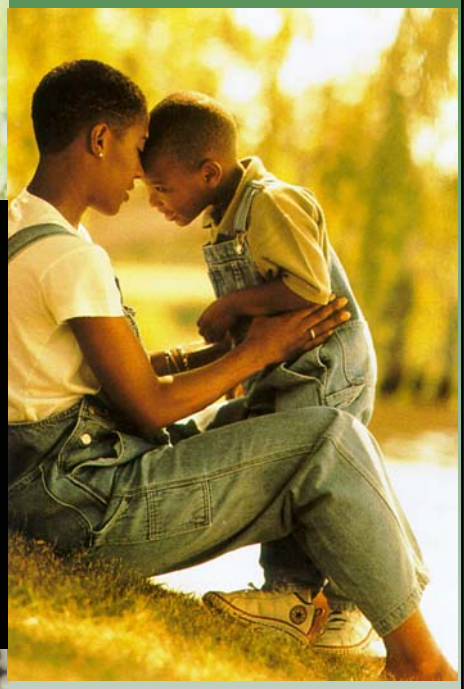

Florida Department of Children and Families
Policy Paper on
Co-occurring Mental Health and Substance Abuse Disorders

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Jeb Bush, Governor

Jerry Regier, Secretary

LETTER FROM THE DIRECTORS

In its endeavor to treat the whole person and ensure the comprehensiveness and continuity of services to the people we serve, the Substance Abuse and Mental Health Program Offices of the Florida Department of Children and Families (DCF) are taking the initiative to improve the system of care for people with co-occurring mental health and substance abuse disorders. The goal is to foster a framework that is coordinated, integrated, and supportive to prevent a person from falling through the cracks of separate "parallel" systems of care. This document is an important step towards achieving this goal of a coordinated and integrated policy framework because both the Mental Health and Substance Abuse Programs are identifying joint issues, system goals and outcomes, and recommendations to implement the necessary action steps. Also, it identifies critical strategic action steps necessary to implement its vision of how the service delivery system should be organized in order to provide high quality, evidence-based services to the co-occurring disorders population in Florida. Most importantly, it draws on the research literature and the experience of other states and national experts.

The growing need for more effective treatment for those with co-occurring disorders prompt a rethinking of the current "parallel" systems. Therefore, this policy paper searched for and incorporated input from a diverse group of key stakeholders in Florida including trade associations, consumers and their family members, and advocacy groups. Several research findings underscored the importance of restructuring Florida's substance abuse and mental health systems of care including:

- At least 10 million people in the U.S. have co-occurring substance abuse and mental health disorders.
- Up to 65.5% of those with a substance dependence disorder had at least one mental disorder and 51% of those with a mental disorder had at least one substance dependence disorder.
- The majority of people with co-occurring disorders typically receive treatment that only addresses one type of disorder which has been found to be less effective than integrated treatment of both types of disorders at the same time in the same setting.
- Individuals with co-occurring disorders typically have multiple co-occurring disorders and problems, and as a group have high rates of physical illness, death, unemployment, homelessness, and criminal justice involvement that often lead to greater costs for public services.
- Clients with co-occurring disorders are more likely to drop out of outpatient mental health and substance abuse treatment programs and have poorer outcomes in these systems than clients with a single type of disorder. They are often high users of expensive hospital and inpatient services due to the severity of their disorders and the frequency of their crises that leads to increase public costs.

It is our hope that the Florida Department of Children and Families' Policy Paper on Co-occurring Mental Health and Substance Abuse Disorders is used as an impetus to carry out the suggested strategic action steps and promote continued cooperation among all stakeholders towards an improved service delivery system to those with co-occurring disorders. We pledge our leadership to advance this important work.

Sincerely,

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Policy Paper on

Co-occurring Mental Health and

Substance Abuse Disorders

***GUIDING QUESTION**: "If I were an individual with co-occurring mental health and substance abuse disorders in Florida, what type of service delivery system would best meet my needs?"*

PURPOSE

The overall purpose of this initiative is to achieve the following goal: to better serve persons with co-occurring mental health and substance abuse disorders so that they can continue to recover and achieve satisfying, productive lives. This document is an important step towards achieving this goal because it provides a coordinated and integrated policy framework, as well as a strategic vision, for the Mental Health and Substance Abuse Programs of the Florida Department of Children and Families (DCF) to implement the necessary action steps towards achieving this goal. Both the Substance Abuse and Mental Health Programs of DCF are in the process of identifying joint issues, system goals and outcomes, and recommendations focused on improving services for individuals with co-occurring disorders. This policy paper includes input from a diverse group of key stakeholders in Florida, with a focus on consensus development. These stakeholders include trade associations such as the Florida Alcohol and Drug Abuse Association (FADAA), the Florida Council of Community Mental Health, consumers and family members of consumers, and advocacy groups such as the Florida branch of the National Alliance for the Mentally Ill (NAMI). This paper identifies critical strategic action steps necessary to implement our vision of how the service delivery system should be organized in order to provide high quality, evidence-based services to the co-occurring disorders population in Florida. This paper also draws on the research literature and the experience of other states and national experts in developing high quality, evidence-based services for individuals with co-occurring disorders.

BACKGROUND

Why is the co-occurring disorders[1] population important and why does the service system for this population need to be restructured?

- At least **10 million people in the U.S. have co-occurring substance abuse and mental health disorders** (SAMHSA, 1997). This group is defined as individuals with at least one substance use disorder in the presence of at least one Axis I major mental disorder, such as major depression, bipolar disorder, and schizophrenia (Matthews, 2001).

- The best study to date documenting the extent of co-occurring disorders (the National Co-Morbidity Survey; Kessler et al., 1994) substantiates the need for restructuring. The study found that, among a representative national sample of community respondents, **up to 65.5% of those with a substance dependence disorder had at least one mental disorder, and 51% of those with a mental disorder had at least one substance**

[1] Note: The term "co-occurring disorders" is used here instead of the terms "dual diagnosis" or "dual disorders" because people in this population often have more than two disorders.

dependence disorder. These percentages tend to be even higher in clinical treatment settings, especially in public mental health and substance abuse treatment settings.

- Such statistics have led a number of experts to declare that **clients with co-occurring disorders should be the "expectation, not the exception,"** for treatment providers in the public substance abuse and mental health treatment systems (Matthews, 2001).

- **The majority of people with co-occurring disorders receive no treatment** (SAMHSA, 1997)**. Treatment that is received typically only addresses one type of disorder, which has been found to be less effective than integrated treatment of both types of disorders at the same time in the same setting.** Successful and cost effective treatment for these complicated conditions must be continuous, comprehensive, integrated and individually tailored to meet the consumer's changing needs and motivation (Minkoff, 2000).

- Individuals with co-occurring disorders typically have **multiple co-occurring disorders and problems**, and as a group have high rates of physical illness, death, unemployment, homelessness, and criminal justice involvement**, which often lead to greater costs for public services** (Matthews, 2001). Post-traumatic stress disorder (PTSD), often from previous or ongoing physical and/or sexual abuse, also tends to be a problem for this group of people, especially among females (NASMHPD/NASADAD, 1998).

- While clients with co-occurring disorders are more likely to drop out of outpatient mental health and substance abuse treatment programs and have poorer outcomes in these systems than clients with a single type of disorder, they are often high users of expensive hospital and inpatient services due to the severity of their disorders and the frequency of their crises, **leading to increased public costs** (Matthews, 2001). More effective and cost-effective strategies focused on continuity of treatment in community settings have been developed and need to be made more widely available.

- Additionally, many substance abuse and mental health programs use criteria that exclude people with co-occurring disorders from their programs. Such exclusions lead to people "falling through the cracks" caused by service gaps, or being sent back and forth between the mental health and substance abuse systems. These types of system problems contribute to poor outcomes and higher rates of repeatedly cycling through higher-cost services, including arrest, incarceration and emergency admissions to hospitals, crisis stabilization units and detoxification units, none of which are effective long-term solutions for keeping this population stable and functional in the community (Matthews, 2001).

- The public mental health and substance abuse service systems are typically separate in most states, have little cross-training for staff, and limited availability of integrated treatment for co-occurring disorders (Matthews, 2001). Substance abuse and mental health treatment systems typically have different philosophies, administrative structures, and funding mechanisms. This level of separation prevents consumers and providers from moving easily among service settings. Such barriers are a crucial deficit, because **the**

primary cause of relapse into mental illness is untreated substance abuse, and the primary cause of relapse into substance abuse is untreated mental illness (SAMHSA 1997). Clearly, the co-occurring disorders population needs to be a priority for both public health and economic reasons, as many agencies are beginning to recognize (Matthews, 2001).

- **The Connection Between Addictive and Mental Disorders**
  People with mental disorders are typically much more susceptible to the negative effects of substance abuse. Even using a small amount of drugs or alcohol can rapidly destabilize someone who has a mental illness and make their symptoms much worse. Additionally, when someone has a mental disorder, that can also make it more difficult for them to maintain abstinence or comply with treatment due to associated cognitive impairments. Such impairments associated with mental disorders include increased confusion, impaired judgment, impulse problems, memory problems, limited attention span or problems concentrating, and difficulty planning ahead. In addition to making mental disorders worse, substance abuse and withdrawal can also mimic or induce symptoms of mental disorders (Matthews, 2001).

THE NATIONAL PERSPECTIVE ON CO-OCCURRING DISORDERS

Over the last ten years, the concept of integrated service provision for individuals with co-occurring mental and substance use disorders has been gaining increasing support at the national level as evidenced by the following initiatives:

- In June of 1998, a panel consisting of state mental health and substance abuse commissioners, alcohol and drug abuse directors, experts in the field of mental health and substance abuse, and federal officials met for the **National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders.** This panel was sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). It was also supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and two of its centers - the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT). Through a collective effort the panel published a comprehensive report that not only defined the population and barriers to care, but also outlined and described a model conceptual framework for a comprehensive system of care (NASMHPD/NASADAD, 1998). This system of care is based on three forms of service coordination: (1) consultation, (2) collaboration and (3) integration. In addition, the framework for the system of care is based on the four-quadrant model that classifies individuals with co-occurring disorders based on high or low severity of mental disorders and substance use disorders. The report also outlined desirable system characteristics and recommendations for the future at both the national and state levels.

- In June of 1999, the Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders met to explore ways to develop and finance a system of care for persons with co-occurring disorders and to market the conceptual framework developed and adopted by the first

National Dialogue. This meeting, co-sponsored by NASMHPD and NASADAD, was also supported by CMHS and CSAT and included representatives from the National Association for County Behavioral Health Directors (NACBHD) and the National Council for Community Behavioral Healthcare (NCCBH). One outcome of this second National Dialogue resulted in publication of **Financing and Marketing the New Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders**. This document not only supports the original conceptual framework but also highlights financial solutions in implementation of quality services for co-occurring disorders. This paper also outlines general marketing principles and specific recommendations to push the national agenda forward.

- In February of 1999, SAMHSA developed the **SAMHSA Position Statement on Use of Substance Abuse Prevention and Treatment Block Grants (SAPTBG) and Community Mental Health Services Block Grant (CMHSBG) Funds to Treat People with Co-Occurring Disorders**. In sum, this paper stated that SAPTBG and CMHSBG funds can be used to treat individuals with co-occurring disorders in a variety of treatment settings, including settings in which integrated services are delivered. However, all funds must be utilized in accordance with the specific regulatory and statutory requirements that govern the funding source, including reporting and audit requirements, and those outlined below:

  - SAPTBG must be used for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse.

  - CMHSBG funds must be used for the purpose of carrying out the State plan for comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbances; for evaluating programs and services carried out under the plan; and for planning, administration and educational activities related to the provision of services under the plan.

  - SAPTBG and CMHSBG funds may not be blended in such a way that would make use of those funds subject to only the statute and regulations governing one or the other source of funding (for additional detail and information on Federal Block grants, see SAMHSA's Report to Congress on Co-occurring Disorders at http://www.samhsa.gov/news/cl_congress2002.html; see below for a description of this report).

- In February of 1999, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued the **SAMHSA Position on Treatment for Individuals with Co-Occurring Addictive and Mental Disorders**. SAMHSA "enthusiastically" supports the conceptual framework set forth in the National Dialogue developed by NASADAD and NASMHPD and encourages and supports the development, delivery, and evaluation of integrated service models for treatment of people with severe co-occurring disorders as described in the framework developed by the State Directors.

- In 1999, the **Surgeon General's Report on Mental Health** (USDHHS, 1999; available online at http://www.nimh.nih.gov/research/sgreports.cfm) was supportive of combined and simultaneous treatment for individuals with co-occurring mental and substance abuse disorders citing the fact that a large body of research indicates that this approach is effective.

- SAMHSA reauthorization required SAMHSA to deliver a **"Report to Congress on the Prevention and Treatment of Co-occurring substance Abuse Disorders and Mental Disorders"** (SAMHSA, 2002; available online at http://www.samhsa.gov/news/cl_congress2002.html). SAMHSA is viewing this report as a blueprint for action. The report includes:

  (1) Characteristics and Needs of the Population: A summary of the manner in which individuals with co-occurring disorders are receiving treatment, including the number of children and adults with co-occurring mental illness and substance abuse disorders.

  (2) The Impact of Federal Block Grants and a summary of State Initiatives

  (3) A summary of Prevention practices for those with co-occurring disorders.

  (4) A summary of Evidence-Based Practices for treating individuals with co-occurring mental and substance use disorders and recommendations for implementing such practices.

  (5) Blueprint for Action: A summary of improvements necessary to ensure that individuals with co-occurring mental and substance use disorders receive the treatment they need, and a 5 year plan to implement those changes.

FLORIDA INITIATIVES RELATED TO CO-OCCURRING DISORDERS

The Florida Commission on Mental Health and Substance Abuse was created in 1999 by House Bill 2003 for the purpose of conducting a systematic review of the overall management of the state's mental health and substance abuse system. A final report to the Governor and Legislature was submitted in January 2001 (Florida Commission, 2001; available online at http://www.fmhi.usf.edu/fcmhsa/finalreports.html) which included a history and overview of the Florida systems, findings and recommendations for improvement, and specific sections on children, adults, older adults, and data systems. The Commission found that, during 1998, approximately 30%[2] of Floridians aged 15-54 years experienced a mental health disorder or a substance dependence disorder, and a significant number of these Floridians experienced co-occurring substance dependence and mental health disorders. Based on their application of Kessler et al.'s (1994) national estimates, the Florida Commission found that, at some point during their lifetimes, up to 65.5% of those in Florida with a substance dependence disorder

[2] This figure does not include substance abuse diagnoses, only substance dependence diagnoses, which are more severe. It is therefore reasonable to assume that this figure would be substantially higher if it included substance abuse as well.

had at least one mental disorder, and 51% of those with a mental disorder had at least one substance dependence disorder. Additionally, the Florida Commission found that the service system in Florida needs increased integration and coordination of services across multiple settings and agencies, including Mental Health and Substance Abuse.

In 2000, the Florida Legislature amended s. 394.75, F.S., requiring DCF to establish a comprehensive planning process for publicly-funded mental health and substance abuse services in consultation with the Agency for Health Care Administration (AHCA). Beginning in 2001, DCF was directed to submit a state master plan covering a three-year period and to submit annual updates in years 2 and 3 of the planning cycle.

The State Mental Health and Substance Abuse Plan 2000-2003 and subsequent annual updates have consistently highlighted the need for integrated services for persons with co-occurring mental and substance use disorders. Historically, clients have been treated through parallel systems, receiving services from mental health providers to address mental health symptoms and separately receiving services from substance providers for alcohol and other drug problems. This fragmentation within the system of care has created barriers to access of appropriate integrated care for persons with co-occurring disorders.

The state plan and plan updates identified a series of strategies focused on enhancing and integrating service delivery and funding for persons with co-occurring disorders. They recommended that the following strategies be implemented:

- Develop formal agreements among key stakeholders about the need for and value of treatment systems working together to improve treatment outcomes for individuals with co-occurring disorders.

- Cross-train personnel to develop knowledge in each other's field of expertise (including assessment and treatment) to develop service competencies and capabilities.

- Develop requirements for universal screening and assessment for both types of disorders to help determine placement and to facilitate treatment planning and follow-up services. Such requirements would mandate that clinicians use appropriate, research-validated screening and assessment tools to identify both mental and substance use disorder symptomatology whenever screening or assessment occurs. The requirements would not dictate the use of specific screening and assessment tools because there is not one set of screening measures that are appropriate for every population and setting. For instance, traditional substance use disorder screening instruments typically focus on symptoms of physiological dependence and consequences of heavy amounts of use. However, persons with severe and persistent mental illness (SPMI) may be functionally impaired by relatively small amounts of substance use even if they are not physiologically dependent. Thus, settings which focus on clients with SPMI are better served by more sensitive substance use screening measures, because they are more likely to detect lower, but still problematic, levels of substance use in this population.

- Develop common performance measures and methods for data collection, including integrated data systems.

- Develop funding streams that may permit the most effective response to consumers and that will allow providers to be reimbursed.

- Develop and implement integrated treatment models for individuals with co-occurring disorders in both the mental health and substance abuse service systems.

During the 2001 session, the Florida legislature passed SB 1258 (Chapter 2001-191, Laws of Florida). This legislation provided several additional initiatives that relate to co-occurring disorders, and which are included in the 2002 update to the State Mental Health and Substance Abuse Services Master Plan. These initiatives are described as follows:

- DCF was provided with the authority to pilot programs that integrate children's mental health Crisis Stabilization Units (CSUs) with children's Addiction Receiving Facilities (ARF) in Fort Myers, Sarasota, and Naples. Thus far, a 10-bed combined CSU/ARF was opened in Fort Myers on October 1, 2001. Additionally, in Sarasota an existing children's CSU was converted to a 10-bed children's CSU/ARF in May of 2002. Both programs are currently undergoing a program evaluation, as mandated by SB 1258.

- Chapter 2001-191 also provided for the establishment of a Behavioral Health Services Integration workgroup, for the purpose of assessing the barriers to the effective and efficient integration of mental health and substance abuse treatment services across various service systems and to propose solutions to those barriers.

  This workgroup includes representatives from the following groups in Florida:

  - The Department of Children and Families
  - The Department of Juvenile Justice
  - The Department of Health
  - The Department of Corrections
  - The Department of Elder Affairs
  - The Department of Education
  - The Office of Drug Control Policy
  - The Agency for Health Care Administration (AHCA)
  - The Louis de la Parte Florida Mental Health Institute
  - County jail systems, homeless coalitions, county government
  - Public and private Baker Act receiving facilities
  - Assisted living facilities serving behavioral health clients
  - Providers of behavioral health services and child protection services
  - Consumers of behavioral health services and their families

- Additionally, Chapter 2001-191 permitted DCF and AHCA to establish two behavioral health service delivery strategies that will test methods and techniques for coordinating, integrating, and managing the delivery of mental health and substance abuse treatment

services. Districts 1 and 8 were chosen for implementation of these strategies (see Strategic Implementation Plan later in this paper for a detailed description of District 1 activities related to co-occurring disorders).

- Effective July 1, 2001, the Florida Supplement (DCF, 2001) to the most recent revision of the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance Related Disorders (ASAM-PPC-2-R; ASAM, 2001), incorporates the ASAM-PPC-2-R's new language requiring placement of clients with co-occurring disorders into either Dual Diagnosis Capable or Dual Diagnosis Enhanced[3] substance abuse treatment programs. Those who have a co-occurring emotional, behavioral, or cognitive condition or complication, including mental disorders, are required to be placed in a Dual Diagnosis Capable treatment level at minimum**.**

  As stated in the Florida Supplement to the ASAM-PPC-2-R, **"**Dual Diagnosis Capable programs primarily focus on the treatment of substance abuse disorders and are also capable of treating patients who have stable diagnostic or sub-diagnostic co-occurring mental health problems related to the criteria of dimension 3 [i.e., emotional, behavioral, or cognitive condition or complication]. Dual Diagnosis Enhanced programs are designed to treat patients who are unstable or disabled by their co-occurring mental health disorders in addition to the substance-related disorders. The Florida Supplement includes the criteria of Dual Diagnosis Enhanced Programs for clients who have a diagnosis of mental health problems and are not stable enough to be treated solely for substance abuse. Clients who have a dual diagnosis and are stable and exhibiting symptoms in any Dimension 3 criteria can be placed in Dual Diagnosis Capable programs based upon meeting dimension 3 criteria" (DCF, 2001, p. 3).

- Florida Assertive Community Treatment (FACT) teams were established to facilitate the treatment and support of persons with severe and persistent mental illness (SPMI) in the community and to reduce the need for hospitalization. As indicated in the 2002 plan update "The FACT initiative is uniquely designed to address persons with co-occurring mental health and substance abuse disorders. The staffing of a FACT team addresses the issue of co-occurring disorders by requiring that at least one staff of the team be trained in the treatment of substance abuse disorders. FACT teams provide comprehensive substance abuse services as one of 15 mandated services. Minimally, these services include individual and group interventions to assist persons in the following ways:" (p. 66).

  - "Identify substance use, effects, and patterns" (p.66).
  - "Recognize the relationship between substance use and mental illness and psychotropic medications" (p.66).

[3] Although this paper uses the term "Co-occurring Disorders" rather than "Dual Diagnosis" elsewhere, we do use the terms "Dual Diagnosis Capable" and "Dual Diagnosis Enhanced" in order to be consistent with the terminology used for these levels of care by the ASAM PPC-2R and the American Association of Community Psychiatry.

- "Develop motivation for decreasing substance use" (p.66).
- "Develop coping skills and alternatives to reduce or minimize substance use" (p.66).
- "Achieve periods of abstinence and stability" (p.66).

Other initiatives related to co-occurring disorders in Florida include the following:

- The Tampa-Hillsborough County Community Action Grant on Co-occurring Disorders - This Center for Mental Health Services (CMHS) funded Community Action Grant is intended to provide resources for technical assistance and community consensus-building in order to implement effective services for co-occurring disorders in Hillsborough County. Representatives from the majority of key community stakeholders met throughout 2001-2003 and achieved consensus to use Minkoff's Comprehensive Continuous Integrated System of Care (CCISC) Model as the basis for evidence-based systems change in improving services for individuals with co-occurring disorders. This working group has developed and is implementing a strategic action plan based on this model in mental health and substance abuse provider agencies in Hillsborough County, and applied for and received a renewal grant under the leadership of the Louis de la Parte Florida Mental Health Institute (FMHI). An additional project that emerged out of this effort was the development by FMHI, under contract with the DCF ADM Suncoast Region, of a nine-module, online training series on co-occurring disorders (e.g., "Evidence-based Treatment Models for Co-occurring Disorders", Matthews, 2002; available online at http://mhlp.fmhi.usf.edu/Training/ole/mhlpole.htm).

- The Florida Alcohol and Drug Abuse Association (FADAA) and the Florida Council for Community Mental Health (Florida Council) have established a joint Workgroup on Co-occurring Disorders, which meets several times per year with representatives from these two trade associations and other interested parties from around the state. This workgroup has formed two sub-committees, one focused on Policy and Finance, the other on Clinical Services. Both sub-committees have begun to identify barriers to improving services for co-occurring disorders and are developing initial action plans and recommendations for how to overcome these barriers. The Workgroup agreed to review and make suggestions and recommendations for the ongoing development of this policy paper. Additionally, Florida's new Center for Substance Abuse Treatment (CSAT)-funded Southern Coast Addiction Technology Transfer Center (SCATTC; www.scattc.org) has been involved in sponsoring, along with FADAA and FCCMH, trainings on co-occurring disorders around the state.

- Suncoast Practice and Research Collaborative (SPARC)/Tampa Practice Improvement Collaborative (PIC). The Florida Mental Health Institute applied for and received ongoing grants from SAMHSA's Center for Substance Abuse Treatment (CSAT) to form SPARC, which is a collaboration between FMHI, local substance abuse community providers, and policy makers to improve services for substance-involved offenders. Projects related to co-occurring disorders to date have included the development and implementation in local

agencies of a co-occurring disorders group treatment manual and client workbook (Moore, Matthews, and Hunt, 2001; available online http://www.fmhi.usf.edu/mhlp/sparc), and the implementation of a gender-specific treatment manual for women with PTSD and Substance Abuse (Najavits, 2002; available online at www.seekingsafety.org). An additional project developed by SPARC, in collaboration with DCF and FADAA and interested researchers, policy makers, and providers from around the state of Florida, is the Florida Research to Practice Consortium, which has thus far chosen to focus on co-occurring disorders as its primary focus.

- Triad Women's Project on Co-occurring Substance Abuse, Mental Disorders, and Histories of Trauma: Tri-County Human Services, in partnership with FMHI, Winter Haven Hospital Behavioral Health Division, and ACTS, has been involved in an ongoing SAMHSA-funded project since 1998 to develop, implement, and evaluate services specifically for women with the "Triad" of co-occurring substance abuse, mental disorders, and traumatic histories of violence and abuse. This project has been implemented in semi-rural District 14 (which includes Polk, Hardee, and Highland counties). The Triad program includes the following features: (1) an integrated clinical case management program by staff who were cross-trained in mental health, substance abuse, and trauma/violence/abuse issues; (2) development of a 16 hour cross-training package on video; (3) an integrated social assessment instrument; (4) development of a group treatment manual; and, (5) use of peer support groups as treatment adjuncts. Furthermore, this comprehensive program is designed to be implemented within existing resources, service systems, and billing requirements. Pilot evaluation results thus far appear promising, indicating reductions in mental health symptoms, including those related to traumatic histories of child sexual abuse, and improvement in substance abuse recovery coping skills[4].

As outlined above, work has already begun in Florida to improve services to individuals with co-occurring disorders, but there are still many issues that need to be addressed. Some of the deficiencies and needs of the present system are already being identified, explored and solutions sought. Among them are the following:

- People with co-occurring disorders who receive treatment in state funded mental health programs should also have their substance abuse needs addressed, and vice versa.

- Integrated treatment models for individuals with co-occurring disorders need to be developed and implemented in both the mental health and substance abuse treatment system.

- Integrated mental health/substance abuse acute care facility services should be made available and accessible to all who need them. This might entail the creation of integrated or co-located mental health Crisis Stabilization Units with Addictions Receiving Facilities and/or Detoxification programs.

[4] For more information about the Triad project, e-mail Colleen Clark, Ph.D., at cclark@fmhi.usf.edu.

- Universal screening of both types of disorders (mental disorders and substance use disorders) in both mental health and substance abuse agencies needs to be implemented. This does not necessarily mean that all settings need to use the same instruments, since different settings may require different instruments specifically developed for their treatment populations.

- Mental health and substance abuse staff and programs need to develop basic minimum competencies to serve persons with co-occurring disorders, who already make up the majority of their clients in most settings. "This will be especially important for staff in crisis stabilization and detoxification units as well as inpatient and intensive residential programs in both systems" (DCF, 2001, p. 143).

- After defining "the competencies necessary for assessment and treatment of individuals with co-occurring disorders within each system" (DCF, 2001, p. 143), appropriate training and consultation will need to be made available to both mental health and substance abuse administrators and staff.

- "Specific funding mechanisms are necessary to support the philosophy of consultation, collaboration, and integration. State and local planners need to develop funding mechanisms that allow such partnership activities (work groups, task forces, networks, etc.) to be reimbursed" (DCF, 2001, p. 143).

While both the mental health and substance abuse systems have many of the necessary pieces to begin integrating and improving treatment services there is still much to be done.

GUIDING PRINCIPLES OF EFFECTIVE SERVICES FOR CO-OCCURRING DISORDERS

Desirable Co-occurring Treatment System Characteristics (adapted in part from NASMHPD/NASADAD, 1998)

> "An effective system of care for people with co-occurring disorders [is] one that encourages and allows for consultation, collaboration and integration" (NASMHPD/NASADAD, 1998, p. 19), and will have addressed issues related to co-occurring disorders in such key areas as philosophy, service delivery, staffing and funding.

Philosophy

- Ongoing Commitment and Consensus Building – "Any service system that can effectively care for people with co-occurring disorders must be built on a strong foundation of shared principles and values. There must be agreement among all key stakeholders, including federal, state and community officials, policy makers, mental health and substance abuse treatment and primary health providers, consumers, and advocates about the need for and the value of treatment systems working together to improve consumer outcomes" (NASMHPD/NASADAD, 1998, p. 19). Whenever possible, such agreements should be formalized in memoranda of understanding, and there should be "ongoing and shared commitments to address the needs of this group. It should be clear to all parties that

provide consultation, collaboration and integration are not only allowed, but are encouraged and programmatically supported" (NASMHPD/NASADAD, 1998, p. 19), based on the needs of the individual.

- Person-centered - Any successful service system must be person-centered as well as culturally competent. A person-centered system "is one in which people with mental health and substance abuse problems and their families are actively involved not only in treatment decisions but also in program design, administration, evaluation" (NASMHPD/NASADAD, 1998, p. 19), quality assurance and quality improvement.

Service Delivery System

- "No Wrong Door" - The service delivery system for people with co-occurring disorders "must be available and accessible, wherever and whenever the person enters [the] system" (NASMHPD/NASADAD, 1998, p. 19-20). Often referred to as "no-wrong door", this approach ensures that an individual will receive treatment (even if this includes referral), "whether he or she seeks help for a mental health problem, a substance abuse problem or a general medical condition. This eliminates unnecessary duplication of services and reduces the likelihood that an individual will fall through the cracks of an uncoordinated system of care" (NASMHPD/NASADAD, 1998, p. 19-20).

- Comprehensive, Long Term Care – "Because of the chronic and severe nature of many co-occurring conditions, treatment for such individuals must be comprehensive, longitudinal" (NASMHPD/NASADAD, 1998, p. 20) and appropriate to the consumer's changing needs and motivation.

- Engagement – Because many individuals with co-occurring disorders are not currently receiving any treatment, [it is recommended] that providers [also] focus on engaging those [persons] who are not currently in the mental health or substance abuse treatment systems. Special efforts should be made to reach out to children and adolescents at risk for developing mental health and substance abuse disorders, many of whom are present in primary care settings or school-based clinics. In addition, individuals with co-occurring disorders are found in jails and prisons, hospital emergency rooms and living in shelters or on the streets" (NASMHPD/NASADAD, 1998, p. 20). Some individuals who are already receiving treatment in one system or the other, and who are identified as having co-occurring disorders, may need persuasion and motivational interventions in order to become engaged in treatment for both types of disorders.

- Integrated Service Delivery – "While service delivery for some individuals with co-occurring disorders should be [fully] integrated" (NASMHPD/NASADAD, 1998, p. 20) (i.e., Dual Diagnosis Enhanced settings for those persons with the most severe disorders), this does not mean that all settings need to be integrated to that degree. "Because both the mental health and substance abuse systems have unique characteristics… their efforts should be combined, but it may not be either practical or desirable to [completely] merge the systems themselves" (NASMHPD/NASADAD, 1998, p. 20). Rather, each setting should develop and maintain a minimum standard (i.e., Dual Diagnosis Capable) to serve their clients with co-occurring disorders effectively.

- Universal Screening – All clients should be screened for both mental and substance use disorders, regardless of where they present for services.

- Aftercare - In keeping with the need for comprehensive and long term care, a critical element in the treatment continuum for people with co-occurring disorders should be aftercare/follow-up services for those who complete primary treatment episodes. Individuals with co-occurring disorders are at a greater risk for relapse or return to the problems of their pre-treatment state. This means that they need additional supports and services to help them maintain their treatment gains.

- Integrated Data Systems - Integrated data systems should facilitate and enhance access to and movement between the mental health and substance abuse systems, as well as help to identify ways in which the system could be further improved.

- Shared Performance Indicators - With shared performance indicators to assess treatment for co-occurring disorders, the people served by either system or both systems, as well as family members, advocates and funding sources can better determine whether outcomes are met.

- Special Populations and Co-occurring Disorders- Prevention, treatment, and other services also need to be made available to special populations with (or at risk of developing) co-occurring disorders, including the following (1) children and adolescents (including prevention and early intervention for co-occurring disorders), (2) women (3) individuals involved in the criminal and juvenile justice systems, (4) the elderly, and (5) child welfare and family safety clients.

Staffing

- Respect and Trust – "A comprehensive service delivery system for people with co-occurring disorders will be as successful as permitted by the individuals who staff [the system]. Their ability to work together begins with an appreciation for the skills and strengths of providers in both systems... Front-line staff must be able to trust one another and know they are working for the good of the consumer" (NASMHPD/NASADAD, 1998, p. 20).

- Cross-Training – Treatment providers must demonstrate competency in both mental health and substance abuse in order to provide the most effective services. While cross-training will be a vital ingredient in the effort to provide effective services to those individuals with co-occurring disorders, it should be offered with the understanding "that cross-training alone [will] not make one an expert in the other field… In order to be effective, [staff in the substance abuse and mental health fields] must have enough knowledge to [determine] what they don't know and to seek advice [or consultation] from one another. In addition, primary health care providers would also benefit from further training in mental health and substance abuse" (NASMHPD/NASADAD, 1998, p. 20).

Funding

- Flexible Funding Streams – "Flexible funding is a necessary tool [for] mental health and substance abuse providers… to meet the needs of individuals whose disorders don't fall neatly into one or another categorical funding stream. Maintenance of separate funding streams at the [national] and state levels [should] ensure that the mental health and substance abuse systems remain viable and able to complement [each] other… In the final analysis, coordination and [integration] of those funding streams at the local level by community providers may permit the most effective response to… needs of consumers with co-occurring disorders" (NASMHPD/NASADAD, 1998, p. 21).

- Specific Funding Mechanisms – "To support [the] philosophy of consultation, collaboration, and integration, state and local planners may need to develop… funding mechanisms that allow such partnership activities (e.g., work groups, task forces, [networks], etc.) to be reimbursed" (NASMHPD/NASADAD, 1998, p. 21).

Four Quadrant Model: Co-occurring Disorders by Severity (Figure 1)

Commonly called the "Four Quadrant Model" or "New York Model" (NASMHPD/NASADAD, 1998), the framework outlined in Figure 1 is based on the assumption that persons with co-occurring disorders vary in the degree of severity of their co-occurring mental health and substance use disorders. Some persons will be affected by mental disorders to a greater degree than their co-occurring substance use disorders. Others may be affected by their substance use disorders to a greater degree than by their mental disorders and still others may be greatly affected by both. The present model places individuals in four major categories based on severity:

- Quadrant I - Less severe mental disorder/Less severe substance use disorder. Persons in Quadrant I are those individuals who may or may not already be involved in the mental health or substance abuse service systems. Those who are involved may generally be found in outpatient settings with problems such as anxiety, depression, or family problems or in substance abuse treatment programs with substance abuse problems (not usually clear cut substance dependence). In many instances, the problems may not be severe enough to bring them to the attention of either system. This category may include children, adolescents and adults at-risk for developing mental or substance use disorders who will frequently be found in primary health care settings, school or community programs or receiving no care at all. Programs may have the greatest impact on this group by minimizing the future impact of these disorders through prevention and early intervention programs.

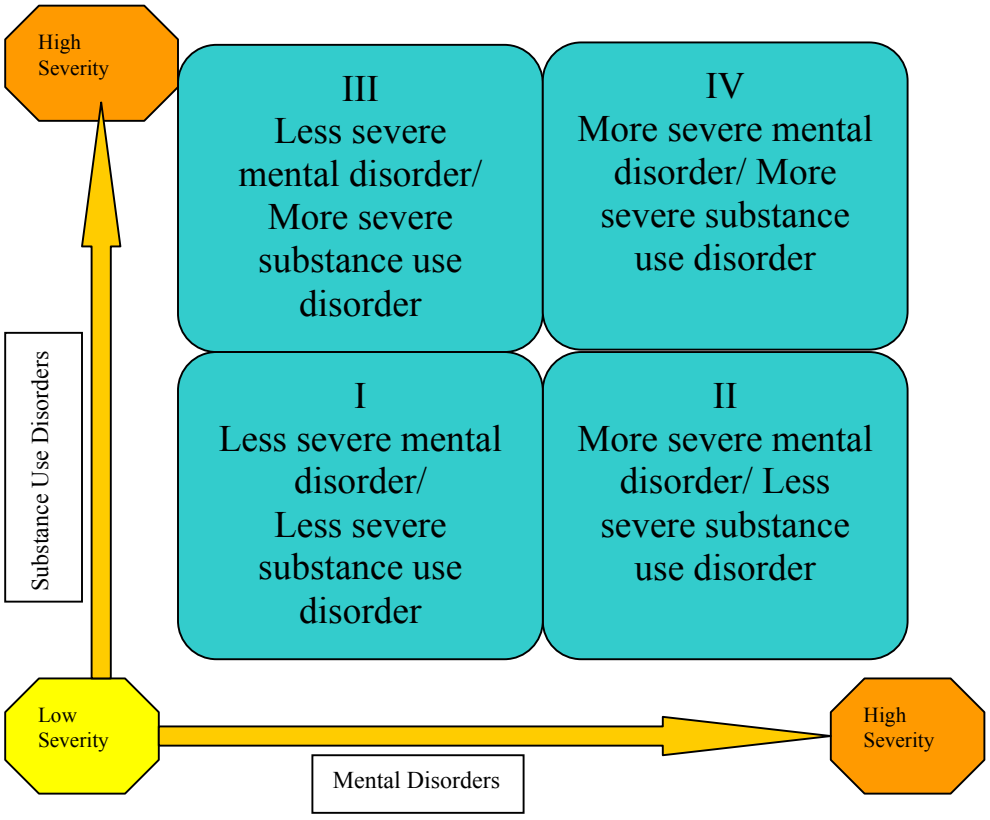
- Quadrant II - More severe mental disorder/Less severe substance abuse disorder. Persons in Quadrant II are likely to be or have been involved with the mental health system due to a more readily apparent mental disorder. This group often includes persons with a severe mental illness complicated by substance abuse (whether or not the person sees their use as a problem).

- Quadrant III- Less severe mental disorder/More severe substance use disorder. Persons in Quadrant III are more likely to be or have been involved with the substance abuse system due to a more readily apparent substance use disorder. Individuals in this group are more likely to have a diagnosis of substance dependence with psychiatric symptoms but do not have a severe and persistent mental illness. Included within this group will be persons with substance-induced and substance exacerbated psychiatric disorders.

- Quadrant IV - More severe mental disorder/More severe substance abuse disorder. Persons in Quadrant IV are those with a severe and persistent mental illness who have an accompanying problem of substance dependence. These individuals typically need integrated treatment for both disorders. Individuals in this group often are found in settings that are largely inappropriate for their needs (e.g., jails, prisons, homeless shelters, the streets, state hospitals). This group tends to be the most chronic and severe, uses the most resources, is the most difficult to serve, and tends to have the worst outcomes in fragmented systems of care. However, integrated, comprehensive, continuous services provided to this group can improve long-term outcomes for these individuals.

Figure 1

Co-occurring Disorders by Severity



Service Coordination by Severity

"Based on the severity of their disorders and the location of their care, the following levels of coordination among the substance abuse, mental health, and primary care systems are recommended to address the needs of individuals with co-occurring mental illness and substance abuse impairments" (NASMHPD/NASADAD, 1998, p. 16).

- Consultation (used primarily for Quadrant I population) – This includes "informal relationships among providers that ensure both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention and early intervention. An example of such consultation might include a telephone request for information or advice regarding the [diagnosis and treatment] of depression in a person abusing alcohol or drugs" (NASMHPD/NASADAD, 1998, p. 16).

- Collaboration (used primarily for Quadrants II/III populations) – This includes "more formal relationships among providers that ensure both mental illness and substance abuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co-occurring disorders and contribute to service delivery" (NASMHPD/NASADAD, 1998, p. 16). Another example might include "swapping" staff between mental health and substance abuse agencies for designated periods of time per week in order to provide more integrated treatment services; this approach can also serve as an effective way to facilitate increased inter-system linkages and cross-training of staff.

- Fully Integrated Services (especially needed for Quadrant IV population) – This includes "relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen" (NASMHPD/NASADAD, 1998, p. 20).

Dual Diagnosis Capable and Dual Diagnosis Enhanced Services

Both mental health and substance abuse providers should ideally provide either Dual Diagnosis Capable (DDC) or Dual Diagnosis Enhanced (DDE)[5] services in all of their programs. These levels of care are described in more detail in the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R; ASAM, 2001), and by Minkoff's adaptation of the American Association of Community Psychiatry Position Statement on Co-occurring Disorders (see Attachment B).

Dual Diagnosis Capable (see Attachment B) services provide a minimal level of integrated mental health and substance abuse services for clients with co-occurring disorders in a single setting. Thus, individuals with low severity of substance abuse disorders and high severity of mental disorders (i.e., Quadrant II) should be able to have both their mental health and substance abuse needs met through a single program, most likely in a mental health provider

[5] Although this paper uses the term "Co-occurring Disorders" rather than "Dual Diagnosis" elsewhere, we do use the terms "Dual Diagnosis Capable" and "Dual Diagnosis Enhanced" in order to be consistent with the terminology used for these levels of care by the ASAM PPC-2R and the AACP.

agency. Similarly, individuals with a low severity of mental disorders and a high severity of substance abuse disorders (i.e., Quadrant III) should be able to have both their mental health and substance abuse needs met through a single program, most likely in a substance abuse provider agency.

For example, motivational interventions, such as motivational interviewing (Miller & Rollnick, 2002), should be used in DDC Programs to encourage clients with co-occurring disorders being treated in mental health agencies to develop motivation for reducing their substance use, and eventually receive active treatment for substance use disorders if needed. Motivational interviewing and other motivational enhancement techniques are not licensable substance abuse program activities in Florida, but rather counseling techniques, which are appropriate for and can be applied successfully in both mental health and substance abuse settings, as well as other settings as appropriate (e.g., primary care). Client motivation should also be assessed regularly in order to match clients with the appropriate stage of treatment based on their readiness to change (see Attachment C). Motivational techniques can also be applied in mental health, substance abuse, and other treatment settings to help increase client motivation to take psychiatric and other medications as prescribed.

In addition to Dual Diagnosis Capable programs, special Dual Diagnosis Enhanced programs (DDE; see Attachment B) are also necessary as part of an effective continuum of care. DDE programs are commonly needed by individuals with a high severity of both mental and substance use disorders (i.e., Quadrant IV), or by those in Quadrants II or III who are not stable enough in terms of either mental or substance use disorders to be able to currently benefit from treatment in a DDC setting. Due to the severity of the population they are designed for, DDE programs require a more comprehensive and typically more costly set of services per client than DDC programs. DDE programs should be available in both substance abuse and mental health treatment agencies, with adequate systems capacity for the Quadrant IV population and for indicated clients in Quadrants II and III (i.e., those who are not stable enough yet for DDC programs).

Comprehensive, Continuous, Integrated System of Care (CCISC) Model

Dr. Kenneth Minkoff has developed a conceptual model to improve systems of care for persons with co-occurring disorders, referred to as the Comprehensive, Continuous, Integrated System of Care (CCISC) model. This model draws on and expands on the work of the American Association for Community Psychiatry's (AACP) Position statement "Principles of Treatment for Individuals with Co-occurring Psychiatric and Substance Disorders" (see Attachment B). It also draws on the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R) and outlines different levels of program competency to treat co-occurring disorders for both mental health and substance abuse treatment agencies.

Minkoff's model outlines principles for effective systems of care for individuals with co-occurring disorders, as well as a twelve step implementation process for systems change in order to develop a Comprehensive, Continuous, Integrated System of Care (see Attachment A). This model is unique in the country due to its focus on systems change at multiple levels in order to improve services for persons with co-occurring disorders. It is also compatible with and informed by the pioneering and nationally recognized research and clinical models

focused on co-occurring disorders developed by Dr. Robert Drake and others at the Dartmouth New Hampshire Psychiatric Research Center (see Attachment C). The CCISC model has also been recognized as a promising practice by the federal government's Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has awarded a number of Community Action Grants around the country focused on the implementation of this model, including one in Tampa/Hillsborough County, Florida (described earlier in this paper).

TARGETED PRIORITY GOALS FOR FLORIDA TO DEVELOP AN IMPROVED SERVICE SYSTEM FOR CO-OCCURRING DISORDERS

Workgroups (with appropriate representation from key stakeholders) and action plans need to be developed for the following areas in order to improve services for persons with co-occurring disorders in Florida.

Funding

- DCF Funding Mechanisms - The DCF Mental Health (MH) and Substance Abuse (SA) Program Offices agree to collaborate with each other and FADAA, the FL Council, and FMHI, to remove existing barriers in DCF Cost Centers that might prevent adequate and enhanced levels of funding to providers for integrated MH/SA services for individuals with co-occurring disorders, while protecting the integrity of funding categories. This effort should build upon the system re-design effort, authorized by SB1258, which is currently taking place in ADM District 1.

- Agency for Health Care Administration (AHCA) Funding Mechanisms - Similarly, the DCF MH and SA Program Offices agree to collaborate with AHCA to remove any existing barriers that might prevent adequate and enhanced levels of Medicaid and Medicare funding for provision of integrated MH/SA care for individuals with co-occurring disorders. FADAA, FL Council, and FMHI should have input into this process as well. This process should build upon the current efforts of AHCA, who, in collaboration with the Tampa-Hillsborough Community Action Grant on Co-occurring disorders, and the FADAA/FL Council Workgroup on Co-occurring Disorders, are developing recommended revisions to descriptions of existing Medicaid codes in order to facilitate their use for co-occurring disorders services. This effort should also build upon the system re-design effort, authorized by SB1258, which is currently taking place in ADM District 1 (i.e., AHCA Area 1).

- Funding Categories - Appropriation categories, program categories, and budget categories, including activity OCA's, also need to allow flexibility at the provider level to utilize funding from various sources to provide integrated services for co-occurring mental and substance use disorders in a single setting. Thus,

    (1) Mental health funding should be able to support services for an individual's co-occurring substance use disorder(s) in addition to their mental disorder(s).

(2) Similarly, substance abuse funding should be able to support services for an individual's co-occurring mental disorder(s), in addition to their substance use disorder(s).

Case Mix and Risk Adjustment, Including Adjustment of Performance Outcome Standards and Service Rates for Co-occurring Disorders

Performance outcome standards should be adjusted based on severity of population served. Individuals with co-occurring disorders are typically more severe, complicated, and difficult to serve than those with "single disorders" and show more gradual improvement. Thus, because outcomes for individuals with co-occurring disorders are reasonably expected to be lower compared to those with "single disorders", service rates should be enhanced to reflect the need for greater intensity, comprehensiveness, and length of services for the co-occurring disorders population. As much as possible, performance outcome standards for providers should be based on research evidence and the experience of other states, and should be guided by consensus among national and Florida experts and constituents, including FMHI, FADAA, FL Council, and Florida providers and consumers. This is not to suggest that new statewide performance measures be established for the co-occurring disorders population at this time, because more experience and system development needs to occur before something of that nature is contemplated.

Scope of Practice and Regulatory Barriers to Integrated Care

As much as possible, the DCF MH and SA program offices, in conjunction with AHCA and other organizations (including regulatory bodies, national experts, FMHI, FADAA, FL Council, FL providers, and consumers), agree to collaborate on the following goals:

(1) Address existing scope of practice and regulatory barriers so that they do not interfere with providers and service systems' ability to offer, within a single setting, an appropriate level of integrated MH/SA services to individuals with co-occurring disorders.

(2) Instead, regulatory mechanisms should promote provider flexibility in providing appropriate, high quality, integrated MH/SA services for individuals with co-occurring disorders while continuing to ensure the quality of services.

Areas in which scope of practice issues may need to be addressed as outlined above include, but are not limited to: (a) Licensure, (b) DCF Designation as type of provider (MH and/or SA), (c) Conflicts between DCF MH and SA Administrative Rules, and between DCF and Medicaid/AHCA requirements (d) ADM Contracts language, and (e) other regulatory mechanisms. Such issues and barriers need to be addressed at the following levels: (1) System of Care, (2) Agency, (3) Program, and (4) Individual Staff and Professional levels.

The above scope of practice, regulatory and funding sections do not necessarily mean that all MH and SA providers will be fully integrated across MH and SA, but rather, appropriate guidelines will be developed for reasonable levels of MH/SA integration of services in various settings. This process should occur under the guidance of a consensus panel of national and Florida experts and constituents, including the input of FL Council, FADAA, FMHI (including the Tampa-Hillsborough Community Action Grant on co-occurring disorders which has begun

this process), and FL providers and consumers. This process should also be informed, as much as possible, by research, evidence-based practices and standards, and the experience of other states that have already begun this process.

Substance Abuse Program Licensure Requirements

The Substance Abuse and Mental Health Offices recognize that DCF requirements for licensure as a substance abuse program/facility have been reported by mental health provider agencies as barriers to providing integrated co-occurring services to their clientele with co-occurring disorders. However, there is a need to comply with Chapter 397, F.S., and to maintain the integrity of substance abuse licensure for programs/facilities that primarily provide substance abuse services. Such licensure standards should not be a barrier to integrated co-occurring services provided by mental health provider agencies as part of comprehensive mental health services.

Although the Substance Abuse and Mental Health Programs have begun to address this issue, a high priority is to convene a workgroup that will develop and implement reasonable solution(s) to this issue, with appropriate input from key stakeholders, including mental health and substance abuse providers. As stated in the 2003 update to the DCF State Mental Health and Substance Abuse Plan: “The Substance Abuse and Mental Health Program Offices are currently developing licensure requirements and exemption allowances for mental health providers that serve persons with co-occurring disorders. Providers serving persons with primary mental health disorders that have a co-existing substance use disorder should be able to provide integrated services as part of their treatment protocol. For mental health agencies providing licensable substance abuse components, options for licensure under discussion include:

(1) Hire a qualified professional (pursuant to Chapter 397, F.S.) to provide substance abuse treatment services on-site, no separate substance abuse license required; or

(2) Contract with a licensed substance abuse agency to provide [overlay] substance abuse services; or

(3) Obtain a substance abuse license for a licensable facility or program component.

Under Chapter 397, F.S., a “qualified professional” is defined as one of the following:

(1) “a physician licensed under chapter 458 or 459”

(2) “ a professional licensed under chapter 490 or 491”, including licensed psychologists (chapter 490) or licensed social workers, marriage and family therapists, or mental health counselors (chapter 491).

(3) “a person certified through a department-recognized certification process for substance abuse treatment services and who holds, at minimum, a bachelor’s degree” (i.e., a Certified Addictions Professional or CAP).

(4) “a person who is certified in substance abuse treatment services by a state-recognized certification process in another state at the time of employment with a licensed substance abuse provider in this state may perform the functions of a qualified professional as defined in this chapter but must meet certification requirements contained in this subsection no later than 1 year after his or her date of employment”.

Targeted High Priority Areas for Dual Diagnosis Capable Services Development

The guiding principle behind the exemptions to substance abuse licensure (described in the section above) is that all mental health and substance abuse programs should become Dual Diagnosis Capable (see Attachment B), which means that they are able to provide at least a minimal level of integrated mental health and substance abuse services for clients with co-occurring disorders. Priority areas that need to be targeted for improvement in order for all mental health and substance abuse treatment agencies in Florida to become Dual Diagnosis Capable include the following:

- Clients with co-occurring disorders who are served in Substance Abuse (SA) agencies need increased access to psychiatric medications and services. Many substance abuse agencies currently have little or no capacity to provide access to psychiatric medications, although the majority of their clients have some type of co-occurring mental disorder. Thus, a number of system and resource barriers to medications need to be addressed, including the following: (1) supplemental funding of the Indigent Drug Program to cover the increased cost necessary to expand coverage for persons in SA programs, (2) SA providers need to build and expand the capacity to bill Medicaid for prescriptions and services, (3) increased SA provider capacity to pay for prescribing clinicians’ time, including psychiatrists, psychiatric nurses, primary care physicians, and/or nurse practitioners, from both DCF and AHCA sources.

- Clients with co-occurring disorders who are served in Substance Abuse agencies also need increased access to the following: (a) case management services and (b) outreach services. SA agencies currently have quite limited capacity and resources to provide such services. For instance, case management is not currently a reimbursable Medicaid procedure for patients with a substance abuse diagnosis.

- Clients with co-occurring disorders who are served in mental health agencies need increased access to drug testing, psychosocial substance abuse services (e.g., motivational interviewing, counseling, etc.), and outreach services, as MH agencies currently have limited training, capacity and/or resources to provide these services. The above services need to fundable as part of comprehensive mental health care, either through DCF or Medicaid. Additionally, individuals with co-occurring disorders who are served in MH agencies need increased access to psychiatric medications, in order to close the gap between the existing need for and current limited availability of medications, so that all individuals who need psychiatric medications have access.

STRATEGIC IMPLEMENTATION PLAN

In addition to the need for development of work groups and action plans for the Targeted High Priority Goals (as described in above section), the following section outlines needed and ongoing action steps to implement improved services for persons with co-occurring disorders in Florida.

Action Step 1: Develop an Integrated System Planning Process and Structure

The first step for Florida to improve its service system for the co-occurring disorders population as outlined in the preceding document is to develop an integrated system planning process and structure. This is also the first step in Minkoff's 12-steps of implementation of his CCISC model (see Attachment A).

- Florida Work Group on Co-occurring Disorders - The Florida Alcohol and Drug Abuse Association (FADAA) and the Florida Council on Community Mental Health have developed a joint Workgroup on Co-occurring Disorders. In addition to representatives from FADAA and the Florida Council, current membership includes interested parties from the Florida Behavioral Health Services Integration Workgroup, community substance abuse and mental health treatment providers, the Tampa-Hillsborough Community Action Grant on Co-occurring Disorders, and the Louis de la Parte Florida Mental Health Institute. It is recommended that this committee expand its membership to include additional key stakeholders from around the state, and perhaps change its name to reflect the broader membership to the Florida Work Group on Co-occurring Disorders. Additional members might include stakeholders from the following: the Department of Children and Families Mental Health and Substance Abuse Program Offices, including key District ADM staff (e.g., from District 1); the Agency for Health Care Administration (AHCA); Departments of Corrections and Health; consumers of behavioral health services and their families; law enforcement; county governments; homeless coalitions; county jails; the Southern Coast Addictions Technology Transfer Center; consumers, family members and other key stakeholders, including those from other projects related to co-occurring disorders in Florida (see section on "The Florida Situation").

- Statewide and Regional forums - Forums should be held in different locations in Florida in order to ensure input from a diverse geographical sample into the Florida Work Group on Co-occurring Disorders. Developing consensus in adopting a broad vision for how our state should improve our service system to better serve individuals with co-occurring disorders should be the first major task of this group. This policy paper has served as an initial catalyst for review and input from all interested stakeholders. As a result, this final draft of this document is based on a shared consensus, which will lead to ongoing Strategic Implementation and Action Plans with incremental action steps to achieve our goals, including measurable objectives and outcomes, in order to gradually implement our broad vision.

- Expert Consultation and Review - This type of review should also be included in the planning process to provide strategic guidance at key points. Individuals such as Dr. Kenneth Minkoff and Dr. Robert Drake, two of the top experts in the area of co-occurring disorders, are possible candidates for reviewing strategic implementation plans and providing ongoing consultation to Florida's effort to improve services for persons with Co-occurring Disorders.

- Regional, District and Local Planning Groups - These groups should be convened to build consensus and support regarding how to improve services for co-occurring disorders in local communities. These groups should also include all key stakeholders and should develop their own consensus documents, including Memoranda of Understanding, as well as their own Strategic Implementation Plans. These local efforts should coordinate with the overall vision outlined in the statewide planning process.

- CCISC Model Planning Process - The following is a brief description of this planning process from the CCISC model (Minkoff, 2002; see attachment B): "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 funding sources, 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 (individuals with co-occurring disorders) and their families."

Action Step 2: Continue to Implement Current Projects in Florida Related to Improving Services for Co-occurring Disorders

- District 1 DCF/ADM Activity Related to Co-occurring Disorders and Integrated Services - Florida Senate Bill 1258 authorized AHCA and the Alcohol Drug Abuse, and Mental Health (ADM) office to integrate Medicaid and ADM-funded mental health and substance abuse data systems, funding and services in at least two parts of the state, Districts 1 and 8. In District 1 this is being done through a pilot Medicaid waiver for a pre-paid mental health plan (PMHP) that was implemented by AHCA 11/1/01 and through integrated ADM services. AHCA and ADM are contracting on a prepaid basis with the same managing entity, Lakeview Center.

  Since September of 2001, District 1 workgroups, including local providers, have been redesigning the data system to make it flexible and user-friendly in order to capture data in real-time, and to make it completely web-based to allow providers to easily and quickly report their data. Under the old system still in use in other parts of the state, if a client has not already been "enrolled" as a substance abuse client, any subsequent substance abuse

services provided are not accepted by the database, even if they were previously enrolled in the mental health service system. Similarly, if a client has not been “enrolled” as a mental health client, any subsequent mental health services are not accepted by the database, even if they were previously enrolled in the substance abuse service system. Additionally, under the old system, enrollment in the substance abuse and mental health systems each required their own separate enrollment forms. All of the above have created barriers to providing integrated services and data management of clients with co-occurring disorders.

District 1’s pilot data system, which began its first data uploads in approximately July of 2002, has eliminated the need for either mental health or substance abuse “enrollment forms”. This means that clients are automatically enrolled when data from their first services (either mental health or substance abuse) are entered. Furthermore, once data from a client’s first service are entered, the system will automatically accept subsequent data for any future substance abuse or mental health services. This relational database also allows for flexibility in how the data is analyzed. Almost any level and type of analysis can be performed as needed for clinical or policy decisions, as well as state and federal reports (e.g., for SISAR outcomes or federal SAPT or CMHS block grants reporting requirements). A long-term goal of the pilot data project is to disseminate its integrated data management system to other parts of the state for future implementation and adaptation, and it is expected that this roll out to other parts of the state will commence July of 2003.

An additional innovation in District 1 ADM Services is the streamlining and integration of categorical funding streams from approximately 40 different cost centers to 4 programs (i.e., adult mental health, adult substance abuse, child mental health, and child substance abuse). Streamlined funding has also helped reduce unnecessary barriers to providing integrated services for clients with co-occurring disorders, and it is hoped that this approach also may spread to other parts of the state. Complete integration of funding at the local or District level remains a potential goal.

Because the District 1 PMHP could not integrate substance abuse into the pre-paid benefit under Medicaid, it currently maintains a fee-for-service structure for Medicaid funding of substance abuse services. It is possible that this could be used as a strategic incentive to increase substance abuse services provided to clients with co-occurring disorders, especially those who receive most of their services through the PMHP. Since this arrangement allows for an additional funding stream, more clients with co-occurring disorders may be able to receive both substance abuse and mental health services, although it is not yet clear to what extent providers have taken advantage of this incentive. Additionally, mental health services provided to clients who are in substance abuse treatment have also increased through the use of mental health care managers and greater flexibility in allowable services for clients with co-occurring disorders.

Thus, the prepaid plans and integrated data and funding systems allow for greater clinical flexibility in providing what the client needs when they need it, instead of services being driven by separate mental health and substance abuse reporting requirements, funding

sources, and regulations. Additionally, local providers (e.g., Lakeview Center), in collaboration with Dr. Paul Rollings and other ADM staff, have endorsed Minkoff's Comprehensive Continuous, Integrated System of Care (CCISC) model, and have periodically utilized his services as a consultant and trainer. Adoption of the CCISC model in District 1 is further guiding the development of integrated mental health and substance abuse services for persons with co-occurring disorders, as in other parts of the state (e.g., Hillsborough County).

- Evaluation and Implementation of Integrated Acute Care Units - As noted earlier, there are currently two pilot integrated children's Crisis Stabilization Units/Addiction Receiving Facilities operating in Ft. Myers and Sarasota. These pilot programs are currently undergoing an independent evaluation as mandated by SB 1258. The evaluation report is due to legislature by December 2003, and is mandated to address the following questions:

  (1) Number of clients served by the CSU/ARF's.

  (2) Quality of services provided by the CSU/ARF's.

  (3) Performance outcomes for the CSU/ARF's.

  (4) Feasibility of continuing or expanding the CSU/ARF demonstration models (to other parts of the state).

  (5) In addition to the above specific areas, the evaluation should "identify the most effective ways to provide integrated CSU/ARF services to children".

  In addition, program evaluation of the co-located secure detoxification and crisis stabilization unit in District 4 may also be useful and inform the potential expansion of integrated acute care services. Recommendations for this type of expansion should also be informed by the ongoing DCF-funded, FMHI focus-group study and analysis of the acute care system in several DCF Districts as part of the Behavioral Health Integration Workgroup created by S.B. 1258, as well as the separate analysis of the Sarasota County acute care system currently being developed by FMHI.

- Other Florida initiatives related to Co-occurring Disorders - As outlined earlier in this paper under the "Florida Situation", there are a number of other initiatives related to co-occurring disorders in the state. It will be important to continue to support these projects as well, and to bring key stakeholders from these different projects together at strategic points in order to facilitate more effective system planning, and to facilitate the sharing of information regarding lessons learned, solutions obtained, and possible barriers to overcome.

Additional Action Steps- Minkoff's 12 Steps of Implementation of CCISC Model

Minkoff outlines 12 broad steps in order to implement his CCISC Model in any size system (see Attachment A on following pages). Action Step 1 for Florida, Developing an Integrated System Planning Process and Structure (see above), is only the first of these 12 steps. The additional 11 steps of implementation will need to be developed over time in a collaborative,

consensus building process by the Florida Work Group on Co-occurring Disorders. These additional steps can then be included in revisions of this Policy Paper on Co-occurring Disorders, or in other documents, as needed. In brief, these steps are listed below (see Attachment A for a detailed description of what each entails).

1. Integrated system planning process
2. Formal consensus on CCISC model
3. Formal consensus on funding the CCISC model
4. Identification of priority populations, and locus of responsibility for each
5. Development and implementation of program standards
6. Structures for inter-system and inter-program care coordination
7. Development and implementation of practice guidelines
8. Facilitation of identification, welcoming, and accessibility
9. Implementation of continuous integrated treatment
10. Development of basic dual diagnosis capable competencies for all clinicians
11. Implementation of a system wide training plan
12. Development of a plan for a comprehensive program array

Attachment A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE (CCISC) MODEL

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Description

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. Implementation of the model integrates the use of system change technology 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.

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.

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 clinicians.

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. Epidemiological data defining the high prevalence of co-morbidity, 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 (NASMHPD, 1998) 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. 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. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community-based reinforcements to make incremental progress within the context of continuing treatment.

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" (Minkoff, 1989) 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 or stages of treatment, and demonstrated the value of stage wise treatment (Drake et al, 2001.)

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

Implementation of the CCISC requires utilization of system change strategies (e.g., continuous quality improvement), in the context of an organized process of strategic planning, to develop the specific elements of the CCISC. Minkoff (2001) has described a "12 Step Program for Implementation of a CCISC" that defines this process sequentially, and, in collaboration with Cline, has organized a CCISC Implementation Toolkit that promotes the successful accomplishment of many of the specific steps. Implementation of the CCISC occurs incrementally in complex systems, over a period of years, and is characterized by establishment of the following elements, which reflect fidelity to the model.

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

funding sources, 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.

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 funding source 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. Identify Priority Populations and Focus 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. Develop and Implement 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; Minkoff & Cline, 2001) 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. Develop and Implement 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 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 (Minkoff, 1998; Arizona DHS, 2001) 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 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. Facilitate the Identification, Welcoming, and Accessibility
This requires several specific steps: 1. Modify MIS capability to facilitate and encourage the identification, reporting, and tracking of ICOPSD. 2. Develop "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. Establish policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

9. Implement a 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, 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. Develop 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, Minkoff & Cline, 2001) can be utilized to facilitate this process.

11. Implement 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, or are being developed, in a variety of states, including Connecticut, New York, New Mexico, and Arizona.

12. Develop a Plan for a Comprehensive Program Array
The CCISC model requires development of a plan in which each existing program is assigned 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 initiating at least one Continuous Treatment Team (or similar service) for the most seriously impaired individuals with SPMI and substance disorder. This can occur by building dual diagnosis enhancement into an existing intensive case management team.

b. Peer dual recovery supports: The system must identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous, Double Trouble in Recovery) and establish a plan to facilitate the creation of these groups throughout the system.

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).

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

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.

CCISC implementation requires a plan that includes attention to each of these areas in a comprehensive service array.

Attachment B

AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRY (AACP) POSITION STATEMENT ON PROGRAM COMPETENCIES IN A COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

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Introduction

In June, 2000, AACP released a consensus position statement entitled Principles of Treatment for Individuals with Co-occurring Psychiatric and Substance Disorders, indicating the need for welcoming, accessible, integrated, continuous, and comprehensive treatment interventions and treatment programs, organized into a comprehensive, continuous, integrated system of care (CCISC).

The current document builds upon that position statement, by indicating AACP support for recently disseminated program categories for mental health and substance disorder programs, that define Dual Diagnosis Capable (DDC-MH, DDC-CD) programs and Dual Diagnosis Enhanced (DDE-MH, DDC-CD) programs within each service system, and recommend the following important principles of system design:

1. All MH (Mental Health) and CD (Chemical Dependency) programs should be expected to be Dual Diagnosis Capable, according to the definitions below.

2. Within any system of care, at each level of care, there should be a plan for appropriate DDE capacity.

3. Within any system of care, there needs to be a full range of housing options for individuals with psychiatric disabilities, as described below.

Definitions

System of Care: For purposes of this document, mental health (MH) programs are any programs organized, licensed, and/or funded to specifically treat individuals with psychiatric disorders, often prioritizing individuals with serious mental illness; the array of such programs serving a defined population is termed the mental health system of care for that population. Similarly, addiction or chemical dependency (CD) programs are any programs organized, licensed and/or funded specifically to treat individuals with substance disorders; the array of such programs serving a defined population is termed the chemical dependency system of care for that population. Program Categories include DDC-CD, DDE-CD, DDC-MH, and DDE-MH.

DDC-CD: The concept of Dual Diagnosis Capability in CD programs is incorporated in the ASAM PPC2R (ASAM, 2001), in which DDC is described as a standard of care for ALL addiction treatment programs, based on the high prevalence of expected co-morbidity among individuals seeking addiction treatment.

DDC-CD represents a measurable basic standard of care, which can be implemented within the context of existing program requirements, with additional technical assistance and training support, but without additional clinical operational cost, and can be reliably assessed through routine program audit, such as would occur during licensure review.

DDC-CD applies to any and all levels of care in the addiction treatment system, and implies that the program routinely admits individuals with co-occurring disorders, provided that the symptomatology and disability associated with those disorders is not severe enough to substantially interfere with participation in routine program functions or require substantially increased levels of staff support in order to sustain such functioning.

Thus, an individual may have baseline psychotic symptoms or suicidal ideation, but these symptoms are sufficiently limited or controllable that the individual can participate in groups, complete assignments, perform independent ADLs, etc.

The measurable criteria that define DDC status are as follows:

1. Mission and Philosophy
The program's mission, philosophy, and admission policies specifically welcome individuals with co-occurring disorders, and create no barriers to admission based solely on psychiatric history, diagnosis, or non-addictive prescribed medication. Assessment of motivation and functional capacity to participate in treatment are assessed for this purpose, as they would be for anyone seeking admission. (Note that individuals with psychiatric presentations or medication regimes that are more complex or controversial will ordinarily require DDE-CD programs for addiction treatment.)

2. Screening for Co-morbidity
There are specific screening procedures for the presence of psychiatric disorders and symptoms, and evidence that such procedures or tools are followed and used competently.

3. Assessment
The assessment process is ongoing, and incorporates routinely gathering information about psychiatric history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability. There is evidence that this process, and the associated forms, are followed and used competently. In addition, proactive linkage is provided to ensure access to mental health treatment for those individuals who need mental health services beyond the capabilities of the program.

4. Diagnosis and Treatment Planning
Psychiatric diagnoses are identified in the treatment record, and, where current treatment is required, listed as problems on the treatment plan. Specific goals and objectives are identified for each such problem.

> **Ex. Problem:** Major Depression, on meds, currently minimal symptoms.
> **Goal:** Maintain stability and prevent interference with addiction rx.
> **Objective**: Patient demonstrates competency in taking meds as prescribed.
> Patient identifies techniques for addressing med issues in Twelve-Step meetings.

5. Documentation
Progress notes document monitoring of the psychiatric disorder in relation to the treatment plan.

6. Programming
Treatment programming (at least one group per week) addresses issues related to co-occurring mental illness directly and openly, educating ALL clients about basic symptoms of mental illness, the possibility of co-morbidity, and the need for continued medication compliance while working an addiction recovery program.

7. Medication Policies
Program policies address obtaining medication prescriptions, as well as medication distribution and compliance, directly, and support medication compliance with MD prescription as a program requirement, including staff's responsibility to support such compliance.

8. Psychiatric Emergency Policies
Program has specific procedures for dealing with psychiatric emergencies.

9. Mental Health Consultation
Program has access to MH consultation for diagnostic assessment and treatment planning assistance. (Ideally, an existing program supervisor has MH background and training.)

10. Collaboration with MH Clinicians
Program has defined policies and procedures for integrating input from outside MH clinicians into treatment plans, progress notes, and discharge plans, including obtaining routine input from psychiatric counselors. (Psychiatrist on site is preferable, but not required.)

11. Competencies
Human resource policies and staff training and supervision policies incorporate attention to specific competencies in co-occurring disorders related to program function (e.g. screening, running the group), and continuing education to support and enhance those competencies.

12. Discharge Planning
Discharge or transition planning documents specific attention to continuity of care for psychiatric disorder.

DDE-CD: DDE-CD programs are psychiatrically enhanced programs at any level of care or type of treatment in the addiction system, in which additional resources and capabilities are added to an existing addiction program model in order to accommodate individuals with psychiatric disorders who have moderate levels of acute symptomatology or psychiatric disability. This type of program may include individuals who are motivated for addiction treatment, but also have active symptoms of PTSD which may include intermittent flashbacks and/or suicidal ideas, or who also have stable schizophrenia with persistent disability that may interfere with usual functioning required in a DDC addiction program.

DDE-CD programs are more costly than usual DDC addiction programs, and require additional funding, often through braiding or blending MH funding into the addiction program funding base. The ASAM recommendation is that within each system of care, at each level of care in the addiction system, there is a plan for DDE-CD capacity. This may involve distinct programs, or it may involve a component of an existing DDC program.

The specific characteristics of DDE programs are as follows:

1. Meets all DDC criteria, plus;
2. Increased staffing levels, with more staff with MH training;
3. Direct psychopharmacology presence on site;
4. On site availability of MH supervision/consultation;
5. Smaller group size, with more flexible expectations, and more specific MH symptom management incorporated into program content;
6. Documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes;
7. Continuing documentation of collaboration with continuing care mental health clinicians, and involvement of those clinicians in treatment planning meetings;
8. Program materials, such as skills training modules for substance reduction or relapse prevention, adapted to individuals with psychiatric impairment who may have impediments to learning new skills, by utilizing shorter, simpler, and more flexible assignments;
9. Policies that support welcoming return for individuals who lapse in treatment or who are unable to adhere to rules during the current treatment episode. More likelihood to accommodate more than one lapse before discharge;
10. Increased availability of individualized counseling and case management;

DDC-MH: The concept of DDC-MH was developed by Minkoff (Minkoff, 2000) as an extension of conceptualizations developed in the 1998 CMHS Expert Consensus Panel Report on Standards of Care for individuals with co-occurring disorders. Like DDC-CD, DDC-MH is considered to be an expectation for ALL mental health programs, and can be implemented with technical assistance and training support, but without additional clinical operational resources.

DDC-MH programs routinely welcome individuals with active co-occurring substance disorders, and provide appropriate phase specific interventions to treat those disorders.

Capacity for medically-monitored detoxification is dependent upon the availability of medical and nursing care comparable to that found in an ASAM Level III detoxification program, but intoxicated individuals who do not require medical detoxification can be routinely stabilized in appropriately staffed settings.

Like DDC-CD, DDC-MH is evaluated through routine program audit procedures, through chart review of specific, measurable criteria.

Specific characteristics of DDC-MH programs include:

1. Mission and Philosophy
Mission statement and philosophy clearly welcome individuals with active substance use, and promote continued mental health treatment of such individuals even when actively using.

2. Screening for Co-morbidity
Specific screening for substance use disorders documented, with evidence that such screening is performed competently.

3. Assessment
For individuals who are screened positively for past or present disorder, there is documentation of substance assessment, incorporating types and amounts of use, patterns of use, problems associated with use, specific substance diagnoses, past successful interventions, characteristic MH symptoms during previous sobriety periods, current treatment if any, and specific documentation of stage of change. In addition, proactive linkage is provided to ensure access to substance disorder treatment for those individuals who need substance disorder services beyond the capabilities of the program.

4. Treatment Planning
Substance diagnoses are routinely recorded in the clinical record, and identified as problems in the treatment plan, with specific goals, objectives, and interventions.

5. Substance Disorder Consultation
Documentation of access to consultation with CADAC or another clinician with documented substance expertise, and integration of this input into progress notes and treatment plans.

6. Continuity
In programs responsible for continuity of care, no denial of access or continuity based on continuing substance use for individuals who require treatment for continuing psychiatric disorders, and program policies specify that primary clinicians provide integrated continuous treatment relationships.

7. Stage-Specific Treatment
Availability of stage-specific treatment interventions including a range of group interventions within programs that offer groups.

8. Competencies
Human resource policies incorporate basic competencies in substance use disorders consistent with job requirements, and supervision and training policies include continuing education plans to support and enhance those competencies.

9. Collaboration with CD Clinicians
Documentation of coordination of care with collaborative substance providers integrated into treatment record.

10. Discharge Planning
Discharge or transition planning incorporates specific attention to continuity of phase-specific treatment for co-occurring substance disorder.

DDE-MH: Dual diagnosis enhanced mental health programs incorporate increased capacity to address co-occurring substance disorders in a variety of mental health settings. In general, in any mental health system, at each level of care, there needs to be a plan for appropriate availability of DDE-MH services. In almost every level of care in the MH system, a DDE service is no more costly than a comparable DDC service. Creation of appropriate DDE services in a system with adequate baseline capacity often involves designating some of those services as DDC, and the remainder as DDE, in the planning process.

Characteristics of DDE-MH programs vary according to the type of program. All programs meet DDC criteria, plus additional criteria as follows.

1. One type of program involves provision of an active addiction treatment program in a mental health environment such as an inpatient psychiatric unit, partial hospitalization program, or mental health group residential setting.

    a. The program staff has increased training in addiction with available supervision by credentialed addiction staff.
    b. Program content includes substantial addiction focus (approximately half time as a minimum.), with strong connections to standard (e.g., 12-Step) and dual recovery programs.
    c. Program policies address abstinence expectations, and make provisions for transfer to a setting with lower expectations if the individual lapses.

2. The second type of program emphasizes motivational enhancement interventions for individuals with active substance disorders and severe psychiatric illnesses that are very disengaged: e.g., continuous treatment teams, “wet” housing programs.

    a. Program staff has increased training and experience in working with actively using individuals with severe substance disorders.
    b. Programs incorporate motivational interventions, along with contingency management (e.g., payee-ships), and intensive case management, maintaining continuity with clients who are very disengaged.

3. The third type of program incorporates a range of phase-specific treatment options into a comprehensive program setting that emphasizes working with individuals with co-occurring disorders. Examples include: dual diagnosis specialized continuing day treatment, dual diagnosis specialized damp housing, as well as combinations of services in a comprehensive continuum.

    a. Program staff members have increased training and access to supervision, as above.
    b. Programs have a full range of phase-specific interventions, including connection to dual recovery programs.
    c. Programs have substance use policies that clarify consequences for various types of behavior in each phase of treatment, and procedures for connecting program contingencies to motivational enhancement strategies.
    d. Programs incorporate a combination of continuing care strategies with interventions attached to increased expectation.

Housing Programs

In addition, as described in the AACP Position Statement on Housing Options for Individuals with SPMI, the comprehensive system of care in each local service area must include a full range of housing options for individuals with co-occurring disorders. In particular, psychiatric housing programs (which provide or support a place to live for individuals with psychiatric disability, in order to prevent homelessness) must be distinguished from addiction (or psychiatric) residential treatment programs (which provide episodes of treatment in a residential setting, usually with defined expectations or requirements). Both are important components of a comprehensive system of care.

In most service areas, the addiction treatment system provides a range of addiction residential treatment programs (both DDC-CD and DDE-CD) and sober housing programs (e.g., Oxford House model programs), all of which need to be abstinence-expected programs in order to protect the integrity of the addiction recovery support provided. Individuals who enter these settings are seeking a sober recovery environment, not merely housing, and expect these requirements to be enforced. Ideally, all such individuals have a plan for housing in the event that they fail to meet program requirements and are prematurely discharged.

The mental health system, by contrast, provides mainly housing support programs for individuals with SPMI. Many of these individuals have co-occurring substance use disorders, but vary in their willingness to define substance use as a problem and/or identify sobriety as a goal, even though they may desire assistance to maintain stable housing. Some of these individuals are simply unable or unwilling to limit substance use, even when all housing supports available require such limits; these individuals frequently become homeless as a result.

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring disorder) who need housing assistance due to psychiatric disability, and who are at risk of homelessness, MUST include the following choices:

~~a.~~1. **Abstinence-expected ("dry") housing**: This model (usually a DDE-MH program) is most appropriate for individuals with co-morbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. This model may also be appropriate for individuals with no substance disorder who wish to live in an abstinent environment. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than "one strike and you're out."

~~b.~~2. **Abstinence-encouraged ("damp") housing**: This model (which can be either DDC or DDE) is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than substance use per se. Motivational enhancement interventions are usually built in to program design.

~~c.~~3. **Consumer-choice ("wet") housing**: This model of DDE-MH housing has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (cf. Tsemberis & Eisenberg, "Pathways to Housing Program" in Psychiatric Services, April 2000). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

Each system needs to assess housing needs across all three options and provide an appropriate balance of availability. Consumers with psychiatric disabilities who need housing support, including those who choose to enter dry housing but are unsuccessful in remaining sober, should not be left homeless simply because of inability or unwillingness to maintain abstinence.

Attachment C

Adapted, with permission from the author, from: Matthews, C. O. (2001). Principles of care for persons with co-occurring addictive and mental disorders. (Suncoast Practice and Research Collaborative Practice Brief, Vol. 1, # 2). Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Different Treatment Models for Co-occurring Disorders

There are a number of different treatment models for people with co-occurring disorders. These include:

- **No Treatment** – the most common, and least effective model.
- **Sequential Treatment** – the client first goes through the substance abuse treatment system followed by treatment in the mental health system, or vice versa.
- **Parallel Treatment** – the client receives services in both mental health and substance abuse treatment settings at the same time.
- **Integrated Treatment** – the client receives treatment for both types of disorders at the same time and in the same service setting, with staff who are cross-trained to address both mental and substance disorders concurrently.

Which Treatment Model Works Best?

- Although both sequential and parallel treatment models work better than no treatment, they tend to be largely ineffective, especially for more severe clients. One problem with these two treatment models can be that they give the client different messages about what they need to do to recover. Clients with co-occurring disorders are often the least able to integrate these different messages and navigate two different treatment systems.
- For example, clients with co-occurring disorders commonly receive different messages from the substance abuse and mental health treatment systems regarding psychiatric medications. While the official position of national 12-step organizations is to be supportive of the use of non-addictive psychiatric medications when needed and used as prescribed, some local substance abuse treatment programs or recovery self-help groups may discourage the use of any medications, including ones prescribed for clients by the mental health system in order to stabilize their mental illness. This opposition to medication is usually based on a misconception that psychiatric medications are addictive, when the vast majority of them are not. Non-addictive psychiatric medications include antidepressants to treat depression, mood stabilizers to treat bipolar disorder, and anti-psychotics to treat psychotic disorders such as schizophrenia. When clients with severe

mental illness stop their psychiatric medications without consulting their doctor, this puts them at a much higher risk for relapsing into both mental illness and substance abuse.

- As described in a review by Drake, Mercer-McFadden, Mueser, McHugo, and Bond (1998), clients with co-occurring disorders who receive traditional non-integrated treatment often have high drop-out rates and achieve little to no reduction in substance use. Their research indicates that **integrated, long-term, comprehensive treatment programs, which include assertive outreach and motivational interventions, are most likely to retain SPMI clients with co-occurring disorders and help them achieve meaningful reductions in substance use.**

Ten Principles of Care for Co-Occurring Addictive and Mental Disorders

As outlined below, Osher (1996; see also Drake et al., 1993) described principles of care for a service system responsive to those with co-occurring substance use and mental disorders.

- **Integration of treatment** – both mental and substance disorders and symptoms are addressed in the same treatment program during the same time period, with staff cross-trained in both areas of treatment.

- **Individualized Treatment Based on Valid Assessments** – people with co-occurring disorders come in many different varieties, with different co-occurring disorders, life problems and unique needs. Therefore individualized treatment based on accurate and comprehensive assessments of their unique strengths and needs is necessary. A standardized comprehensive assessment should include a combination of screening instruments, client interviews, and interviews with collaterals, such as family members or other caregivers. It is important to get information from sources other than just the client if possible because clients with co-occurring disorders may have impaired memory or other cognitive impairments, or may be motivated to hide certain aspects of their illnesses. Additionally, it may be difficult to accurately diagnose persons with co-occurring disorders because of the complexity of their clinical presentation, especially during a crisis. For instance, cocaine abuse can induce a temporary psychosis that mimics paranoid schizophrenia.

- **Assertiveness** – people with co-occurring disorders often need more assertive treatment and outreach than has traditionally been provided. For instance, for more severe cases, this may include Assertive Community Treatment (ACT), in which a team of case managers provides ongoing, long-term follow-up and coordinates all aspects of a clients life (housing, finances, physical health, recreation, mental and substance abuse treatment, educational or vocational rehabilitation, etc.) while keeping clients stable enough to remain in the community.

- **Close Monitoring** – as part of assertive treatment, close monitoring keeps clients from "falling through the cracks" in the system. For example, it may include designating a payee to manage disability or other monetary benefits, as well as regular urinalysis drug screens.

The level of monitoring may be able to be reduced as a client improves and moves through the stages of treatment, or conversely, it may need to be increased if the client has a relapse.

- **Longitudinal Perspective** – like diabetes and heart disease, co-occurring disorders are typically chronic, relapsing illnesses requiring long-term treatment. Additionally, over time mental and substance-related symptoms present increases and decreases in severity, and not necessarily at the same time.

- **Stable Living Situation** – in order for integrated substance and mental treatment to be effective, people with co-occurring disorders must first have a stable living situation. Some people with co-occurring disorders who have not yet stopped using substances may need to first be housed in "wet" housing, in which there is no prohibition against use, but which has minimal rules with treatment outreach. The next stage of housing can be classified as "damp" housing, in which residents are prohibited against use or intoxication at home, with continued treatment outreach. Once a patient is able to maintain abstinence, then they can be placed in "dry" housing, which accepts only complete abstinence. The problem with having no wet or damp housing in a community is that it keeps potential co-occurring disorders clients homeless, which keeps them from being able to be engaged in effective treatment, thus continuing the cycle of addiction and homelessness.

- **Harm Reduction Strategies** – Rather than expecting immediate and complete abstinence, which is often unrealistic for people with co-occurring disorders who are living in the community, it is often more effective to persuade them to gradually cut back on the types and amounts of drug use. For instance, if a client cuts out cocaine but continues to use alcohol, this can be seen as a partial success on the road to recovery, rather than a failure of abstinence.

- **Stages of Treatment** – Osher's phasic model of treatment acknowledges that people who have co-occurring disorders may initially have little motivation to receive treatment, and uses motivational enhancement techniques (e.g., Miller and Rollnick, 1991; 2002) as part of treatment. Clients typically do not go through these in an orderly progression, but the stages do give clinicians a guiding framework to know what kind of treatment is needed based on level of motivation for recovery, with the goal of eventually moving clients to the next stage. The stages of treatment include:

  A. <u>Engagement</u> – establishing a relationship with people with co-occurring disorders in the community through outreach and letting them see that you have some benefit to offer them, such as housing, financial assistance, etc.

  B. <u>Persuasion</u> – once a relationship is established, motivational interviewing techniques are used to help clients identify why they wish to enter treatment and help them persuade and motivate themselves to enter treatment

  C. <u>Active Treatment</u> – entering an integrated treatment program, which may include individual and group treatment, psychiatric medications, abstinence, etc.

D. <u>Relapse Prevention</u> – maintaining abstinence and keeping mental illness symptoms manageable after active treatment. Relapse prevention includes training to help people limit the damage of a slip in abstinence to keep it from becoming a full-blown relapse, by being prepared for a slip or an increase in mental illness symptoms if it happens.

- **Cultural Competency and Consumer Centeredness** –the clinician tries to see things from the client's perspective, and actively seeks to get help from the client to understand their perspective. This is particularly important because clinicians and clients with co-occurring disorders are often of different cultural or ethnic groups. When clinicians are culturally sensitive, they are better able to truly understand a client's needs, allowing them to help the client learn more adaptive ways of meeting those needs.

- **Optimism and Recovery** – clinicians, researchers, trainees, clients, and policy makers all need to develop and maintain optimism about the ability to recover from co-occurring disorders in spite of the reality of the multiple problems that need to be overcome. It is important to remember that people with co-occurring disorders deserve help. Communities need to develop a creative vision to address co-occurring disorders and take incremental steps toward implementing it. For instance, a "No Wrong Door" approach can be an ideal to work toward in developing a continuum of care, so that any place in the system a person with co-occurring disorders arrives, they get appropriate care.

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