

# SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

## POLICY AND PROCEDURE MANUAL

Section: Clinical  
Policy Number: 72  
Subject: **Co-Occurring Treatment**

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### Policy

It is the policy of the Shiawassee County Community Mental Health Authority (SCCMHA) that individuals and families experiencing co-occurring psychiatric and substance use disorders obtain services that are accessible as well as recovery oriented. The services will be consistent within the Comprehensive Continuous Integrated System of Care (CCISC) model, and such services will be delivered in a welcoming and cultural competent environment where no door is a wrong door. The integration of best practices with an individualized, person centered philosophy based on an accurate assessment of the needs, strengths, values, and preferences of the consumers is expected. In addition, services are highly responsive to the degree of service coordination the individual requires, that is to provide the most appropriate interventions throughout the continuum of care.

### Purpose

The purpose of this policy is to ensure the highest quality and most effective system of care for individuals and families experiencing co-occurring disorders. SCCMHA recognizes that this population is associated with poor outcomes and high service cost in multiple clinical domains. While no single approach has proven effective, research has demonstrated that integration of services with stage treatment are most likely to produce desired outcomes. The main goal is to provide consumers with timely and easy access to the most current best practices and support services.

### Application

All SCCMHA staff and contracted providers.

### Definitions

Comprehensive, Continuous, Integrated System of Care (CCISC): The 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 (Minkoff, 2000).

Co-occurring Disorders (COD): Co-occurring disorders also known as dual diagnosed disorders, are defined as one or more diagnosable mental illnesses, severe emotional

disorder or developmental disorder occurring for an individual who also experiences a diagnosable substance use disorder. Diagnosable illnesses are defined by the Diagnostic and Statistical Manual current edition (DSM-IV-TR).

Dual Diagnosis Capable: The program assesses for clinicians current attitudes, values, knowledge and skills in relation to the CCISC principles. Dual Diagnosis capable programs are conceptualized as having a primary focus on treatment of substance-related disorders, but are also capable of treating clients who have a relatively stable diagnostic or sub-diagnostic co-occurring mental health problem related to an emotional, behavioral or cognitive disorder.

Dual Diagnosis Enhance: These are programs that are designed to treat clients who have more unstable or disabling co-occurring mental disorders in addition to their substance related disorders.

Evidence-Based Practice (EBP): Reduced to the most core understanding, EBP is defined as the coming together of these elements: The knowledge and skills of the practitioner, the desires and values of the consumer, and the best research evidence that links a particular intervention with a desired outcome (Turning Knowledge into Practice, 2003).

A general definition of EBP found in the Michigan Mental Health Commission Part I: Final Report October 15, 2006, page 54, defines EBP as, “The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, S.E. Strauss, WS Richarson, 2004).

Best Practices: Perhaps most simply understood as the closest fit between what we know, based on science, and what we can actually do in the present circumstances. They are practices that have been rigorously tested using controlled research designs.

Promising Practices: Interventions that are well known and have expert consensus or other support but which haven’t been as rigorously evaluated scientifically.

Emerging Practices: They are very specific approaches to problems or ways of working with particular people that receive high marks for consumers and/or clinicians, but which are used too little or by too few practitioners to have received general, much less scientific attention.

Four Quadrant Model: The four quadrant model is used as a guide for service planning on the system level. In this model, individuals with co-occurring psychiatric and substance use disorders can be divided according to high and low severity for each disorder: High Mental Health (MH)-High Co-occurring Disorder (CD) (Quadrant IV), Low (MH)- High (CD) (Quadrant III), High MH– Low CD (Quadrant II), and Low (MH)-Low (CD) (Quadrant I).

Integrated Dual Diagnosis Treatment (IDDT): A model of evidence based practice used to provide treatment to individuals with co-occurring disorders of a serious mental illness and who have serious a mental illness and serious substance use disorder. In this treatment model a clinician or treatment team provides both mental health and substance use disorder services.

Person Centered Planning (PCP): A process for planning and supporting the individual receiving services that builds upon individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the individual desires or requires.

Recovery: To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over 110 experts discussed and agreed to the following consensus statement: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential".

## **Procedures**

To provide services that are consonant with an integrated system the SCCMHA has adopted the CCISC model developed by Minkoff, 1998, 2000. The model provides eight research-based and consensus-driven principles that will guide the implementation of the CCISC as follows:

1. Dual diagnosis is an expectation, not an exception.
2. Successful treatment is based on an empathic, hopeful, integrated and continuing relationship.
3. Treatment must be individualized utilizing a structured approach to determine the best treatment. The national consensus "four quadrant model" for categorizing individuals with co-occurring disorders will be used to organize treatment matching.
4. Case management and clinical care must be properly balanced with empathic detachment, opportunities for empowerment and choice, contacting and contingent learning.
5. When mental illness and substance use disorder co-exist, each disorder is *primary*.

6. Treatment must be matched to the phase of recovery.
7. There is no one correct approach (including psychopharmacologic approach) to individuals with co-occurring disorders.
8. Clinical outcomes for individuals with co-occurring psychiatric and substance disorders must also be individualized, based on similar parameters for individualizing treatment interventions.

### **Implementation Characteristics**

Using the eight principles, implementation of the CCISC is based on the following four core characteristics:

1. System Change Level - The CCISC system requires a cooperative merger between mental health and substance use systems, with the goal of achieving co-occurring capability standards as well as the capacity to provide dual diagnosis enhanced services when needed.
2. Efficient Use of Existing Resources - The CCISC will be implemented within the context of the existing resources. The goal is to establish a system that eliminates duplication of services while improving consumers' outcomes.
3. Incorporation of Best Practices - 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 individuals with co-occurring psychiatric and substance disorders 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 common language that makes sense from the perspective of the mental health and substance disorder clinicians.

### **Clinical Practice Guidelines**

#### **A. Welcoming and Accessibility**

1. As stated in the Access Alliance Affiliation Partners and Riverhaven Coordinating Agency 2007 Regional CCIS Consensus Agreement a welcoming philosophy is an expectation in all elements of system access and care. SCCMHA will work in accurately identifying, reporting and tracking individuals experiencing co-occurring disorders, to get them connected to suitable services.

2. Individuals who experience co-occurring disorders are considered a high risk, high priority population; therefore staff will engage these consumers in an empathic, hopeful and welcoming atmosphere.

#### B. Screening and Referral

1. In accordance with SCCMHA's Enrollment Screening and Referral Policy, screening for individuals seeking services will include mental, medical, and substance use treatment history as well as screening for mental status, identification of a co-occurring disorder, provisional diagnosis, disability determination, and a narrative section indicating other pertinent information. The information will be entered into SCCMHA's record keeping system.
2. The integrated screening is a formal process of testing to determine whether a person warrants further attention at the current time in regards to a mental health disorder along with a substance use disorder, each in the context of the other.
3. Consumers are not required to have any length of sobriety to access screening, assessment, or psychiatric services.
4. SCCMHA uses a uniform screening procedure for the purposes of: promoting access, determining benefit eligibility, establishing medical necessity and level of care criteria, preauthorizing and authorizing the provision of substance use, mental health and ancillary services for persons experiencing Severe and Persistent Mental Illness (SPMI), Severe Emotional Disturbance (SED) and Mental Retardation or Developmental Disability (MR/DD). A standardized screening tool is used to assist in the determination of the presence of a co-occurring disorder.
5. SCCMHA endeavors that consumers admitted to inpatient psychiatric facilities have uncomplicated access to those substance abuse services deemed clinically appropriate as determined by clinical screening and/or assessment. In addition, assigned SCCMHA staff attempt to coordinate placement to ensure that services will be available on the day of the discharge from the facility.
6. Initial screening and assessment may determine that an individual needs co-occurring service delivery system, however clinicians and/or clinical teams may provide a more comprehensive assessment which serves as the basis for making a decision about offering services to individuals within a single agency or to offer some of the services directly, with additional services delivered in close coordination with other community agencies. A decision about co-occurring enhanced services may also be offered to the individual.

### C. Integrated Assessment

1. Integrated assessment and diagnosis takes into consideration both mental illness and substance use disorders and identifies the nature of the disorders. This process begins immediately after the consumer has been welcomed into care, assessment of safety has been completed, and the consumer or family is capable of giving information. Assessment of needs, preferences and stage of change is an ongoing process in the entire course of treatment.
2. Mental health disorders and substance use disorders are both considered primary diagnoses.
3. Staff will collect information including chronological history of mental health and substance use disorders, cultural implications, onset of disorders, interactions, medication history, effects of treatment and periods of stability or relapse.
4. Staff will collect information from family members or other individuals when the consumer agrees to give informed consent for release of information.
5. Assessment should include: stage of treatment, engagement, motivation, action, and relapse prevention.
6. Continued re-evaluation of diagnosis and treatment responses is expected at least every 90 days (periodic reviews).
7. Assessment of comorbid conditions: Individuals with co-occurring disorder may be asked about trauma history, cognitive disorders, personality traits, personality disorders, and medical conditions. Further assessment needs will be identified in the assessment.
8. Clinicians use the four quadrant framework to consider the levels of coordination needed. These decisions are based on the nature and functional severity of the individual's disorder and the primary location of their care, either in the mental health or substance use disorder service delivery system. Moving from consultation (lower left section of the framework) through collaboration (mid-range) to integrated care (upper right section of framework), it is understood that increasingly serious disorders require greater and more intensive levels of expertise such as staff trained in specific treatment modalities.
9. If during the assessment or re-assessment recommendations are made for the use of co-occurring enhanced services, the assigned clinical team or clinician will initiate an assessment utilizing tools compatible to the EBP criteria.

10. Individuals receiving substance use disorder treatment should be given the Know Your Rights booklet. The booklet contains information regarding a consumer's rights under 42 FR 552.1 to 552.67 – e., June 9, 1987.

#### D. Treatment Interventions

1. It is expected that over time all programs will achieve co-occurring capability, with the capacity for offering co-occurring enhanced services that provide some type of EBPs suited to the condition of individuals seeking mental health and/or substance use services. During the screening and re-assessment processes clinicians will attempt to identify any individual who could benefit from an EBP or a combination of EBPs, such as Integrated Dual Disorder Treatment (IDDT), Assertive Community Treatment (ACT), Family Psychoeducation (FPE), Supported Employment (SE), Illness Management and Recovery (IMR), or other EBP practices modalities. When an existing EBP is appropriate to a given individual that EBP should be used. When there is no EBP appropriate every effort should be made to seek out and offer treatment that has some basis in science rather than a random choice.
2. Integrated mental health and substance use interventions are provided by the same clinician in one setting or a multidisciplinary team of clinicians. At least one clinician will need to be qualified to address substance use disorders.
3. SCCMHA's Person Centered Planning Policy ensures consumers will be assured the process is in accordance with the Michigan Department of Community Health (MDCH) Best Practices Guideline for Person-Centered Planning.
4. Treatment will be individualized using a structured approach to determine the best treatment. The "four quadrant" model for categorizing individuals with co-occurring disorder will be used as a first step to organize treatment.
5. Effective interventions during the course of treatment need to be stage specific. Phase of Recovery/Stage of Change/Stage of Treatment: The literature on Co-Occurring disorders has identified four phases of recovery (Minkoff 1989): acute stabilization, motivational enhancement/engagement, prolonged stabilization (active treatment/relapse prevention) and rehabilitation and recovery; five stages of change (Prochaska & DiClemente, 1992): pre-contemplation, contemplation, preparation, action and maintenance; four stages of treatment for seriously mentally ill individuals with substance disorders (Osher & Kofoed, 1989): engagement, persuasion, active treatment and relapse prevention.
6. Each person receives services and supports through one integrated plan of services that addresses mental health and substance use disorders.

7. Safety is a primary concern and it is assessed initially at the screening, again at intake assessment, during Person Centered Planning Pre-Plan, during Person Centered Plan, and the Crisis Plan as well as throughout the treatment process. If a safety concern rises, the primary worker will assist the consumer to develop or update the safety plan.

#### E. Continuity and Coordination of Care

1. Often consumers are part of other systems of care, therefore coordination, integration and collaborative interactions with other systems in the consumer's behalf is expected. This approach leads the consumer into a "no wrong door" philosophy where the goal is coordinated care.
2. SCCMHA will obtain information related to the consumer's mental health needs during the consumer's initial screen. Responses will be recorded in the consumer's access screening. This includes whether the consumer meets eligibility criteria for mental health services through the Prepaid Inpatient Health Plan (PIHP).
3. SCCMHA will forward a letter of coordination of care to the consumer's Medicaid Health Plan (MHP) in the following situations: all new eligibility assessments and all service denials resulting in a notice of adverse action.
4. SCCMHA will complete the appropriate intake assessment for determination of needs.
5. The consumer handbook shall reference the coordination of care with the MHP procedure to communicate that each Medicaid enrollee is to have an ongoing source of primary behavioral healthcare provider appropriate to his/her needs and that there is a person formally indentified as being primarily responsible for coordinating the consumer's healthcare services.
6. SCCMHA staff will work toward facilitating continuity and coordination of care, including coordination with the consumer's primary healthcare provider.

#### F. Recovery and Relapse Prevention

1. The treatment of co-occurring disorders must blend both substance use and mental health issues, with each applied at appropriate times and situations according to the clients' needs. The goal is to integrate individuals into community settings, encourage them to use their natural supports in their community and promote awareness and resilience.

2. Individuals will be provided with an integrated system of care in which psychiatric care, physical care, housing, education and employment services are coordinated and explored.
3. The process of recovery focuses on valuing and building on strengths and takes into consideration self directions, individualized and person centered/ individual-driven approach, empowering individuals to participate in all decisions that will affect their lives. The recovery process is also associated with a holistic approach in which mind, body, spiritual needs and community are explored.
4. SCCMHA will support and actively pursue the competitive employment of individuals of working age who experience mental illness, developmental disabilities and serious emotional disturbances. This policy is also extended to individuals with Co-occurring disorders. Employment opportunities will be pursued and explored when the individual requests it even when the individual is actively using substances.
5. SCCMHA shall have a peer support program available. Information about the availability of Peer Support Services will be provided to individuals when they first access services and throughout the course of their treatment. Staff will assure that referrals are made for this service when the individual requests the service.
6. The recovery process also includes respect for the individuals including protecting their rights and eliminating discrimination and stigma. The individual assumes responsibility for their own self care and journey toward recovery. Recovery provides a sense of hope.
7. SCCMHA will support individuals who experience mental illness and/or co-occurring disorders of a mental illness and a substance use disorder in assuming active control of their recovery process and prevention of relapse. SCCMHA will structure a delivery system to minimize dependency.

#### G. Secondary Interventions for Substance Use Disorder Treatment Non-Responders

1. If, after a review of progress and several attempts with various intervention strategies, the individual does not respond to treatment, interventions will be used that are consonant to the IDDT model and co-occurring best practices.
2. Secondary interventions are more intensive and require a higher level of care.

#### H. Discharge

1. Planning for discharge begins at the time of assessment. The process involves careful planning to assist the individual to become more independent and self sufficient and will be based on individual needs. Individuals are actively involved in the discharge planning and this is conducted in a person centered approach.
2. SCCMHA will follow its policies to address reduction of services as well as discharge planning.

#### **Attachments**

1. 2007 Access Alliance Affiliation Partners and Riverhaven Coordinating Agency: Regional Comprehensive, Continuous, Integrated System of Care Consensus Agreement.
2. Comprehensive, Continuous, Integrated System of Care (CCISC) model, Kenneth Minkoff M.D., 2000.
3. Comprehensive Continuous Integrated System of Care (CCISC): Psychopharmacology Practice Guidelines for Individuals with Co-Occurring Psychiatric and Substance Use Disorders (SUD), Kenneth Minkoff M.D., January, 2005.

#### **Related Forms**

N/A

#### **Related Materials**

Definitions and standards for co-occurring enhanced services  
Integrated Dual Disorders Treatment (IDDT) Toolkit  
Access to consultants to assist with organizational and practices change

#### **References/Legal Authority**

1. SCCMHA Clinical and Recipient Rights Policies
  - a. Clinical Policy 8 "Person Center Planning"
  - b. Clinical Policy 25 "Recovery and Relapse Prevention"
  - c. Clinical Policy 26 "Employment"
  - d. Clinical Policy 18 "Peer Assistance Program"
  - e. Clinical Policy 22 "Target Population"
  - f. Recipient Rights Policy 45 "Enrollment Screening and Referral"

- g. AAM Policy and procedure 4.5 “Referral Process for Consumers in an Inpatient Psychiatric unit seeking Substance Abuse Services”
  - h. Clinical Policy 16 “Continuity and Coordination of Care”
  - i. Clinical Policy 39 “Coordination of Care
  - j. Recipient Rights Policy 41 “Clinical Protocols”
2. Behavioral Health Recovery Management: Service Planning Guidelines: Co-Occurring Psychiatric and Substance Disorders (The Behavioral Health Recovery Management Project is an initiative of Fayette Companies, Peoria, IL; Chestnut Health Systems, Bloomington, IL; and the University of Chicago Center for Psychiatric Rehabilitation, the project was founded by the Illinois Department of Human Services Office of Alcoholism and Substance Abuse) Kenneth Minkoff M.D., 2001
  3. Co-Occurring Disorder Treatment Workbook 2002, Department of Mental Health Law and Policy, Louis De La Parte Mental Health Institute, University of South Florida
  4. Co-Occurring Disorder Treatment Manual 2002, Department of Mental Health Law and Policy, Louis De La Parte Mental Health Institute, University of South Florida
  5. Commissioner’s Policy Statement Number 84 Servicing People with Co-Occurring Mental Health and Substance Use Disorders, Connecticut, January 11, 2007
  6. Huron Behavioral Health Policy: Procedure SD1.14 “Welcoming Policy”
  7. Integrated Treatment for Co-Occurring Disorders: A Guide to Effective Practice, Kim T. Mueser, Douglass L. Noordsy, Robert E. Drake and Lindy Fox., The Guilford Press 2003
  8. Michigan Mental Health Commission Report (FY 2006 Appropriation Bill – Public Act 154 of 2005)
  9. Oneida County Charter and Consensus Agreement: Co-Occurring Psychiatric and Substance Use Disorders
  10. SAMHASA’s Treatment Improvement Protocol (TIP) # 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders
  11. San Francisco Community Behavioral Health Services: Integration Consensus Agreement - Developing an integrated system and integrated services for adults, older adults, youth and their families with psychiatric and/or substance disorder, April 2005
  12. State of Alaska: Charter Document: Consensus on Co-Occurring Mental Health and Substance Disorders. (version 11/8/04)

13. Transforming Mental Health Care in Michigan: A plan for implementing Recommendations of the Michigan Mental Health Commission, Michigan Department of Community Health, April 2005
14. Turning Knowledge Into Practice: A manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices. The technical Assistance Collaborative, Inc., 2003.
15. 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee—3 for Federal laws and 42 CFR part 2 for Federal regulations

Approved by: *Jerry Walden*  
Board Chairperson

9/23/08  
Date

*Scott Gilman*  
Chief Executive Officer

9/23/08  
Date

