Developing Welcoming Systems for Individuals with Co-Occurring Disorders: The Role of the Comprehensive Continuous Integrated System of Care Model

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ABSTRACT. This paper reviews a best practice model for design and implementation of system-wide integrated services for individuals with co-occurring disorders, and illustrates the application of that model to the implementation of the specific clinical attitude and practice of welcoming in a number of ongoing Comprehensive Continuous Integrated System of Care (CCISC) projects. Welcoming, while not formally an "evidence based best practice," is a clinical service delivery standard that also creates a strategic energy to promote implementation of other best practice interventions. Given that CCISC can be designed within the resource base of any system, and given that initial projects have been able to describe some early success in creating meaningful shifts in clinical practice, the model appears to have some face value in application to complex systems. Clearly, more formal evaluation of system, program, and client outcomes from CCISC projects is needed; the authors are currently in the process of designing such evaluation studies. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-*

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INTRODUCTION

People with co-occurring psychiatric and substance use disorders frequently present in both substance treatment and mental health service systems and are associated with poorer outcomes and higher costs in multiple domains.[1,2] In addition, these individuals have historically been poorly served in both mental health and substance abuse treatment systems, both because of a lack of information on effective treatment programs and interventions, and because of significant systemic barriers in both systems. These system barriers are striking in that these individuals–in spite of their poor outcomes and high cost–are not only not prioritized and specifically welcomed, they are experienced as "misfits" at every level–at the system policy level, at the program design level, at the clinical practice level, and at the clinician competency and training level–in terms of regulations, information systems, funding mechanisms, and clinical credentialing and certification.

Fortunately, as these individuals have emerged increasingly into all service systems (elders, adults and children; mental health, substance abuse, criminal justice, homelessness, child protection, primary health care, and so on) there has been an increasing accumulation of data that has described a range of evidence-supported clinical interventions and programs that have been found to be effective in treating these individuals. It is beyond the scope of this article to summarize all of the program models and interventions that have been investigated; up-to-date summaries can be found in SAMHSA's Report to Congress on Prevention and Treatment of Mental Health and Substance Use Disorders[3] and in the Center for Substance Abuse Treatment's newest Treatment Improvement Protocol for Co-occurring Disorders.[4] Significant innovations include a range of available mechanisms and processes for population- and setting-specific integrated screening and integrated as-

sessment, conceptualization and manualization of stage-specific treatment interventions,[5,6,7] implementation of various strategies for contingency management of individuals in care or supervision.[8] As well, there is an increasing array of skills manuals both to help substance clinicians address mental health symptoms,[9] medications,[10] and trauma issues,[11] and to help mental health clinicians working with seriously mentally ill individuals provide substance abuse skills training.[12] One of the most important emergent innovations is SAMHSA's evidence based best practice toolkit on Integrated Dual Diagnosis Treatment (IDDT) which describes an organized programmatic community based approach to integrating multiple strategies (such as those mentioned above) for addressing substance use disorders in an integrated fashion into ongoing mental health care for adults who have serious and persistent mental illnesses.[13]

As this information has emerged into the literature, there has been increasing attention on how to implement best practice interventions and programs in real world systems, a process termed "science to service." Unfortunately, despite substantial resources dedicated to "technology transfer," the process of bringing these innovations into systems in which the target population is seen as "misfits" has proven to be quite difficult. In a recent review on the subject, Drake and colleagues have commented on the fact that demonstration projects alone do not result in systemic adoption of integrated treatment because of a wide array of system barriers, which include not only regulatory barriers, but attitudinal and philosophical barriers that divide the systems and create resistance to engaging with the clients who have co-occurring disorders.[14] This has led to increasing recognition that the implementation of better services and interventions for individuals with co-occurring disorders cannot be accomplished through simply expanded clinical research or dissemination of funding for demonstration projects; unless the system barriers mentioned above are addressed, service innovation for this high priority population will be extremely limited in its success. As a result, the Report to Congress, after reviewing the literature on program and clinical interventions, concluded that because "dual diagnosis is an expectation" in service delivery systems, and because current nonintegrated approaches to care are associated with poorer outcomes and higher costs, and because system barriers present a major impediment to the dissemination of new technologies for this population, a focus on system level strategies and approaches is needed to address the co-occurring disorder population. Consequently, in the Report to Congress, SAMHSA made a significant commitment to supporting the develop-

ment of federal, state, and local projects designed to address systemic barriers to service integration. In The Report, SAMHSA provided anecdotal information on a number of state projects already in progress, including referencing a technical assistance report prepared by the authors of this paper describing a state level Co-occurring Disorder Services Enhancement Initiative in New Mexico.[15] Further, SAMHSA has begun to fund co-occurring disorder state incentive grants (COSIG) to support state level systems development initiatives, with a plan to eventually fund a grant in every state. In addition, SAMHSA is redesigning its mental health and substance treatment block grants to be performance partnership grants (PPG) with expectations (to begin in FY 2006) that states will be able to provide data concerning screening, identification, integrated assessment, integrated treatment and integrated outcomes for individuals with co-occurring disorders in their service populations. This will require significant system infrastructure development in every state. The conclusion can be drawn that both clinical and systems drivers are making the development of models of system change for implementation of integrated services an increasingly more important priority in all systems. The purpose of this paper will be to discuss one such model, the Comprehensive Continuous Integrated System of Care (CCISC) and to illustrate the application of this model to the implementation of system-wide welcoming attitudes for individuals with co-occurring disorders as part of a more comprehensive strategic approach to systemic implementation of best practice matched integrated treatment for this population within the context of existing system structures and resources. The discussion will be based on the authors' experiences as consultants with the implementation of the model during the last four years in nearly 30 state, provincial, and regional projects in the United States and Canada.

COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE MODEL

The Report to Congress reviewed promising practices for systems development and referenced the Comprehensive Continuous Integrated System of Care (CCISC) model developed by one of the authors (KM) as a best practice model for system design for integrated services. CCISC was first described in 1991,[16] further elaborated in a report developed by a national consensus panel on co-occurring disorders in 1998,[17] and first utilized as a best practice for system design in a

SAMHSA Community Action Grant consensus building (not implementation) project in the state of Massachusetts in 1998-99.[18] Subsequently, CCISC projects have been initiated in–at least–Alabama (Birmingham), Arizona, Alaska, California (San Diego), District of Columbia, Florida (Tampa-Hillsborough plus four other districts), Hawaii, Illinois (Peoria), Indiana (Geminus), Louisiana, Maryland (Worcester and Montgomery Counties), Maine, Michigan (Grand Rapids, Kalamazoo, and six other systems), Minnesota (Crookston), Montana, New Mexico, Oregon (MVBCN), Pennsylvania (Blair County), South Carolina, Vermont, Virginia (Lynchburg), Washington (Spokane), British Columbia (Vancouver Island), and Manitoba. This list includes four of the seven current COSIG states. The model, and its accompanying "Twelve Step Program of Implementation" (including the implementation toolkit developed by the authors[19,20,21]) have been more fully described elsewhere,[22] and will therefore be described only briefly here.

CCISC is a framework for behavioral health system development. Based on standards for system outcome generated by consumers and families in the initial consensus panel project,[23] the goal of the model is to design a *welcoming, accessible, integrated, continuous and comprehensive system of care* that can support an array of evidence-based and consensus-based best practices for individuals with psychiatric and substance disorders. The authors have developed a tool for measuring system outcome and fidelity (COFIT-100™) that objectively measures the degree to which the system achieves these standards from a consumer/family perspective.[24] The rationale for a system-wide approach is that co-occurring disorders are an expectation in all settings (see below), associated with poor outcomes and high costs in multiple domains. Systems must be designed on the recognition that attention to co-occurring disorders must be designed as an expectation in all system activities and in the utilization of all system resources. Consequently, *the system must require <u>all</u> programs to be designed as "dual diagnosis programs" by meeting minimal standards of "dual diagnosis capability" (DDC),*[25] *initially within existing program resources.* Systems may also plan for some program components to be specifically designed as Dual Diagnosis Enhanced (DDE). Even though each program is a dual diagnosis program, each program has a different "job." This job is to provide organized matched services to its existing cohort of dually diagnosed clients by using a set of emerging consensus based and evidence based treatment matching principles–placed within the context of an integrated philosophy of service delivery–to determine the appropriate best practice interventions in that setting. The expectation that *all programs*

in the service system must meet basic standards for DDC, whether in the mental health system or the substance treatment system, is a crucial element of CCISC. DDC, in its most fundamental form, implies that each program organizes its own infrastructure, within the context of its existing resources, so that it can be proactively designed to implement an appropriately matched set of clinical processes to appropriately screen, identify, assess, treatment match, treat and measure outcomes for the co-occurring population that is already present in its service setting. The authors have developed a program self-survey (COMPASS™)[26] to assist programs in understanding and implementing DDC.

CCISC is designed to improve treatment capacity for individuals with co-occurring disorders in systems of any size and complexity–entire states, regions or networks, counties, or local catchment areas; systems based on any funding stream (state funded; Medicaid funded); systems defined by population (adults, children), and systems serving individuals with all types of cultural backgrounds in all types of locations. The model has the following four basic characteristics or goals and objectives:

1. System Level Change: The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. Attention is given to the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.
2. Efficient Use of Existing Resources: The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services within the context of each funding stream, program contract, or service code, rather than *requiring* blending or braiding of funding streams or duplication of services.
3. Incorporation of Best Practices: The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of individuals with co-occurring disorders. An important aspect of CCISC implementation is the incorporation of evidence based and consensus based clinical best practices for the treatment of all types of individuals with mental health and substance disorders throughout the service system, provided that any best practice intervention for one disorder can be organized to facilitate integrating an appropriately matched intervention for the other disorder at the level of the client.

4. Integrated Treatment Philosophy: The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder providers. This model can be used to develop a protocol for individualized treatment matching that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

The Organizing Principles

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception.* Epidemiologic data defining the high prevalence of co-morbidity,[27,28] along with clinical outcome data associating individuals with co-occurring disorders with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning and implementation process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All individuals with co-occurring disorders are not the same; the national consensus four quadrant model for categorizing co-occurring disorders*[29] *can be used as a guide for service planning on the system level.* In this model, individuals with co-occurring disorders can be divided according to high and low severity for each disorder, into high mental health (MH)-high chemical dependence (CD) (Quadrant IV), low MH-high CD (Quadrant III), high MH-low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have severe and persistent mental illness and require continuing integrated care in the mental health system. High CD individuals are appropriate for receiving episodes of addiction treatment in the addiction system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting;*

provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.[30,31] The system needs to prioritize (a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and (b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system different programs are designed to provide this balance in different ways.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting.

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model"*[32] *with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change[33] or stages of treatment,[34] and demonstrated the value of stage-wise treatment.[35]

7. *There is no single correct intervention for individuals with co-occurring disorders; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each pro-

gram in the system is assigned a "job": to work with a particular cohort of individuals with co-occurring disorders, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for individuals with co-occurring disorders must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

IMPLEMENTATION OF CCISC

The implementation of this complex system development model requires an organized approach using strategic planning and continuous quality improvement (CQI) in an incremental process that involves interaction between all layers of the system (administrative, agency or program, clinical practice and policy, clinician competency and training). The authors have articulated a "Twelve Step Program of Implementation" that organizes these activities in a logical, but interactive (top down, bottom up) sequence, in order to facilitate the conceptualization of the implementation process. These steps are as follows:

1. Identification of an empowered leadership entity for integrated planning and implementation (of any aspect of the change initiative) that is embedded in the organizational structure of the system.
2. Development of consensus on the implementation of the model, and chartering of the initial activities by system participants.
3. Documenting a consensus that the above activities will be accomplished within existing resources, as part of an incremental CQI process, with targeted incentives defined within the system.

4. Identification of priority populations for each component of the service system within the initiative, and allocation of responsibility for co-occurring disorder services according to the quadrant model.
5. Identification of Dual Diagnosis Capability program standards as a system goal for all programs, and beginning the process by which each program develops an action plan for incremental implementation.
6. Development of interagency care coordination structures, policies, and procedures, so that the various components of the system share responsibility for the collective co-occurring disordered population formally.
7. Identification and dissemination of a set of clinical practice guidelines based on the principles of the model, to define a direction for system wide best practice implementation.
8. Selection of initial "starting places" for prioritized systemic clinical practice implementation: usually welcoming, access, screening and data capture.
9. Selection of initial "starting places" for developing a scope of practice for each clinician to deliver "integrated treatment" within the context of his job description, license, and caseload.
10. Definition of core competency expectations for each clinician (to become DDC) to implement the above practice expectations.
11. Design of a training plan (e.g., train the trainer) for developing the competency expectations over time.
12. Review of the components of the system, to create a plan for a comprehensive service array, with all required best practice interventions and models included.

Clearly, implementation of the CCISC requires a complex system-wide integrated strategic planning process that can address the need to create change at every level of the system and in every aspect of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee *continuing* implementation of the other elements of the CCISC, use a structured process of system change, incorporate cultural competency, and define measurable system outcomes.

In this context, Continuous Quality Improvement (CQI)–well recognized as an organizing system change technology that works at the process level to improve performance of the process thereby improving the outcome–is a valuable (even necessary) tool for CCISC implementation. Essential to CQI is being able to define the process and measure performance to make adjustments or corrections early to improve the process while it is working. The COFIT-100 has been developed by the authors to facilitate this outcome measurement process at the system level, and the COMPASS™ performs a similar function at the program level. CCISC ultimately requires the identification of consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming and culturally competent, as well as accessible, integrated, continuous, and comprehensive, from the perspective of individuals with co-occurring disorders and their families.

STARTING PLACES: WELCOMING AS A BEGINNING STEP IN CCISC IMPLEMENTATION

As noted above, CCISC implementation is a very complex process. One of the things we have learned in our work with multiple systems is the need for concrete "starting places" that help the system to get organized for change, to begin to experience some success in improving the way the system functions and the way clients are served, and to offer opportunities to learn more about how the CCISC process actually works. In almost all the CCISC projects, the development of "welcoming" has become one of the most important and fundamental starting places for system change. Consequently, we have chosen to focus on the process of "welcoming" in this paper, both as a demonstration of how the CCISC implementation process operates, and as an illustration of how real systems have used this process to improve access and engagement of a population traditionally experienced as particularly "unwelcome."

Why welcoming? There are a number of reasons why welcoming has evolved as an important starting place for CCISC:

1. *Fidelity:* In the original description of the model,[36] the consumer and family system outcomes which CCISC was designed to achieve (as determined by consumer and family participation in the project itself) were Welcoming, Accessibility, Integration, Continuity, and Comprehensiveness. Consequently, welcoming is a logical place to begin. Fur-

ther, in developing a tool (CO-FIT 100™) to measure the fidelity of CCISC implementation at the system level, the authors have used specific measures of these five standards from a consumer/family perspective to evaluate system progress. As a result, systems can incorporate Welcoming very specifically into fidelity measures that may drive continuous quality improvement efforts, as will be described in more detail below.

2. *Best Practice Clinical Principles:* The focus on welcoming is directly connected to the most basic principles of CCISC. First, "dual diagnosis is an expectation," associated with poorer outcomes and higher costs in multiple domains. Clearly, part of the reason these individuals have poorer outcomes and higher costs is that they are experienced as "system misfits," but if they are in fact regarded as the "expectation," then the system needs to re-design itself as the individuals who are specifically welcomed as the most important population to engage successfully in treatment, because they are the individuals who are most in need, and most likely to cost the system dearly for ineffective care. Second, the next core treatment principle involves the development of "empathic, hopeful, integrated treatment relationships," directed through a process of empathic outreach[37] to a group who may not easily be engaged in such relationships. Welcoming as a priority makes a statement that the first step in clinical engagement involves a proactive, clinical stance, in which empathy and hope are a component of actively reaching out to bring clients with co-occurring disorders through "any door."

3. *Strategic Design:* Of equal importance, CCISC implementation requires a strategically planned approach to system change, and "welcoming" makes sense as a strategic starting place as well. First of all, it is well recognized that the implementation of any new set of clinical best practices requires alignment of system culture as well as clinician attitudes and values. This is particularly true when both the target population and the practices themselves challenge current philosophies and beliefs. Attempting to implement "integrated services" in unwelcoming systems engenders resistance that ultimately leads to increased cost and decreased likelihood of success. Second, "welcoming" is a concept around which early consensus can be fairly easily achieved. Because it is relatively non-controversial as a "value," the actual challenges of implementing system change can be more clearly delineated without contamination by value conflict. Third, "welcoming," while not easy to achieve, is a clinical system achievement that can be associated with relatively early success, even in a complex system. Consensus validation that the system has actually used CCISC to create a shift in its values,

and observation that this shift has resulted in improved access to care, enables the participants in the change process to experience a sense of accomplishment and efficacy that fuels their ability to negotiate more difficult implementation processes (such as accurate data capture for population identification) down the line. Finally, although "welcoming" sounds fairly straightforward to accomplish, successful implementation requires a "total system effort," with "action steps" at the system leadership level, and at the level of each program, key clinical practices, and the competency and training of each clinician. As such, the process of implementation of welcoming becomes a "test run" for how the system lines up its infrastructure to accomplish complex change at all levels in order to implement a wider array of "best practice" approaches for individuals with co-occurring disorders as the CCISC project unfolds over time.

USING CCISC TO PROMOTE IMPLEMENTATION OF WELCOMING SYSTEMS OF CARE

We will now proceed to illustrate the application of the CCISC model, as described above, to the systemic implementation of "welcoming" for individuals with co-occurring psychiatric and substance use disorders. As noted earlier, "welcoming" is only one component of a CCISC, but it represents an important strategic starting place to begin a more comprehensive system change process. The discussion is built upon our experiences with CCISC projects in many different systems, and will use examples from these projects to illustrate how the CCISC implementation process moves the system in the direction of creating more consistent "welcoming" for its most difficult clients.

What is a "welcoming" system for individuals with co-occurring disorders? At the broadest level, a welcoming system, from a CCISC perspective, implies that at every level (system, program, clinical practice, clinician competency and training, and outcome evaluation), "welcoming" individuals with co-occurring disorders is written into policy, anchored into contract language and program standards, defined as both a clinical policy requirement and practice expectation in each program for each clinician, incorporated into human resource policies and staff training and credentialing requirements, and embedded in systemic continuous quality improvement and outcome evaluation processes. Further, welcoming is applied not merely to the clients themselves, but to their families. Welcoming is completely intertwined with the imple-

mentation of cultural competency; and welcoming is defined as a practice that is independent of resource availability or program eligibility. With regard to the latter criterion, the emphasis in a welcoming system (sometimes described as the concept of "no wrong door") is that it is especially important to be "welcoming" to an individual who cannot be immediately served in one's program, both to communicate a sincere desire to engage that individual in care as soon as possible, as well as to welcome that person into the system as a whole, and to proactively help the person make a connection with someone in the system who will assume responsibility for making a beginning empathic, hopeful relationship to help that person get the services that he or she needs.

How does a system become "welcoming"? As noted above, the implementation process for this one practice becomes a microcosm for system change at every level of the system. We have termed this process as the "12 step program of implementation," (listed above). The following steps are related to these 12 steps:

1. *Identify an empowered decision making structure, that is appropriately positioned within the service system infrastructure.* The first activity of the system is to figure out how anything will be decided or implemented. In many instances, the system leadership will begin the process by focusing on issues beyond their control: for example, the county will focus on changing the state; or the mental health system will focus on changing the addiction system. One of the first steps is to re-direct whoever is at the table to focus on whatever they as a group have the power to change in their OWN system (whatever the level of system it is), and to organize how they can have that occur. (We call this "the serenity prayer of systems change"; the serenity to accept the things you cannot change, the courage to change the things you can, and the wisdom to know the difference.) Further, in order to have system change take place, it is NOT necessary for the system to have a uniform or merged structure. In many of our projects (for example, District of Columbia and San Diego County), the behavioral health system change effort actually involves relatively autonomous subsystems at the table: Department of Mental Health and Addictions Prevention and Recovery Agency in District of Columbia; Adult and Older Adult Mental Health, Children's Mental Health Services, and Alcohol and Drug Services in San Diego. In such situations, there can be an overarching structure that brings each subsystem to the table in a common effort, but the actual implementation of change will occur in the policies and procedures of each subsystem separately.

2. *Develop a document that defines consensus on the CCISC model, and set of implementation activities with identified priorities and incentives for clinical practice implementation within existing funding streams and existing funding constraints.* We call these documents "charter documents," and they usually have a very basic structure in which they describe the co-occurring disorder problem (high volume, poor outcome, high costs, and poorly served), describe the implementation structure (step one), document consensus on implementation of CCISC, and then outline a set of implementation activities for each participating subsystem, agency or program, usually over a one year period. All implementation activities are designed so programs are almost guaranteed to be successful with a reasonable effort, even without additional resources. Most charters are developed through a prioritization exercise with system stakeholders, so that these stakeholders can "vote" on what three to five priority clinical activities should be targeted for all components of the system in the first year. As noted above, "welcoming" is almost invariably included. The following is a *sample section from one of our project charter documents (Vancouver Island Health Authority, British Columbia)* that illustrates how this is framed in the document. The charter document may or may not be formally signed, but it is generally identified as requiring initial voluntary participation (with some incentive provided by the system, which is occasionally financial, but usually is an opportunity to participate in policy development, and in receiving system funded training and technical assistance) with the understanding that charter expectations will eventually find their way into contract or regulatory language.

Participating Service Provider Programs and Agencies will:

1. Adopt this charter as an official policy statement of the agency/program, with approval of their Director and/or Board of Directors. Circulate the approved charter document and provide training to all staff regarding the principles and the CCISC model.
2. Assign appropriately empowered staff to participate in Vancouver Island Health Authority regional integrated system planning and program development activities.
3. Adopt the goal of achieving dual diagnosis capability as part of the agency's short and long range strategic planning and quality improvement processes.
4. Participate in agency/program self-survey using the COMPASS™ at six-month intervals to evaluate the status of dual diagnosis capability.

5. Develop an agency/program specific action plan outlining measurable changes at the agency level, the program level, the clinical practice level, and the clinician competency level to move toward dual diagnosis capability. Monitor the progress of the action plan at six-month intervals. Participate in system wide training and technical assistance with regard to implementation of the action plan.
6. Participate in system wide efforts to improve identification and reporting of individuals with co-occurring disorders by incorporating agency/program specific improvements in screening and data capture in the action planning process.
7. Participate in system wide efforts to improve welcoming and reduce barriers to access for individuals with co-occurring disorders by adopting agency specific welcoming policies, materials, and expected staff competencies, and identifying specific plans to expand access to services in acute or intermediate settings, and to expand capability to provide integrated continuous treatment in continuing case management programs.
8. Assign staff to participate in system wide efforts to develop dual diagnosis capability standards, and systemic policies and procedures to support welcoming access in both emergency and routine situations. The mission of the system will be to create integrated and welcoming access in crisis for individuals with any psychiatric and substance disorder presentation.
9. Assign appropriate clinical leadership to participate in inter-agency/program care coordination meetings as they are developed and organized.
10. Participate in system wide efforts to identify required attitudes, values, knowledge, and skills for all clinicians regarding co-occurring disorders, and adopt the goal of dual diagnosis competency for all clinicians as part of the long-range plan of the agency/program.
11. Participate in clinician competency self survey using the CODECAT™ at six month intervals, and use the findings to develop an agency/program specific training plan.
12. Identify appropriate clinical and administrative staff to participate as trainers in the system wide train-the-trainer initiative, and to assume responsibility for implementation of the agency/program training plan.

3. *Identify the CCISC process as a systemic CQI initiative, and welcoming as one of the objectives or indicators for the outcome of this*

process. As the following insert from the above charter illustrates, this is usually written into the charter as an expectation for the "system," with the commitment that the system will use the CO-FIT 100™ as an "outcome tool" to monitor systemic progress on targeted priorities. (Welcoming is one of the CO-FIT 100™ domains.) One of the challenges for the system leadership structure is to figure out how to embed the initiative into the routine CQI processes of the system, so that these routine processes become "bureaucratic" (in the best sense of the term) drivers that anchor the process in place over time, whether there is ultimately a special CCISC project or not. One of the components of the CQI process is for the system to develop mechanisms for monitoring program performance in relation to priority activities (including welcoming) that are incorporated into routine QI audit measures. For example, the District of Columbia DMH QI director drafted an audit tool called DC-CODPAT for this purpose (not yet implemented); and in the Tampa-Hillsborough project in Florida, charter activities were incorporated into the QI incentive plan developed by one of the public sector managed care payers.

4. *Identify co-occurring disorder as a system priority population, and write a formal welcoming policy that defines the expectation that all components of the system will themselves develop formal processes to welcome individuals with co-occurring disorders into treatment.* Although this seems like a relatively easy thing to do, it usually takes about a year into the project for such a policy to be adopted. This relates to the time it takes to organize the infrastructure and leadership to accomplish the earlier steps, as well as the need for the system to observe the emergence of energy and progress at the program and clinician level before there is some confidence that "welcoming" can actually become a requirement. (Note that this is a fundamental characteristic of this change process; although it may seem that these steps are "top down," they are actually highly intertwined and interactive, in a manner that may be called: "top down, bottom up and back again.") The formal process of Continuous Quality Improvement (CQI)–with which most systems have some familiarity–provides an organizing framework for application of this multilayered change process. It is important that the policy be disseminated in a fashion that would be taken seriously, and linked to contracting or auditing processes that allow agencies to recognize that this policy is "real." As an example, below is an excerpt from a welcoming policy issued by the District of Columbia Department of Mental Health as a part of its CCISC initiative:

1. *Purpose.* To set forth a policy that ensures that individuals with mental illnesses who are eligible for DMH services and who have co-occurring substance use disorders (SUD) will be welcomed for service at any DMH setting, whether that setting is directly operated by DMH or operated under DMH contract or subcontract with a core services agency. This policy also requires that consumers be proactively engaged in an empathic, hopeful, integrated, and continuing treatment relationship to promote improved outcomes for both disorders over time.

2. *Applicability.* Applies to consumers (adult and children) with mental illness who have a co-occurring SUD; and to community services agencies, Saint Elizabeths Hospital, DMH contractors who provide mental health treatment including residential treatment facilities, all other providers of mental health services or mental health supports that are *certified by DMH*, and to the Mental Health Authority.

3. *Authority.* Mental Health Service Delivery Reform Act of 2001.

4. *Background.* The DMH endeavors to proactively provide mental health treatment and supports which effectively meet the needs of individuals with mental illnesses who have co-occurring substance use disorders. Individuals with co-occurring substance use disorders are highly prevalent, and are associated with poorer outcomes and higher costs in the service system, and therefore need to be prioritized to receive effective treatment. Therefore, in order to improve access and treatment outcomes, the DMH is requiring the system-wide use and implementation of a research-based model known as the Comprehensive, Continuous, Integrated System of Care (CCISC). Co-occurring substance use disorders and mental disorders are both common and highly complex phenomena that have been estimated to affect from 7 to 10 million adult Americans in any one year. According to the U.S. Surgeon General in the 1999 report on mental health: "Forty-one to 65 percent of individuals with a lifetime substance use disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance use disorder."

5. *Policy.*

5a. The Department of Mental Health is committed to providing quality, effective care and a welcoming atmosphere to consumers who are mentally ill who have a co-occurring substance use disorder.

5b. The Department of Mental Health shall use the Comprehensive, Continuous, Integrated System of Care (CCISC) model (see Section 6 below) for serving individuals with co-occurring mental illness and substance use disorders.

5c. All community services agencies, Saint Elizabeths Hospital, DMH contractors who provide mental health treatment including residential treatment facilities, and all other providers of mental health services or mental health supports that are certified by DMH are defined by this policy as "co-occurring disorder or dual diagnosis programs," and shall:

- Meet minimal standards of "dual diagnosis capability" (as described in the CCISC Charter) to ensure cordial, welcoming access to care for any consumer with a co-occurring disorder;
- Provide any DMH eligible consumer with a co-occurring disorder access to an empathic, hopeful, and integrated treatment relationship and continuing coordination of care over time; and
- *Not* require any person to achieve a period of abstinence from alcohol or other drugs before commencing the provision of services and treatment.

These requirements are defined in the CCISC Charter ("Charter," see Section 6 below) which describes the principles and characteristics of the CCISC model, and delineates the implementation activities required of each program. Copies of the CCISC Charter shall be given to each provider and maintained by the Director of Adult Services in the DMH Office of Delivery Systems Management.

Welcoming priority populations can also be framed as a systemic approach to facilitate best practice implementation. In the Vermont DDMHS CCISC project, the ten designated community mental health agencies, which had been provided with flexible funding streams to support any best practice care for severely mentally ill adults, including integrated treatment, had participated in a one year Community Action Grant funded consensus building and training project regarding the IDDT Toolkit evidence based best practice for co-occurring disorders.[38] Although there was broad consensus for the model, there was little actual implementation, and program feedback was framed along the idea that this was a special population requiring special services and additional funding. The CCISC component was added in the second year, and the designated agencies agreed to participate in a project defined by

a charter incorporating "welcoming" as an expectation for all programs with a very small financial incentive for participation; this process established the co-occurring disorder population as a priority, and programs then began to develop internal activities to implement integrated assessment and treatment, and to utilize available training to actually create programmatic change. (This project is currently being evaluated with both CCISC and IDDT program fidelity tools.)

5. *Establish "welcoming" as a priority program standard for implementation of dual diagnosis capability, by charter definition, and incorporate implementation of "welcoming" into a CQI action plan that each participating program is required to develop.* Each charter document includes the expectation that each participating program will begin to move (at its own pace) toward achieving dual diagnosis capability. This involves each programming using the CCISC program self assessment tool (COMPASS™) to begin to understand the concept of DDC, and to identify areas for improvement that would then be included in its own action (CQI) plan. Each program is given flexibility to develop its own plan in most areas, but all programs are supposed to address charter priorities, such as welcoming. In fact, the first section of the COMPASS™ is specifically dedicated to self assessment of documented program welcoming philosophy: is there a welcoming policy, written welcoming mission or vision statement, welcoming orientation materials and physical plant, welcoming orientation for staff, etc. . . . ? Part of the system change activity is that the system policy development is aligned with existing program level action planning to build welcoming. In the projects in which we consult, technical assistance is usually offered to assist programs with action plan development and implementation. Programs frequently ask why there is an emphasis on written policy and documented criteria. We emphasize that documentation is what makes the practice anchored in the system. For example, written policies affect the orientation of new staff, particularly those on off shifts. One addiction program in Oregon which thought written welcoming policies were not necessary discovered that the non-counselor residential staff had been oriented to dual diagnosis clients on hire with the question: "A lot of our clients are on psych meds; do you mind?" Another addiction program, in Peoria, realized that the banners and posters on the walls of its lecture hall were written as if no client had a co-occurring disorder.

6. *Each program defines and implements welcoming clinical practices and procedures for clients with co-occurring disorders that are particularly challenging.* The translation of welcoming policies into actual change in clinical behavior at the clinician-client interface requires

an expectation that all programs incorporate the development of welcoming clinical practices and training in those practices into their action plans. Welcoming clinical practices can be both general (as an example, one of the mental health centers in the Tampa-Hillsborough Project developed a "customer service training and orientation curriculum" for all staff, with co-occurring disorder examples), or specific, where particularly challenging clinical situations are identified. For example, one of the training modules that the authors regularly provide relates to a discussion of what to do when a client appears intoxicated for an appointment, and the distinction between a welcoming set of clinical practices for risk assessment as compared to "limit setting," where the client is made to feel unwelcome. One of the interesting aspects of the top-down bottom-up interactivity is the way in which training staff in welcoming practices immediately begin to interface with policies which do not support those practices. In one of our projects in Michigan, we presented a module to a group of trainers on dealing with an angry paranoid client who had been evicted from his housing and presented in an intoxicated state to his day program. After the trainer group discussed how to be welcoming to this individual, we asked them how many of them were actually allowed to do this in their programs; about one third indicated that their program policies specifically required them to ask the client to leave without any clinical contact.

7. *There is a systemic training plan that creates an expectation that all programs expect their clinicians to develop competency in "welcoming," and provides continuous on site training and supervisory support to implement this competency over time for all staff.* As noted above, training and competency development is an important component of any system change initiative. However, one aspect of CCISC implementation that is extremely significant is that training is not performed "in a vacuum" but is specifically tied to new policy and practice expectations. Consequently, there is some expectation that the trainees actually learn new skills. In addition, competency development tied to attitudinal change (e.g., welcoming) does not occur in one training event; it is an ongoing process that needs to be reinforced regularly on the job. As a result, most CCISC projects develop a systemic training plan that involves the development of a "trainer cadre," in which participating programs contribute one or more "trainers" who are supported and trained individually and collectively not only to train their own staff but to function in the role of system change agents and "opinion leaders," whose job is defined to help the system translate policy into clinical practice, as well as to provide feedback to the system when clinical

practice expectations are not supported by policy. The authors first developed a Train the Trainer Curriculum for this process, incorporating attention to welcoming attitudes and values, in our New Mexico project in 2001,[39] and have subsequently modified and updated this curriculum several times. In addition, as part of the competency development process, there is a tool (CODECAT™) that helps clinicians to evaluate their attitudes and values regarding CCISC, including "welcoming," and to use that self-evaluation to determine training and development needs, as well as to monitor change in attitudes. Most systems begin to develop new human resource policies and job descriptions that incorporate welcoming expectations. The authors have developed a sample scope of practice to guide job description development.[40]

8. *There is a monitoring and feedback "loop" that gathers information about whether "welcoming" is actually occurring as a clinical process in the system, both in relation to consumers and families, as well as to other programs and systems, and provides this information "upstream" to the leadership team so that action can be taken within the CQI process.* The concept of a feedback loop is fundamental to CQI. From the perspective of implementation of "welcoming," there are a number of different sources of data that inform the system of the success of this process. One source of data is consumer satisfaction surveys. In the New Mexico project the state consumer-delivered consumer satisfaction survey was modified to incorporate the ability for self-identified co-occurring disordered consumers to answer questions about welcoming and access. This data provided one source of evidence that as the project progressed service access was improving. Another source of data comes not from clients but from collaborative systems. Part of CCISC development involves the recognition that each component of the system needs to be welcoming to potential referents, and that "unwelcomed" clients often wind up in settings that have fewer resources and supports than the behavioral health settings (e.g., homeless shelters and jails). Systems initiatives that have collaborative systems at the table can use feedback from these systems to indicate how welcoming the programs actually are becoming to referrals of clients who have been customarily extruded. In our project in Winnipeg, for example, one of the participant agencies (and trainers) was from a homeless wet shelter program, which reported that even though it was across the street from the crisis team, the mobile crisis team had never set foot there to evaluate clients, and always made them send their clients to the emergency room. As a consequence of the initiative, crisis team policies and practices were subsequently changed.

SUMMARY

This paper has reviewed a best practice model for design and implementation of system wide integrated services for individuals with co-occurring disorders, and illustrated the application of that model to the implementation of the specific clinical attitude and practice of welcoming in a number of ongoing CCISC projects. Welcoming, while not formally an "evidence based best practice" is a clinical service delivery standard, that also creates a strategic energy to promote implementation of other best practice interventions. Given that CCISC can be designed within the resource base of any system, and given that initial projects have been able to describe some early success in creating meaningful shifts in clinical practice, the model appears to have some face value in application to complex systems. Clearly, more formal evaluation of system, program, and client outcomes from CCISC projects is needed; the authors are currently in process of designing such evaluation studies.

REFERENCES

1. U.S. Department of Health and Human Services. Mental health; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. A report of the Surgeon General. 1999.

2. Substance Abuse and Mental Health Services Administration. Results from the 2001 National Household Survey on Drug Abuse: Volume I. Summary of National Findings. DHHS Publication No. (SMA) 02-3758. Rockville (MD): SAMHSA, Office of Applied Studies; 2002.

3. Substance Abuse and Mental Health Services Administration. Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Health Disorders. 2002.

4. Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Treatment Improvement Protocol for Co-occurring Psychiatric and Substance Use Disorders. Number 9 revised. In Press.

5. Miller WR, Rollnick S. Motivational Interviewing. New York: Guilford Press; 2002.

6. Ziedonis D, Trudeau K. Motivation to quit using substances among individuals with schizophrenia: implications for a motivation-based treatment model. Schiz. Bull. 1997; 23: 229-38.

7. Mueser KT, Noordsy DL, Drake RE, Fox L. Integrated treatment for dual disorders: a guide to effective practice. New York: Guilford Press; 2003.

8. Shaner A, Roberts LJ, et al. Monetary reinforcement of abstinence from cocaine among mentally ill persons with cocaine dependence. Psych Services. 1997; 48:807-10.

9. Daley D, Moss H. Dual disorders: counseling clients with chemical dependency and mental illness. 3rd ed. Center City (MN): Hazelden; 2002.

10. Geppert CMA, Minkoff K. Psychiatric disorders and medications: a reference guide for professionals and their substance-dependent clients. Center City (MN): Hazelden; 2003.

11. Najavits L, Seeking safety, a treatment manual for PTSD and substance abuse. New York: Guilford Press; 2002.

12. Roberts LJ, Shaner A, Eckman TA. Overcoming addictions: skills training for people with schizophrenia. New York: W.W. Norton;1999.

13. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Integrated dual disorders treatment toolkit, in press.

14. Drake, R.E., Essock, S.M., Shaner, A., et al. Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services. 2001; 52(4): 476-496.

15. Substance Abuse and Mental Health Services Administration. A strength-based systems approach to creating integrated services for individuals with co-occurring psychiatric and substance use disorders–A technical assistance document. NMDOH/ BHSD. December 2002.

16. Minkoff K. Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. Minkoff K, Drake RE, editors. Dual diagnosis of major mental illness and substance disorder. New Directions for Mental Health Services, No 50. San Francisco: Jossey-Bass; 1991. p13-27.

17. Minkoff K, chair. Co-occurring psychiatric and substance disorders in managed care systems: standards of care, practice guidelines, workforce competencies, and training curricula. CMHS Managed Care Initiative Panel on Co-occurring Disorders. Center for Mental Health Policy and Services Research; Philadelphia, 1998.

18. Barreira P, Espey E, et al. Linking substance abuse and serious mental illness service delivery systems; initiating a statewide collaborative. Journal of Beh Health Serv Res. 2000; 27: 107-13.

19. Minkoff K, Cline C. CO-FIT 100™ (Version 1): CCISC outcome fidelity and implementation tool. ZiaLogic; 2001.

20. Minkoff K, Cline C. COMPASS™ (Version 1): Co-morbidity program audit and self-survey for behavioral health services/adult and adolescent program audit tool for dual diagnosis capability. Zialogic; 2001.

21. Minkoff K, Cline C. CODECAT™ (Version 1): Co-occurring disorders educational competency assessment tool. Zialogic; 2001.

22. Minkoff K, Cline C. Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. Psychiatric Clinics of North America: Forthcoming.

23. Minkoff K, chair. Co-occurring psychiatric and substance disorders in managed care systems: standards of care, practice guidelines, workforce competencies, and training curricula. CMHS Managed Care Initiative Panel on Co-occurring Disorders. Center for Mental Health Policy and Services Research; Philadelphia, 1998.

24. Minkoff K, Cline C. CO-FIT 100™ (Version 1): CCISC outcome fidelity and implementation tool. ZiaLogic; 2001.

25. American Society of Addiction Medicine. Patient placement criteria 2R. Washington, DC: ASAM; 2001.

26. Minkoff K. Cline C. COMPASS™ (Version 1): Co-morbidity program audit and self-survey for behavioral health services/adult and adolescent program audit tool for dual diagnosis capability. Zialogic; 2001.

27. Regier DA, Farmer ME, et al.: Co-morbidity of mental disorders with alcohol and other drug abuse: results from the epidemiologic catchment area (ECA) study. JAMA. 1990;264(19):2511-18.

28. Kessler RC, Nelson CB, et al. The epidemiology of co-occurring addictive and mental disorders. Am. J. Orthopsychiatry. 1996;66:17-31.

29. National Association of State Mental Health Program Directors/National Association of State Alcohol and Drug Abuse Directors. The new conceptual framework for co-occurring mental health and substance use disorders. Washington, DC: NASMHPD/NASADAD;1998.

30. Drake RE, McHugo GJ, Noordsy DL. Treatment of alcoholism among schizophrenic outpatients: 4 year outcomes. Am J Psychiatry. 1993; 150(2):328-30.

31. Mueser KT, Noordsy DL, Drake RE, Fox L. Integrated treatment for dual disorders: a guide to effective practice. New York: Guilford Press; 2003.

32. Minkoff K. Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. Minkoff K, Drake RE, editors. Dual diagnosis of major mental illness and substance disorder. New Directions for Mental Health Services, No 50. San Francisco: Jossey-Bass; 1991. p13-27.

33. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. Am. Psychol. 1992;47:1102-14.

34. McHugo GJ, Drake RE, Burton HL, Ackerson TH. A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. J Nervous & Mental Disorders. 1995; 183(12):762-767.

35. Drake RE, Essock SM, et al. Implementing Dual Diagnosis services for clients with severe mental illness. Psych Services. 2001; 52(4).

36. Minkoff K, chair. Co-occurring psychiatric and substance disorders in managed care systems: standards of care, practice guidelines, workforce competencies, and training curricula. CMHS Managed Care Initiative Panel on Co-occurring Disorders. Center for Mental Health Policy and Services Research; Philadelphia, 1998.

37. Drake RE, McHugo GJ, Noordsy DL. Treatment of alcoholism among schizophrenic outpatients: 4 year outcomes. Am J Psychiatry. 1993; 150(2):328-30.

38. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Integrated dual disorders treatment toolkit, in press.

39. Minkoff K, Cline C, New Mexico co-occurring disorders train the trainer curriculum. NMDOH/BHSD; 2001.

40. Minkoff K, Cline C. Scope of practice guidelines for addiction counselors treating the dually diagnosed. Counselor. 2003;4:24-27.

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