LOCUS 2010 *and* ***ASAM PPC 2R*** *are both potentially helpful tools.*

Principle 8

Comprehensive Continuous Integrated System of Care (CCISC) is designed so that all policies, procedures, practices, programs and clinicians become welcoming, recovery/resiliency oriented, and co-occurring capable

CCISC CHARACTERISTICS

- 1. SYSTEM LEVEL CQI PARTNERSHIP
- 2. USE OF EXISTING RESOURCES
- 3. BEST PRACTICES UTILIZATION
- 4. INTEGRATED RECOVERY PHILOSOPHY

CHANGING THE WORLD

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

12 STEPS OF IMPLEMENTATION

- 1. INTEGRATED SYSTEM CQI PLAN
- 2. CONSENSUS ON CCISC MODEL
- 3. CONSENSUS ON FUNDING PLAN
- 4. IDENTIFICATION OF PRIORITY POPULATIONS WITH 4 BOX MODEL
- 5. DDC 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

CO-OCCURRING CAPABLE

ROUTINELY ACCEPTS PEOPLE OR FAMILIES WITH CO-OCCURRING CONDITIONS

WELCOMING ATTITUDES TO PEOPLE WITH CO-OCCURRING CONDITIONS

CD PROGRAM: MH CONDITION MILD TO MODERATELY SEVERE AND PATIENT CAN PARTICIPATE IN TREATMENT, INTEGRATES SKILLS FOR MANAGING MH SYMPTOMS AND DISORDERS INTO ALL PROGRAMMING

MH PROGRAM: INTEGRATES STAGE-SPECIFIC INTERVENTIONS FOR ANY SUBSTANCE DX INTO ALL SERVICES

BOTH: POLICIES AND PROCEDURES ROUTINELY LOOK AT COMORBIDITY IN ASSESSMENT, RX PLAN, DX PLAN, PROGRAMMING

CARE COORDINATION RE MEDS (CD)

Co-occurring Capable: Substance Programs

- 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

Co-occurring Capable: Mental Health Programs

- 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

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 implementation, state provider association tool license
- Hawaii – CCISC partial implementation, COSIG
- Idaho – CCISC consultation and some implementation
- Iowa – CCISC implementation
- Louisiana – CCISC implementation, COSIG
- Maine – CCISC implementation, COSIG
- Manitoba – CCISC implementation
- Maryland – CCISC consultation, tool license
- Massachusetts – CCISC consensus 1999
- Michigan – CCISC implementation
- Missouri – CCISC implementation, COSIG
- Montana – CCISC implementation
- New Mexico – CCISC implementation (BHSD), COSIG
- Oklahoma – CCISC implementation, COSIG
- Pennsylvania – CCISC local implementation, COSIG
- South Carolina – CCISC consultation, tool license
- South Dakota – CCISC implementation, COSIG
- 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, Alameda, Amador, Shasta, Fresno Counties, Mental Health Systems, Inc (network), Fred Finch Youth Centers
- Colorado – Larimer County, Pikes Peak County
- Florida – Tampa, Miami, Ft. Lauderdale, Polk County, Pensacola Districts
- Illinois – Peoria (Fayette Companies)
- Indiana – Regional provider network
- Maryland – Montgomery, Worcester, Anne Arundel, Kent Counties
- Manitoba – Winnipeg RHA
- Michigan – Kent, Oakland, Detroit-Wayne, Venture Behavioral Health, Washtenaw, and multiple other networks and counties.
- Minnesota – Crookston
- Missouri – Missouri Foundation for Health, ReDiscover, Inc.
- Nebraska – Omaha region
- Nevada – Northern Nevada Adult MH
- New York – Oneida County, Monroe County
- Nova Scotia – Cape Breton RHA
- Ohio – Summit County
- Ontario – Central West LHIN, Champlain LHIN
- Oregon – Mid Valley Behavioral Care Network
- Pennsylvania – Blair, Beaver, Bucks Counties
- Washington – Spokane RSN, Kitsap County
- Wisconsin – Milwaukee County