

**CHANGING THE WORLD: THE DESIGN AND IMPLEMENTATION OF  
COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEMS OF CARE FOR  
INDIVIDUALS WITH CO-OCCURRING DISORDERS**

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## **Background**

Individuals with co-occurring psychiatric and substance disorders are increasingly recognized as a population that is highly prevalent in both addiction and mental health service systems, associated with poor outcomes and higher costs in multiple domains. In addition, they have long been recognized to be “system misfits” in systems of care that have been designed to treat one disorder only or only one disorder at a time. Thus, instead of being prioritized for attention, these individuals with challenging problems are made more challenging because the systems of care in which they present have significant regulatory, licensing, and reimbursement barriers to the implementation of successful treatment.

In spite of these system barriers, there has been increasing accumulation of evidence supporting a range of “best practice” treatment programs and interventions in this population, summarized recently in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Report to Congress on Co-occurring Disorders [1] and in the Center for Substance Abuse Treatment’s (CSAT) soon to be released Treatment Improvement Protocol on Co-occurring Disorders. [2] There is less information available on the implementation of these “best practices,” particularly within scarce resourced public sector delivery systems. One avenue that is being investigated is the implementation of a specific evidence based practice for individuals with serious mental illness and severe co-occurring disorders, termed Dual Diagnosis Integrated Treatment (IDDT) [3], for which SAMHSA will soon be releasing a formal implementation toolkit

(2004). As part of the national EBP implementation project, several states are studying the implementation of this targeted program using additional resources for program start up and continuation. At present, the literature describing outcomes of this project is very preliminary, but two things are clear: First, implementation of any evidence based practice (EBP) cannot be isolated from the system context in which that implementation takes place, so that EBP implementation and system change strategies must be linked. [4] Second, the high prevalence of co-occurring disorders in all service populations and service settings indicates that this high priority population will never be adequately served by implementation of a small number of “programs” in a scarce resourced system. [5] Consequently, properly matched services and interventions must be provided for individuals with co-occurring disorders wherever they present, not only in specialized “programs”. As a result, in recent years, there has been increasing recognition of the need for system level change strategies to improve services for individuals with co-occurring disorders (cod). [6]

. The Report to Congress (SAMHSA, 2002) indicates that because “dual diagnosis is an expectation” associated with poor outcomes and high costs, SAMHSA is beginning to develop systemic strategies to address the needs of individuals with cod, and plans to create funding mechanisms to support state level or regional initiatives to build better service capacity for cod within the entire service system. The Report to Congress provides anecdotal information on a number of state projects already in progress, specifically referencing a Technical Assistance document commissioned by SAMHSA describing one such project (the New Mexico Co-occurring Disorders Service Enhancement Initiative (NM-CDSEI) [7], which utilized the CCISC model to organize a

system wide implementation of integrated services. The Report to Congress also references the Comprehensive Continuous Integrated System of Care (CCISC) model utilized in the NM-CDSEI as a best practice model for system design for co-occurring disorders.

The purpose of this paper is to describe the CCISC model, to outline a strategic implementation process termed the “12 Step Program of CCISC Implementation, and then to describe examples of current CCISC implementation projects in the United States and Canada, along with information on project evaluation and outcomes.

## **CCISC**

The CCISC was first outlined by Minkoff [8], organized and elaborated as part of a national consensus best practice development project [9] and first utilized in a formal consensus process in Massachusetts in 1998-1999. [10] The CCISC model is built on 8 evidence based principles of service delivery for co-occurring disorders that provide a framework for developing clinical practice guidelines for treatment matching [11] and can also be utilized to design a welcoming, accessible, integrated, continuous, and comprehensive system of care, initially within the context of existing resources. The rationale for system design is that dual diagnosis is an expectation in all settings, associated with poor outcomes and high costs in multiple domains, so that attention to cod must be a priority in all system activities and in the utilization of all system resources. Consequently, the system must require all programs to be designed as “dual diagnosis programs” by meeting minimal standards of “dual diagnosis capability” (DDC)

[12], initially within existing program resources, (The system may also plan for some program components to be specifically designed as Dual Diagnosis Enhanced (DDE), but with the understanding that each program has a different “job”, providing organized matched services to its existing cohort of dually diagnosed clients, utilizing the treatment matching principles to determine the appropriate best practice interventions in that setting.

**The Four Basic Characteristics of the Comprehensive, Continuous, Integrated System of Care Model**

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

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. All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources, with a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders. Implementation of the model integrates the use of strategically planned system change technology (e.g, Continuous Quality Improvement) with clinical practice

technology at 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 to ICOPSD 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. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance, and training. The most basic implementation strategy involves exploring regulatory guidelines for any funding stream (e.g. Medicaid) in any program or service (e.g., mental health care in a mental health clinic) and providing a specific set of guidelines and instructions for how to provide and document appropriately matched integrated treatment within the context of the already funded service.
3. **Incorporation of Best Practices:** The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of ICOPSD. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system. This is based on the recognition that co-occurring disorders are not a single entity with a single “best practice” intervention, but rather that individuals with cod have a wide range of disorders and needs in combination, and that best practice treatment

involves integrating the provision of best practice treatment for each disorder at the level of the client. This encourages the system to develop as extensive a range of best practices for mental health and substance disorders as it can, and organize them so that any best practice for either type of disorder is provided in a dual diagnosis capable fashion.

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 Eight Principles of Treatment for the CCISC**

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 [13, 14], along with clinical outcome data associating ICOPSD 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 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 ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders [15] can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high CD (Quadrant III), high MH – low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD 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. [16, 17]* 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. For example, dual diagnosis housing for individuals with SPMI may incorporate programming that is dry, damp, and wet. [18] On an individual client level, individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community-based reinforcers to make incremental progress within the context of continuing treatment. [19]
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. This incorporates psychopharmacology guidelines that define the expectation of continuing necessary non-addictive medication for the treatment of known serious mental illness for individuals who are continuing to use substances. [20] This incorporates the utilization of specific “disease management” skills training in

either disorder to individuals in treatment for the other disorder [21, 22, 23], including adaptation of skills training in substance abuse reduction or elimination skills to individuals who have psychiatric disabilities. [24]

6. *Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” [25] 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 [26] or stages of treatment [27], and demonstrated the value of stage-wise treatment. [28]
7. *There is no single correct intervention for ICOPSD; 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 program in the system is assigned a “job”: to work with a particular cohort of ICOPSD, 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 ICOPSD 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**

The implementation of a complex multi layered system model requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process that involves interaction between all layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the size or complexity of the system. Implementation can occur in systems of any size (entire state, regions, counties, complex agencies, individual programs),

and in any population or funding stream (adults, elders, children; Medicaid, private payers, state block grant funds; urban/rural; culturally diverse populations). In order to organize the complexity of this process the authors have developed the “Twelve Step Program of Implementation” (first implemented in Michigan in 2002), and have created a CCISC Toolkit to provide a framework for evaluating and monitoring progress at the system level, the program level, and the clinician level. [29]

### **Twelve Steps for CCISC Implementation**

1. Integrated system planning process: Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level 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, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and

culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families. The COFIT-100™ (Zialogic, Albuquerque, NM) [30] has been developed by the authors to facilitate this outcome measurement process at the system level.

2. Formal consensus on CCISC model: The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.
3. Formal consensus on funding the CCISC model: CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.
4. Identification of priority populations, and locus of responsibility for each: Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access,

assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

5. Development and implementation of program standards: A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stage-wise implementation. Program competency assessment tools (e.g., COMPASS™ Zialogic, Albuquerque, NM) [31] can be helpful in both development and implementation of DDC standards.

6. Structures for intersystem and inter-program care coordination: CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.
7. Development and implementation of practice guidelines: CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination and incremental developmental implementation via CQI processes of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents [32, 33, 34] are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes

(both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation, (See items 8 and 9).

8. Facilitation of identification, welcoming, and accessibility: This requires several specific steps: 1. modification of MIS capability to facilitate and incentivize accurate identification, reporting, and tracking of ICOPSD. 2. development of “no wrong door” policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible. 3. Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.
9. Implementation of continuous integrated treatment: Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected “scope of practice” for singly licensed clinicians regarding co-occurring disorder [35, 36], and incorporated



into standards of practice for reimbursable clinical interventions – in both mental health and substance settings – for individuals who have co-occurring disorders.

10. Development of basic dual diagnosis capable competencies for all clinicians:

Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT™ Zialogic, Albuquerque, NM) [37] can be utilized to facilitate this process.

11. Implementation of a system wide training plan: In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career ladders for advanced certification, and opportunities for experiential learning. Train the trainer curricula have been developed [38] that have been adapted for use in a variety of state and regional systems, and which emphasize that the trainers are actually

positioned individually and collectively as “system change agents” to link system managers with front line clinicians in order to appropriately advocate for policy to support good clinical practice, and to transmit that policy in turn to direct care staff.

12. Development of a plan for a comprehensive program array: The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:

- a. **Evidence based best practice:** There needs to be a specific plan for identification of any evidence based best practice for any mental illness (e.g. Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g. buprenorphine maintenance), or an evidence based best practice program model for a particular co-occurring disorder population (e.g. Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that

facilitates access to co-occurring clients that might be appropriately matched to that intervention..

- b. **Peer dual recovery supports:** The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous [39], Double Trouble in Recovery [40]) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports, such as peer outreach and peer counseling.
- c. **Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:
  - 1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs) [41].
  - 2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.
  - 3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
  - 4. Consumer – choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness. [42]
- d. **Continuum of levels of care:** All categories of service for ICOPSD should be available in a range of levels of care, including outpatient

services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization. This can often be operationalized in managed care payment arrangements [43] and may involve more sophisticated level of care assessment capacity. [44, 45]

**CCISC implementation is an ongoing quality improvement process that encourages the development of a plan that includes attention to each of these areas in a comprehensive service array.**

### **Project Descriptions and Outcomes**

CCISC implementation efforts date back to 1998 [46], and have become progressively more sophisticated as more experience with the technology has accumulated, and more structure for implementation (e.g. toolkits) has been developed. Currently, there are state and or regional CCISC projects that have been initiatives in collaboration and consultation with one or both of the authors in the following systems: Arizona, Alaska, Alabama, California, District of Columbia, Florida, Hawaii, Illinois, Idaho, Louisiana, Maine, Maryland, Michigan, Montana, Minnesota, New Mexico, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, Manitoba, and British Columbia.

The following discussion will describe activities and outcomes in a selection of projects.

New Mexico: The Co-occurring Disorder Services Enhancement Initiative [47] began under the leadership of one of the authors in her role as state behavioral health medical director in response to recognition of a higher death rate among individuals with co-occurring disorders as well as dramatic under--recognition of this population in both clinical processes and state data collection. A systematic CQI approach was organized to implement welcoming, screening, and improved data collection into contractual requirements for state Regional Care Coordination entities, that were expected to in turn contract for improved performance from providers. Quality performance was positively incentivized in contract language. Multilayered implementation included state commitment to removal of administrative barriers to data collection and promotion of utilization of block grant dollars to support integrated care, as well as identification of a train the trainer group that facilitated training and system improvement on the program level in each region. In addition, the state behavioral health authority has gotten legislative direction to work with the licensure agencies to implement a recommendation (developed by clinicians) for a defined integrated scope of practice for single licensed clinicians of any type. Over the past three years, this trainer group has expanded to include a wider array of programs. Data capture efforts have tripled, and the death rate for co-occurring disordered individuals has gone down significantly. The state has incorporate a first layer of Dual Diagnosis Capable requirements in behavioral health program standards, once it was clear

that the vast majority of programs could already demonstrate adherence to those standards.

Vermont: The Vermont DDMHS adult services division received Community Action Grant funding in 2000 to implement consensus on utilizing Integrated Dual Disorder Treatment (IDDT) as a best practice in its existing case rate funded intensive case management teams. After one year of consensus building and training, there was consensus that IDDT was a good thing, but very little organized implementation and resistance to change without new funding. In the second year, CCISC was added to develop a systemic approach to engaging agencies in implementation of core practices of integrated treatment (consistent with IDDT) in the context of existing resources. This process included development of a charter document that committed each agency to a change process, the development of small financial incentives for each agency to initiate activity in relation to project participation, and the development of a trainer cadre. As in all the other projects, the authors provided a customized curriculum, continued consultation and strategic planning with the leadership team, training of the cadre in both clinical and system change issues (here, quarterly), and program technical assistance visits to every agency during the first year. During the course of the first year of the project, all the agencies began to demonstrate new clinical processes for welcoming, identifying, assessing and providing integrated treatment. More than half the agencies moved the initiative from only adults with SPMI to encompass additional programming (often the whole agency), such as children's services, substance abuse services, and developmental disability

services. The CCISC model was expanded for application to a statewide human services integration project involving mental health, public health, substance abuse, corrections, child welfare, Medicaid, and juvenile justice, which is currently in the process of developing its own charter and work plans for effecting system change. The project is utilizing outcome measures for adult service agencies that combine the CCISC tools with IDDT fidelity tools, and expects to be able to explore the relationship between system change strategies and best practice implementation.

Manitoba: The first CCISC project in Manitoba began as a regional collaborative between the Winnipeg Regional Health Authority, the Addictions Foundation of Manitoba, and Manitoba Health. Entitled CODI (Co-occurring Disorders Initiative), the project was implemented under the direction of an intersystem leadership team that was the first element of any kind of structure for integrated system planning. The leadership team drafted a charter document, aligned with regional strategic planning priorities, and was able to obtain broad consensus and sign off from both mental health and addiction treatment programs, including inpatient and outpatient, adult and children's services. The team arranged for a jointly funded Project Coordinator, who was able to handle project logistics, such as coordinating training materials, access to web based resources, and a project newsletter. The system organized a group of "trainers", working with the authors to receive training and consultation, and to utilize the toolkit in their own agencies to move in the direction of dual diagnosis capability. In addition, the authors provided program technical assistance visits to adapt the

broad vision of the project to the concrete needs of each program developing its own action plan. The trainer cadre included individuals of multiple disciplines, including psychiatrists, and was able to organize itself to provide training in small groups to each other's programs. Over time this group began to function as a team of change agents, and, in addition to work within their own programs, formed a regular meeting for the purpose of interagency case conferencing. By the end of the first year, the leadership team began to construct mechanisms for creating universal expectations of data collection across all providers. The project was experienced as having a dramatic impact on improving service system functioning at all levels. As a result, Manitoba Health has initiated an expansion of the project to all health authorities in the province, each of which is now in the process of designing its own initiative. The existing trainer group is a resource to assist other provincial systems in this process.

San Diego: The San Diego County Health and Human Services Agency, composed of three divisions (Adult and Older Adult MH, Children's MH, and Alcohol/Drug Services) which have historically operated fairly independently. Over the past several years, co-occurring disorders have been recognized as a systemic priority, particularly in the adult population, and an extensive interdivisional strategic planning process resulted in a comprehensive report in 2000 recommending systemic implementation of co-occurring disorder services. The strategic plan recognized that the co-occurring population was highly prevalent, but dramatically under-recognized; chart reviews indicated that only about 20—25% of clients who had co-occurring disorders by chart review had



their dual diagnoses reported into the system data base. San Diego began a project to use the CCISC process to implement recommendations of its strategic plan. This involved the construction of a small interdivisional leadership team (3 members) under the auspice of a county leadership team from each division; an interagency committee in which executive directors of participating agencies were engaged, voluntary (at first) participation of agencies providing services in all three divisions. As in the above projects, a charter was developed that involved participating programs in using the tools for self assessment, developing an action plan, receiving technical assistance, and participating in the trainer cadre (about 40 individuals). Because the divisions initially were in different stages of readiness to begin implementation, the initiative was designed to allow each division to participate at its own pace. Over time (the initiative has just begun its second year), the project has “attracted” more participation from the other divisions, with the following accomplishments:

- a. Incorporation of CCISC language and charter expectations into one regional contract for adult services, and into certain RFPs for children’s services. Incorporation of welcoming language planned for ADS contracts.
- b. Incorporation of co-occurring principles into the revision of the system mental health assessment form.
- c. Development of a ground breaking policy for welcoming individuals with co-occurring disorders into mental health services (adults and children), defining the population for data collection (including

identifying substance abusing family members of child clients), and providing instructions for assessment, billing, and documentation. (This policy was presented in February, 2004 at a statewide meeting of county behavioral health leadership, and has generated widespread interest in other counties, at the state level in California, and at the SAMHSA level (Charles Curie was presenting at the conference).

- d. Incorporation of CCISC language into the Children's MH Services business plan, and into the functioning of its CMHS System of Care grant, including the "wraparound training academy".
- e. Development of a committee to update the 2001 consensus psychopharmacology practice guidelines
- f. Creation of a gradually more organized process of interdivisional quality improvement and planning
- g. Development of the cadre as an "independently functioning" team of change agents, who began to meet on their own, and to participate in policy change committees and activities.
- h. Availability of the trainer group to facilitate implementation of new system policies.
- i. Beginning of cooperative discussions of possible design of an integrated behavioral health department.

## Conclusion and Discussion

This article has described the CCISC model, and the process of implementation of systemic implementation of co-occurring disorder services enhancements within the

context of existing resources. Four projects were described as illustrations of current implementation activities. Clearly, there is great need for improved services for these individuals, and increasing recognition of the need for systemic change models that are both effective and efficient. The CCISC model has been recognized by SAMHSA as a consensus best practice for system design, and initial efforts at implementation appear to be promising. The existing toolkit may permit a more formal process of data driven evaluation of system, program, clinician, and client outcomes, in order to better measure the effectiveness of this approach. Some projects have begun such formal evaluation processes, but clearly more work is needed, not only with individual projects, but also to develop opportunities for multi-system evaluation, as more and more projects come on line.

## SYNOPSIS

Individuals with co-occurring psychiatric and substance disorders are increasingly recognized as a population with high prevalence, poor outcomes, and high costs who are not well served in current service delivery systems. As increasing research has delineated evidence based programs and interventions that demonstrate success with this population, it has become abundantly clear that specialized programs are insufficient to meet the need. This article describes a recognized best practice model for systems design, the Comprehensive, Continuous, Integrated System of Care (CCISC), that organizes all aspects of the system to meet minimal standards of dual diagnosis capability (DDC) within the context of its existing resources and mission. The basic characteristics of the model are delineated, along with eight evidence based treatment principles that fit an integrated treatment philosophy and provide a framework for treatment matching throughout the system. The article then outlines a “Twelve Step Program of Implementation” for CCISC developed by the authors, and describes some examples of existing projects and outcomes. Evaluation of project outcomes is in process, but more research is needed to quantify methodologies for system design and implementation for individuals with co-occurring disorders.

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